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The Estimated Effects of the Affordable Care Act on Medicare

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by

Richard S. Foster, F.S.A.
Chief Actuary
Centers for Medicare & Medicaid Services

Chairman Camp, Representative Levin, distinguished Committee members, thank you for inviting me to testify today about the financial and other impacts on the Medicare program from the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

I would like to begin by saying a little about the role of the Office of the Actuary at the Centers for Medicare & Medicaid Services. We have the responsibility to provide actuarial, economic, and other technical assistance to policy makers in the Administration and Congress on an independent, objective, and nonpartisan basis. Our highest priority is to help ensure that policy makers have the most reliable technical information possible as they work to sustain and improve Medicare and Medicaid. The Office of the Actuary has performed this role on behalf of Congress and the Administration since the enactment of these programs over 45 years ago. We have also provided actuarial estimates for various past national health reform initiatives, including the proposed Health Security Act in 1993-1994 and the Affordable Care Act as it was developed and enacted in 2009-2010.

I am appearing before your Committee today in my role as an independent technical advisor to Congress. My statements, estimates, and other information provided in this testimony are my own and do not represent an official position of the Department of Health & Human Services or the Administration. Unless noted otherwise, the estimates used in this testimony are drawn from my memorandum of April 22, 2010, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," and from *The 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These reports and the other documents to which I refer are available on the CMS website at <http://www.cms.gov/ActuarialStudies/>. We are in the process of updating many of these estimates for use in the President's 2012 Budget, the 2011 Medicare Trustees Report, and a forthcoming article on national health expenditure projections. Although some of the updates will be significant, they will not substantially change the overall outlook for the effects of the health reform act on Medicare as described in this testimony.

Affordable Care Act

The March 2010 health care reform legislation, generally known as the Affordable Care Act, affects nearly every aspect of health care in the U.S. As noted in my April 22, 2010 memorandum, the Affordable Care Act will significantly increase the proportion of people in the U.S. with health insurance by expanding eligibility for Medicaid and by implementing Federal premium and cost-sharing subsidies for individuals and families with incomes below 400 percent of the Federal Poverty Limit. Many of the Act's provisions apply to the Medicare program,

resulting in lower costs and additional revenues. As part of the changes expected to have a significant financial effect on Medicare, the Act:

- Reduces “market basket” payment updates by varying amounts by type of provider during 2010-2019 and permanently reduces the annual Medicare payment updates for most categories of providers by the increase in economy-wide multifactor productivity (approximately 1.1 percent per year).
- Reduces Medicare Advantage payment benchmarks and rebate percentages, varies rebate percentages and plan bonuses by plan quality ratings, and permanently extends the authority to adjust for coding intensity.
- Reduces Medicare disproportionate share hospital (DSH) payments, refines imaging payments, expands competitive bidding for durable medical equipment, and eliminates the 2014 spending authority for the Medicare Improvement Fund.
- Creates an Independent Payment Advisory Board together with Medicare expenditure growth rate targets for the purpose of slowing Medicare cost growth. The Board’s proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings over a 10-year period.
- Increases payment rates for rural providers.
- Increases the HI payroll tax rate by 0.9 percentage point for individuals with earnings above \$200,000 and families above \$250,000 and raises Part D premiums for single enrollees with incomes above \$85,000 and couples above \$170,000. Freezes income thresholds for Part B and Part D income-related premiums at 2010 levels through 2019.
- Phases out the Part D coverage gap (“donut hole”) and reduces payment rates for Part B and Part D biosimilar generic drugs.
- Initiates numerous steps to improve the quality of Medicare services, including reporting of physician quality measures, reducing payments in cases of hospital-acquired infections, reducing payments for hospital readmissions, and implementing evidence-based coverage of preventive services.
- Adds certain new preventive health services, including coverage of an annual wellness visit, and eliminates remaining cost-sharing requirements on most preventive services.
- Expands existing programs and adds new ones to combat fraud and abuse in Medicare.
- Creates a Center for Medicare and Medicaid Innovation in CMS for testing alternative models of health care delivery systems, payment methods, etc. and establishes a Medicare Shared Savings Program for accountable care organizations (ACOs). In addition, begins (or extends funding for) a series of demonstrations and pilot programs designed to evaluate specified payment methodologies and incentives and implements additional value-based purchasing programs.

Estimated impacts of Affordable Care Act on Federal expenditures and total national health expenditures

It is useful to consider the financial effects of the Affordable Care Act on Medicare in the context of the Act’s overall impacts on the Federal Budget and on total national health expenditures. There has been some confusion in the press and elsewhere regarding these two

sets of results. The legislation is estimated to substantially increase gross Federal expenditures in support of expanded health care coverage (approximately \$948 billion total in fiscal years 2010-2019), with about half of this cost offset by lower Medicare expenditures (\$486 billion). The net increase in Federal health expenditures is thus about \$462 billion over the period, with this budgetary cost offset by other provisions such as the penalties from nonparticipating employers and individuals plus additional Medicare and other revenues.

The budgetary impacts described above are similar in some ways to the effect of the Affordable Care Act on total health expenditures in the U.S., but the two concepts are fundamentally different. For example, in certain instances the Act increases the share of existing Medicaid expenditures paid by the Federal government. These changes will raise Federal spending on health care but have little or no impact on overall national health expenditures. Conversely, the excise tax on high-cost employer health insurance plans is expected to reduce total health expenditures in 2018 and later, with minimal impact on Federal health expenditures. Both financial measures are useful and legitimate for their intended purposes, but one cannot be used to answer questions related to the other. The balance of this section describes the Federal budget and national health expenditure impacts in more detail.

As shown in my April 22, 2010 memorandum, the Affordable Care Act is estimated to reduce the number of uninsured persons in the U.S. by 34 million in 2019. The following table summarizes the estimated financial effects of selected provisions of the Affordable Care Act on the Federal Budget in fiscal years 2010-2019.

Estimated Federal costs or savings under selected provisions of the Affordable Care Act

[Costs (+) or savings (-) in billions]

Provisions	Fiscal Year										Total, 2010-19
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
Total*	\$9.2	-\$0.7	-\$12.6	-\$22.3	\$16.8	\$57.9	\$63.1	\$54.2	\$47.2	\$38.5	\$251.3
Coverage†	3.3	4.6	4.9	5.2	82.9	119.2	138.2	146.6	157.6	165.8	828.2
Medicare	1.2	-4.7	-14.9	-26.3	-68.8	-60.3	-75.2	-92.1	-108.2	-125.7	-575.1
Medicaid/CHIP	-0.9	-0.9	0.8	4.5	8.6	5.1	4.6	3.4	1.3	1.7	28.3
Cost trend‡	---	---	---	---	-0.0	-0.1	-0.2	-0.4	-0.6	-0.9	-2.3
CLASS program	---	-2.8	-4.5	-5.6	-5.9	-6.0	-4.3	-3.4	-2.8	-2.4	-37.8
Immediate reforms	5.6	3.2	1.2	---	---	---	---	---	---	---	10.0

* Excludes Title IX revenue provisions except for sections 9008 and 9015, certain provisions with limited impacts, and Federal administrative costs.

† Includes Federal costs for coverage expansion through expanded Medicaid eligibility, additional funding for CHIP, tax credits for small employers who offer coverage, and premium and cost-sharing subsidies for private health insurance coverage through Exchange policies, less Federal receipts from penalties for large employers who do not offer coverage and for affected individuals who do not obtain health insurance coverage.

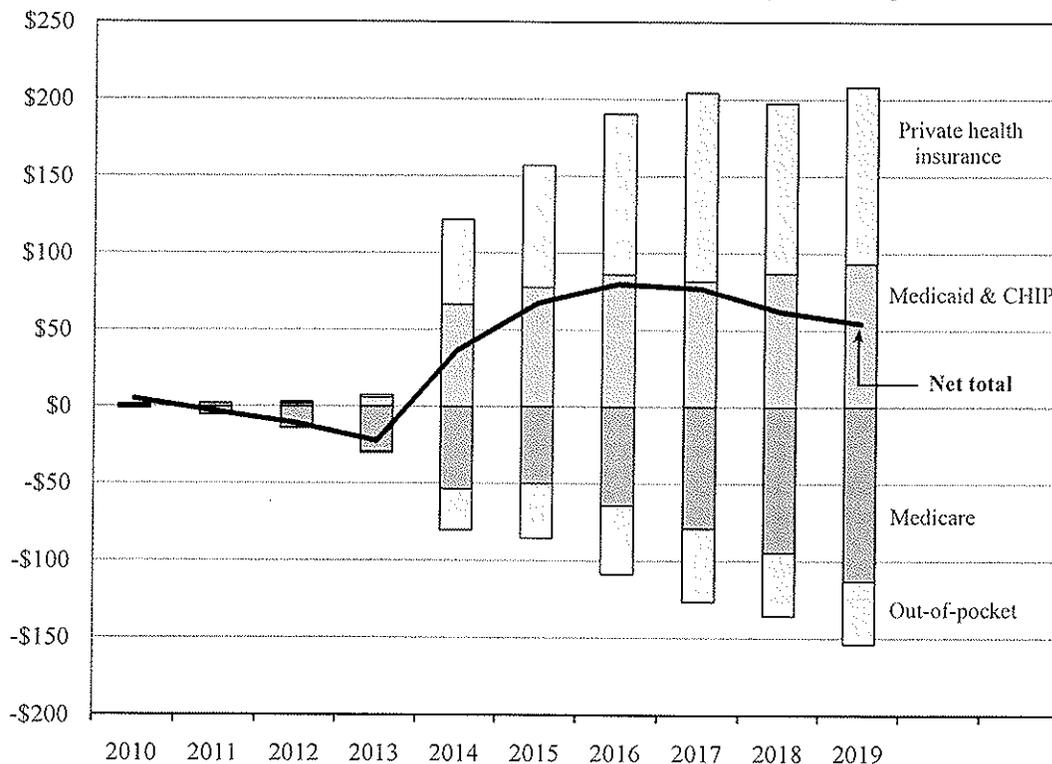
‡ Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare payment rates (which are reflected in the Medicare line) and the section 9001 excise tax on high-cost employer plans.

As indicated, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes and extended funding for the Children’s Health Insurance Program) are estimated to cost \$828 billion through fiscal year 2019, net of penalty receipts from nonparticipating individuals and employers. The Medicare, other Medicaid and CHIP, growth-trend, CLASS, and immediate reform provisions are estimated to result in net savings of about \$577 billion, leaving a net overall cost for this period of \$251 billion before consideration of additional Federal administrative expenses and the increase in Federal revenues that would result from the excise tax on high-cost employer-sponsored health insurance coverage and certain other revenue provisions. (The new Supplementary Medical Insurance revenues from fees on brand-name prescription drugs under section 9008 of the Affordable Care Act, and the higher Hospital Insurance payroll tax income under section 9015, are included in the estimated Medicare savings shown here.) The Congressional Budget Office and the Joint Committee on Taxation have estimated that the total net amount of Medicare savings and additional tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall reduction in the Federal deficit through 2019.

The estimated effects of the Affordable Care Act on overall national health expenditures (NHE) are shown by the “net total” curve in the following chart. In aggregate, we estimate that for calendar years 2010 through 2019, NHE would increase by \$311 billion, or 0.9 percent, compared to prior law. Year by year, the relative increases are largest in 2016, when the coverage expansions would be fully phased in (2.0 percent), and gradually decline thereafter to 1.0 percent in 2019.

Estimated effect of the Affordable Care Act on total national health spending

[Estimated increase (+) or decrease (-) in annual spending, in billions]



The net total increase in NHE reflects several large—and largely offsetting—effects on expenditures by private health insurance, Medicare, Medicaid, and individuals’ own out-of-pocket costs, as shown by the columns in the chart above. Health expenditures are expected to increase by about \$200 billion annually due to the substantial expansions of coverage under the Affordable Care Act. Numerous studies have demonstrated that individuals and families with health insurance use more health services than otherwise-similar persons without insurance. Under the health reform legislation, by 2019 an estimated 34 million currently uninsured people would gain comprehensive coverage through the health insurance Exchanges, their employers, or Medicaid. The availability of coverage would typically result in a fairly substantial increase in the utilization of health care services, with a corresponding impact on total health expenditures. These higher costs would be partially offset by the sizable discounts imposed on providers by State Medicaid payment rules and by the significant discounts negotiated by private health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of the Affordable Care Act would increase NHE in 2019 by about 3.4 percent.

The Affordable Care Act will also affect aggregate NHE through the Medicare savings provisions. We estimate that these impacts would reduce NHE by roughly 2.4 percent in 2019, assuming that the productivity adjustments to Medicare payment updates can be sustained through this period. The legislation would have only a slight impact on the utilization of health care services by Medicare beneficiaries (subject to a caveat mentioned below regarding possible access issues if Medicare payment rates become inadequate). As shown in the chart, the Medicare savings accumulate rapidly, principally due to the compounding effect of the slower payment updates for most categories of providers.

Individuals’ out-of-pocket spending would be reduced significantly by the Affordable Care Act (an estimated net total decline of \$237 billion in calendar years 2010-2019). This reduction reflects the net impact of (i) the substantial coverage expansions through Medicaid and the health insurance Exchanges, (ii) the significant cost-sharing subsidies for low-to-middle-income persons with Exchange coverage, (iii) the maximum out-of-pocket limitations associated with the qualified health benefit, (iv) lower cost-sharing payments by beneficiaries in fee-for-service Medicare, (v) higher cost-sharing payments by Medicare Advantage enrollees, and (vi) the increases in workers’ cost-sharing obligations in plans affected by the excise tax on high-cost employer-sponsored health insurance coverage.

Estimated impact of Affordable Care Act on Medicare expenditures and revenues

As indicated above, net Medicare savings are estimated to total \$575 billion for fiscal years 2010-2019. Substantial savings are attributable to the provisions that would reduce Part A and Part B payment levels and reduce future “market basket” payment updates by the increase in economy-wide multifactor productivity (\$233 billion); eliminate the 2014 spending authorization for the Medicare Improvement Fund (\$27 billion); reduce DSH payments (\$50 billion); reduce Medicare Advantage payment benchmarks and permanently extend the authority to adjust for coding intensity (\$145 billion); freeze the income thresholds for the Part B income-related premium for 9 years (\$8 billion); implement an Independent Payment Advisory Board together with strict Medicare expenditure growth rate targets (\$24 billion); and increase the HI payroll tax rate by 0.9 percentage point for individuals with earnings above \$200,000 and families above

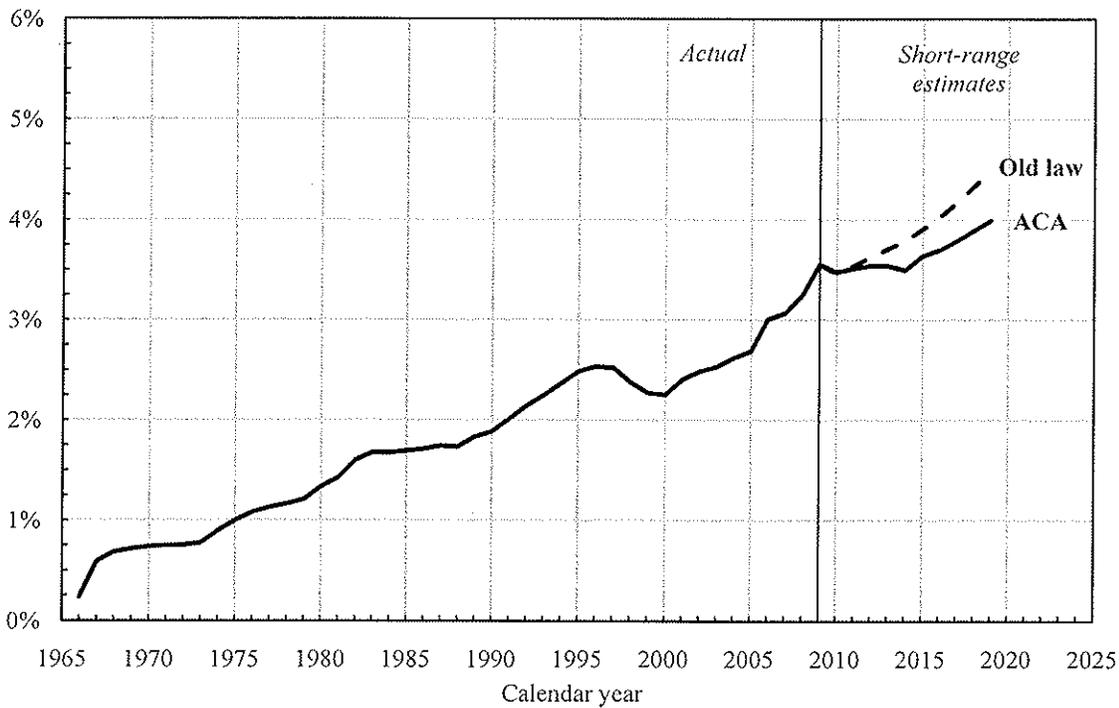
\$250,000 (\$63 billion). Other provisions would generate relatively smaller amounts of savings, through such means as reporting physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, refining imaging payments, increasing Part D premiums for higher-income beneficiaries, and implementing evidence-based coverage of preventive services.

These savings are slightly offset by the estimated costs of closing the Part D coverage gap (\$12 billion); reducing growth in the Part D out-of-pocket cost threshold (\$1 billion); extending certain special payment provisions scheduled to expire, such as the postponement of therapy caps (\$5 billion); and improving preventive health services and access to primary care (\$6 billion).

The Affordable Care Act also authorizes a substantial program of research and development for innovative new health delivery systems and payment methods. This program has significant potential for improvements in the quality and cost efficiency of health care, but its effects on Medicare expenditures cannot be assessed until specific plans have been developed and tested.

The following chart shows actual past Medicare expenditures as a percentage of gross domestic product (GDP), together with estimated future amounts for 2010-2019 under the Affordable Care Act and under the prior law. Of the estimated net total Medicare savings of \$575 billion over this period, \$486 billion is attributable to a net reduction in Medicare expenditures (with the balance due to increased revenues from taxes and fees). The chart illustrates the expenditure impact only.

Medicare expenditures before and after the Affordable Care Act
(as a percentage of GDP)



By 2019, the net reduction in Medicare expenditures is estimated to be 0.5 percent of GDP, which represents an 11-percent decrease from the level projected prior to the Affordable Care Act. This percentage reduction would grow larger over time as a result of the compounding effect of the slower annual updates in Medicare payment rates for most categories of health care providers.

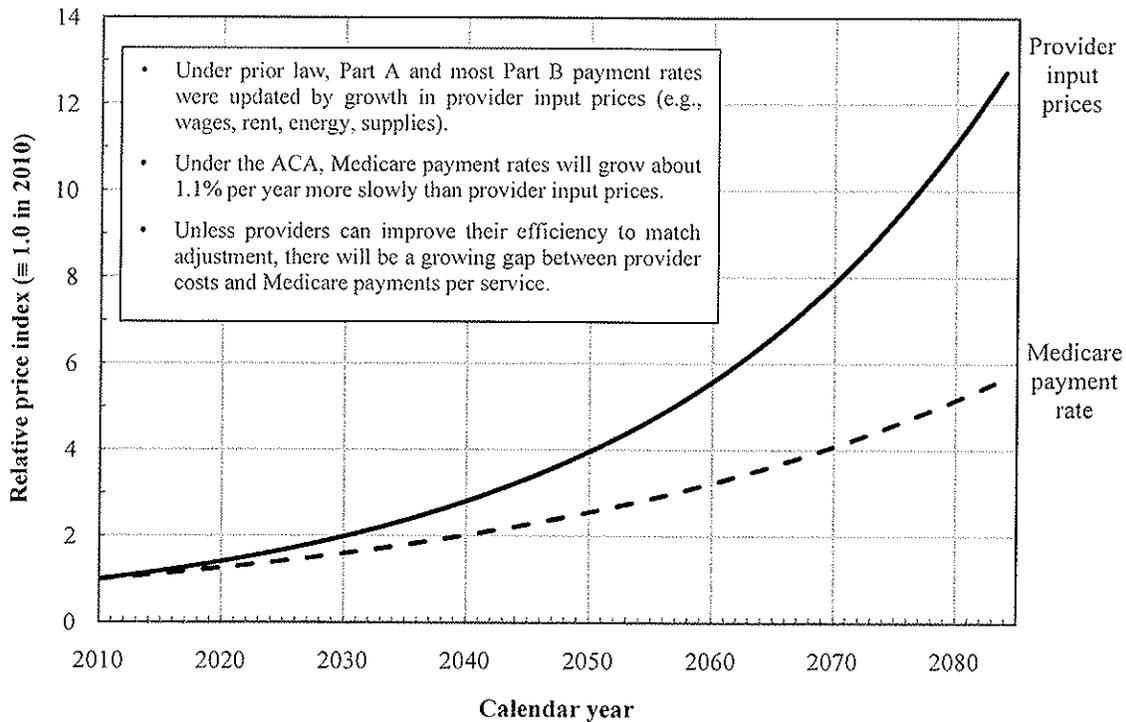
Based on the estimated savings for Part A of Medicare, and using the 2010 Trustees Report as a baseline, the assets of the Hospital Insurance trust fund would be exhausted in 2029 compared to 2017 under the prior law—an extension of 12 years. The combination of lower Part A costs and higher tax revenues results in a lower Federal deficit based on budget accounting rules. However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the HI trust fund. In practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions. Conversely, expenditure reductions under Part B translate directly to lower financing requirements from general revenues and beneficiary premiums, since financing is re-established annually to match program costs. Thus, in the case of Part B, the savings under the Affordable Care Act are not needed to help pay for future benefit expenditures, and the full reduction in Federal general revenues attributable to such savings can be used to offset other Federal costs, such as those arising under the health reform coverage expansions. (Part D expenditures will increase under the Affordable Care Act, requiring additional Federal general revenue financing.) More detailed information on the financial status of the Medicare trust funds is available in the 2010 Medicare Trustees Report; an updated assessment will be shown in the forthcoming 2011 report.

It is important to note that the estimated savings for one category of Medicare provisions may be unrealistic. The Affordable Care Act requires permanent annual productivity adjustments to price updates for most providers (such as hospitals, skilled nursing facilities, and home health agencies), using a 10-year moving average of economy-wide private, non-farm productivity gains. While such payment update reductions will create a strong incentive for providers to maximize efficiency, it is doubtful that many will be able to improve their own productivity to the degree achieved by the economy at large.¹

The following chart illustrates the very large differential that would accumulate over long periods between the prices that health care providers have to pay to obtain the inputs they need to provide health care services and the corresponding Medicare payment rates. In practice, providers have few alternatives to paying market-based increases in wages and fringe-benefit costs for their employees. Similarly, price increases for office space, energy, utilities, and medical equipment and supplies are generally outside of providers' control.

¹ The provision of most health services tends to be very labor-intensive. Economy-wide productivity gains reflect relatively modest improvements in the service sector together with much larger improvements in manufacturing. Except in the case of physician services, I am not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy. The Office of the Actuary's most recent analysis of hospital productivity highlights the difficulties in measurement but suggests that such productivity has been small or negligible during 1981 to 2005. (See <http://www.cms.hhs.gov/HealthCareFinancingReview/downloads/07-08Winterpg49.pdf>.)

Cumulative increase in provider input price vs. Medicare payment rate
 (for providers subject to productivity adjustments under current law)



Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers' costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries). Simulations by the Office of the Actuary suggest that roughly 15 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments.² Although this policy could be monitored over time to avoid such an outcome, changes would likely result in smaller actual savings than described here for these provisions.

In their 2010 report to Congress on the financial status of the program, the Medicare Board of Trustees cautioned:

The Affordable Care Act improves the financial outlook for Medicare substantially. However, the effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the longer-range future. For example, the ACA initiative for aggressive research and development has the potential

² The simulations were based on actual fiscal year 2007 Medicare and total facility margin distributions for hospitals, skilled nursing facilities, and home health agencies. Provider revenues and expenditures were projected using representative growth rates and the Office of the Actuary's best estimates of achievable productivity gains for each provider type, and holding all other factors constant.

to reduce Medicare costs in the future; however, as specific reforms have not yet been designed, tested, or evaluated, their ability to reduce costs cannot be estimated at this time, and thus no specific savings have been reflected in this report for the initiative.

Another important example involves lower payment rate updates to most categories of Medicare providers in 2011 and later. These updates will be adjusted downward by the increase in productivity experienced in the economy overall. Since the provision of health services tends to be labor-intensive and is often customized to match individuals' specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large. Over time, the productivity adjustments mean that the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to provide health care services. Unless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries.

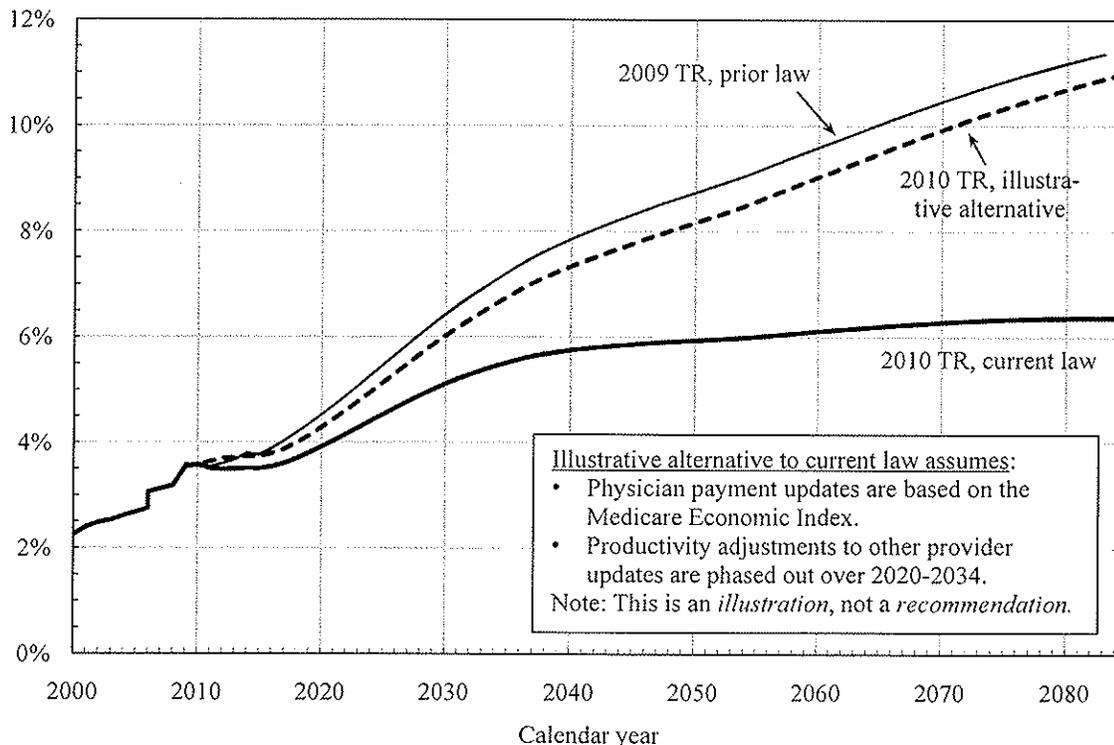
It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Similarly, the implementation of payment and delivery system reforms, facilitated by the ACA research and development program, could help constrain cost growth to a level consistent with the lower Medicare payments. These outcomes are far from certain, however. Many experts doubt the feasibility of such sustained improvements and anticipate that over time the Medicare price constraints would become unworkable and that Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law.

The annual report to Congress on the financial status of Medicare must be based on current law. In this report, the productivity adjustments are assumed to occur in all future years, as required by the Affordable Care Act. In addition, reductions in Medicare payment rates for physician services, totaling 30 percent over the next 3 years, are assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override these latter reductions.

In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections in this report. We recommend that the projections be interpreted as an illustration of the very favorable financial outcomes that would be experienced if the productivity adjustments can be sustained in the long range—and we caution readers to recognize the great uncertainty associated with achieving this outcome. Where possible, we illustrate the potential understatement of Medicare costs and projection results by reference to an alternative projection that assumes—for purposes of illustration only—that the physician fee reductions are overridden and that the productivity adjustments are gradually phased out over the 15 years starting in 2020.

The following chart shows long-range projections of total Medicare expenditures, as a percentage of GDP, under three scenarios. The substantial impact of the Affordable Care Act on expenditures is apparent by comparing the current-law projections from the 2010 Trustees Report (which includes the effect of all ACA provisions) to the corresponding projections from the 2009 Trustees Report (pre-ACA). Medicare expenditures in 2030 are currently projected to be about 20 percent lower than shown in the 2009 report, primarily as a result of the Affordable Care Act provisions. By 2050 and 2080, the projected difference increases to 32 and 43 percent, respectively.

**Long-range projections of Medicare expenditures under current law,
prior law, and an illustrative alternative to current law**
(as a percentage of GDP)



The growing difference between the current-law and prior-law projections in the long range is primarily attributable to the compounding effect of the slower Medicare price updates. To help assess the potential understatement of Medicare costs under current law, the Board of Trustees asked the Office of the Actuary to make projections under an illustrative alternative to current law. The alternative assumes that (i) Medicare payment updates for physicians would be based on the Medicare Economic Index, rather than the sustainable growth rate (SGR) formula, and (ii) the productivity adjustments to most other categories of providers would be gradually phased out after 2019. As indicated in the chart above, Medicare costs under the illustrative alternative to current law would be substantially greater than the current-law projections. It is important to note that the illustration represents only a means by which to consider the potential understatement of costs under current law. No endorsement of the illustrative payment changes by the Trustees, CMS, or the Office of the Actuary should be inferred.

Estimated effects of Affordable Care Act on out-of-pocket payments by Medicare beneficiaries

In addition to the effects of the Affordable Care Act on Medicare expenditures and revenues, it is useful to assess its financial and other impacts on beneficiaries. The Act expands coverage, primarily by adding certain preventive services, eliminating cost-sharing requirements for most preventive services that still had such requirements, and phasing out the Part D coverage gap (or “donut hole”). The legislation also has the potential to improve the quality and cost-efficiency of care through the design, testing, evaluation, and nationwide implementation of innovative new

health care delivery systems and payment methods. The ultimate effect of these innovations cannot be determined at this time but will become clearer as specific ideas are tested.

Somewhat similarly, the potential for Medicare payment rates to become inadequate, with adverse consequences for beneficiary access to care, cannot be determined at this time. Careful monitoring of payment levels by CMS and the Medicare Payment Advisory Commission (MedPAC) should provide sufficient advance notice to Congress if payment rates become an issue.

Various provisions of the Affordable Care Act will affect Medicare beneficiaries through the average level of coinsurance payments, premiums for Part B and Part D, and the amount of extra benefits provided to beneficiaries enrolled in Medicare Advantage. Medicare beneficiaries have the option of receiving their coverage through the traditional fee-for-service program or through a private Medicare Advantage (MA) health plan. As of 2010, more than one-fourth of Medicare beneficiaries were enrolled in MA plans. Since the Affordable Care Act has very different effects on these two programs, the beneficiary out-of-pocket impacts will be analyzed separately.

Fee-for-service Medicare

For individuals enrolled in the traditional Medicare program, the expenditure reductions under the Affordable Care Act are expected to cause a reduction in the average coinsurance amounts, as shown in the following table. For Part A, the savings under the Act would result in lower beneficiary coinsurance payments for inpatient hospital and skilled nursing care. These effects are the result of the application of the productivity adjustments to the Medicare “market basket” payment updates. For Part B, the average reduction in beneficiary coinsurance is significantly larger than for Part A, since almost all Medicare enrollees have physician or other Part B services in a year, versus a minority with Part A services. The estimated program savings result in an associated reduction in average annual coinsurance payments that reaches \$47 for Part A and \$160 for Part B by 2019. These estimates assume that the productivity adjustments to Medicare payment updates can be sustained through this period.

Average coinsurance impact for fee-for-service Medicare beneficiaries
(estimated change in yearly per capita amount)

CY	Part A	Part B	Part D
2010	\$0	\$6	-\$37
2011	-\$1	-\$13	-\$86
2012	-\$4	-\$37	-\$94
2013	-\$8	-\$54	-\$117
2014	-\$13	-\$66	-\$126
2015	-\$18	-\$83	-\$145
2016	-\$23	-\$101	-\$162
2017	-\$29	-\$119	-\$188
2018	-\$37	-\$138	-\$221
2019	-\$47	-\$160	-\$259

The coinsurance payments for Part D enrollees will be significantly reduced by the Affordable Care Act, with the average reduction reaching \$259 per year by 2019. This impact is largely due

to phasing out the Part D coverage gap, commonly referred to as the “donut hole.” Specifically, the following four provisions will affect the coverage gap.³

- (i) Beginning in 2011, a 50-percent price discount on brand-name drugs is established for prescriptions that are dispensed once a beneficiary reaches the coverage gap, paid for by pharmaceutical companies.
- (ii) The 50-percent price discounts described in (i) are counted as part of a beneficiary’s true out-of-pocket (TrOOP) spending and therefore will not change the point at which the beneficiary reaches the threshold for catastrophic coverage.
- (iii) Coverage for brand-name and generic drug expenditures in the existing coverage gap will be phased in, beginning in 2013 and 2011, respectively, reducing enrollees’ cost-sharing requirement to 25 percent by 2020.
- (iv) The maximum out-of-pocket spending limit for 2014 through 2019 will increase at a slower rate.

The next table shows the estimated impacts on Part B and Part D standard premiums resulting from the Affordable Care Act, on a monthly and annual basis. Expenditure reductions under Part B translate directly to lower financing requirements from general revenues and beneficiary premiums, since financing is re-established annually to match program costs. In addition, Part B will receive revenues from the fees on manufacturers and importers of brand-name prescription drugs. Since no changes were made in the existing statutory provisions for Part B beneficiary premiums and general revenue matching amounts, which by law are set each year at a level adequate to finance Part B expenditures, these additional revenues would result in an excessive level of financing for Part B and an unnecessary accumulation of account assets. To maintain Part B assets at an appropriate contingency level, a negative “premium margin” will be incorporated, reducing beneficiary premium rates and matching general revenues by an amount equal to the new revenues from prescription drug fees. The estimated Part B premium impacts shown below reflect such reductions. As before, the estimated Part B premium reductions depend in significant part on the viability of the productivity adjustments to payment updates.

Estimated fee-for-service Medicare beneficiary premium impact				
CY	Part B premium		Part D premium	
	Monthly	Annual	Monthly	Annual
2010	\$0.00	\$0	\$0.00	\$0
2011	-\$1.60	-\$19	\$0.51	\$6
2012	-\$4.40	-\$53	\$0.14	\$2
2013	-\$6.00	-\$72	\$0.00	\$0
2014	-\$7.50	-\$90	\$0.05	\$1
2015	-\$9.40	-\$113	\$0.16	\$2
2016	-\$11.60	-\$139	\$0.19	\$2
2017	-\$14.10	-\$169	\$0.58	\$7
2018	-\$16.00	-\$192	\$1.07	\$13
2019	-\$18.20	-\$218	\$1.66	\$20

³ The estimated reduction in average Part D coinsurance in 2010 is attributable to the one-time \$250 rebates for enrollees with costs in the coverage gap.

Part D premiums are estimated to be slightly higher as a result of the Affordable Care Act. By statute, the base beneficiary premium for Part D is 25.5 percent of the national average bid amount plus the estimated catastrophic reinsurance value. Providing additional coverage for prescription drugs dispensed in the coverage gap will cause an increase in costs for the prescription drug plans and therefore an increase in the average Part D premium rate. Slightly offsetting this increase in premiums is the anticipated movement of many of the Medicare beneficiaries currently enrolled through the retiree drug subsidy (RDS) program to Part D plans. This enrollment shift is expected to result from the loss of tax deductibility for employer costs reimbursed by the RDS payments, as well as from the improvement in the Part D benefit due to filling in the coverage gap. Since RDS beneficiaries have lower drug costs than average, the Part D premium for all enrollees is estimated to be reduced.

The standard premium impacts shown above are for a typical beneficiary. Beginning in 2007, beneficiaries with incomes that exceeded a certain threshold were required to pay higher premiums to receive Part B.⁴ The Affordable Care Act freezes the thresholds at the 2010 level through 2019. Consequently, through 2019, there will be steady, incremental increases in the number of individuals subject to the higher premium rates. It is estimated that 10 percent of Part B beneficiaries (5.6 million) will be subject to the higher Part B premium in 2019, compared to 8 percent (4.5 million) under the prior law.

The Affordable Care Act also requires higher, income-related premiums for Part D enrollees, using the same income thresholds as Part B. By 2019, it is estimated that 8 percent of Part D enrollees (3.4 million) will have to pay a higher Part D premium. The following table shows the 2011 Part D income-related additional monthly and annual premium adjustment amounts to be paid by beneficiaries who file individual tax returns (including married individuals filing separately who lived apart from their spouses for the entire taxable year), or who file joint tax returns. The adjustment amounts are payable in addition to the standard enrollee premium for a given prescription drug plan.

Part D income-related premium adjustment amounts in 2011

Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Part D income-related monthly adjustment amount	Part D income-related annual adjustment amount
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$0
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$12.00	\$144
Greater than \$107,000 and less than or equal to \$160,000	Greater than \$214,000 and less than or equal to \$320,000	\$31.10	\$373
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$50.10	\$601
Greater than \$214,000	Greater than \$428,000	\$69.10	\$829

Note: The monthly premium adjustment amounts to be paid by beneficiaries who are married, but file separate returns from their spouses and lived with their spouses at any time during the taxable year, are \$50.10 for beneficiaries with incomes greater than \$85,000 but less than or equal to \$129,000 and \$69.10 for those with incomes greater than \$129,000.

⁴ The high-income threshold for 2011 through 2019 is \$85,000 for individuals and \$170,000 for married couples filing a joint tax return.

Medicare Advantage

Payments to Medicare Advantage plans are generally based on the costs in fee-for-service Medicare. Therefore, the provisions of the Affordable Care Act that produce the reductions in Medicare premiums and coinsurance amounts described above would produce a corresponding reduction in the out-of-pocket spending for MA enrollees. These reductions are expected to be more than offset by the changes made to the prospective MA payments in the legislation.

Under the prior law, MA payment benchmarks were generally in the range of 100 to 140 percent of fee-for-service costs. The Affordable Care Act sets the 2011 MA benchmarks equal to the benchmarks for 2010 and specifies that, ultimately, the benchmarks will equal a percentage (95, 100, 107.5, or 115 percent) of the fee-for-service rate in each county. During a transition period, the benchmarks will be based on a blend of the prior ratebook approach and the ultimate percentages. The phase-in schedule for the new benchmarks will occur over 2 to 6 years, with the longer transition for counties with the largest benchmark decreases under the new method.

The Affordable Care Act also introduces MA bonuses and rebate levels that are tied to the plans' quality ratings. The law specifies that, beginning in 2012, benchmarks will be increased for plans that receive a 4-star or higher rating on a 5-star quality rating system.⁵ The bonuses will be 1.5 percent in 2012, 3.0 percent in 2013, and 5.0 percent in 2014 and later, and are subject to the same phase-in schedule as the benchmarks. An additional county bonus, which is equal to the plan bonus, will be provided on behalf of beneficiaries residing in specified counties. The percentage of the "benchmark minus bid" savings payable as a rebate, which historically has been 75 percent, will also be tied to a plan's quality rating. In 2014, when the provision is fully phased in, the rebate share will be 50 percent for plans with a quality rating of less than 3.5 stars, 65 percent for a quality rating of 3.5 to 4.49, and 70 percent for a quality rating of 4.5 or greater.

The new provisions will reduce MA rebates to plans and thereby result in less generous benefit packages. MA plans use rebate revenues to reduce Medicare coinsurance requirements, add extra benefits such as vision or dental care, and/or reduce enrollee premiums for Part B or Part D of Medicare. The following table shows the impact of the Affordable Care Act on the average annual per capita rebate, as estimated at the time of enactment. The reduction in the average MA rebate was estimated to grow steadily as the ACA benchmark and other changes phase in and to reach about \$1,500 in 2019.⁶

The reduction in MA rebates will cause a large increase in the out-of-pocket costs incurred by MA enrollees. As mentioned previously, this effect will be somewhat offset by the impact on plan costs from the reductions in fee-for-service Medicare. The net effects of the reduced MA rebates and the decreases in the out-of-pocket costs are shown in the last column of the table. The result is a decrease in beneficiary out-of-pocket spending of \$30 for 2010 and then substantial increases in such costs that begin in 2011 and reach an estimated \$873 in 2019.

⁵ In November 2010, CMS announced the Medicare Advantage Quality Bonus Payment Demonstration, which will apply a sliding scale bonus to plans with at least 3 stars.

⁶ As a result of (i) lower-than-expected MA plan bids in 2009 and 2010, and (ii) no further adjustment to the 2011 MA payment formula for "excess diagnosis coding intensity," updated estimates would indicate somewhat higher average rebate levels under both the prior law and the Affordable Care Act. The estimated reductions in average MA rebates due to the ACA would remain very similar to the amounts shown in the table.

Estimated impact on beneficiary out-of-pocket spending for MA enrollees
(estimated change in yearly per capita amount)

CY	ACA impact on the average MA rebate			Impact from FFS provisions	Net out-of-pocket impact of the ACA
	Prior-law rebate	Current-law rebate	Reduction in MA rebate		
2010	\$1,093	\$1,093	\$0	-\$30	-\$30
2011	\$1,143	\$684	\$459	-\$113	\$346
2012	\$1,181	\$522	\$660	-\$186	\$473
2013	\$1,240	\$399	\$841	-\$250	\$591
2014	\$1,311	\$278	\$1,034	-\$295	\$739
2015	\$1,311	\$142	\$1,169	-\$357	\$812
2016	\$1,372	\$84	\$1,288	-\$422	\$866
2017	\$1,441	\$20	\$1,421	-\$498	\$923
2018	\$1,509	\$42	\$1,468	-\$575	\$892
2019	\$1,580	\$43	\$1,537	-\$664	\$873

The reductions in the value of MA benefit packages because of the lower rebate levels are expected to significantly reduce the attractiveness of many MA plans relative to fee-for-service Medicare. In our April 22, 2010 memorandum, we estimated that in 2017, when the MA provisions will be fully phased in, enrollment in MA plans would be lower by about 50 percent (from a projected level of 14.5 million under the prior law to about 7.3 million under the new law).⁷

Conclusions

The Affordable Care Act makes far-reaching changes to most aspects of health care in the U.S., including mandated coverage for most people, required payments by large employers not offering insurance, expanded eligibility and other provisions for Medicaid, Federal premium and cost-sharing subsidies for many individuals and families, a new system of health benefits Exchanges for facilitating coverage, and a new Federal insurance program in support of long-term care. Federal revenues will be increased through an excise tax on high-cost insurance plans; fees or excise taxes on drugs, devices, and health plans; higher Hospital Insurance payroll taxes for high-income taxpayers; a new tax on investment revenues and other unearned income; and other provisions.

Numerous provisions will reduce Medicare outlays, increase trust fund revenues, add certain benefit enhancements, further combat fraud and abuse, and support research into innovative health delivery systems and payment mechanisms, with the goal of improving both the quality and efficiency of Medicare services. These provisions will affect not only the financial status of the Medicare trust funds but also beneficiary out-of-pocket costs for premiums and cost-sharing requirements. The provisions of the Affordable Care Act are expected to have a very different effect on beneficiaries' out-of-pocket costs depending on whether they are enrolled in fee-for-

⁷ Reflecting the same factors cited in footnote 6, together with later data on the sensitivity of MA enrollment to changes in supplemental benefit value, an updated estimate of the enrollment reduction under the Affordable Care Act would be about 40 percent, from a prior-law level of 14.6 million in 2017 to about 8.7 million under the new law.

service Medicare or a Medicare Advantage plan. For beneficiaries in fee-for-service Medicare, out-of-pocket costs for coinsurance amounts and premiums will be significantly reduced by the ACA, assuming the continuing viability of the slower payment rate updates for most categories of health providers. For individuals enrolled in Parts A, B, and D, average costs will be reduced each year beginning in 2010, and the difference will reach an estimated \$664 in 2019. MA enrollees will experience the opposite effect. Their out-of-pocket costs will be higher by an estimated \$873 in 2019. It should also be noted that for certain beneficiaries with relatively high incomes, their premiums for Parts B and D will increase as a result of the Affordable Care Act.

In our independent capacity as technical advisors to the Administration and Congress, the Office of the Actuary at CMS has estimated the effects of the non-tax provisions of the Affordable Care Act on Federal outlays, overall national health expenditures, and health insurance coverage in the U.S. Our estimates are based on available data sources and what we believe are reasonable assumptions regarding individual, employer, and health plan responses to the legislation, together with analyses of the likely changes in the cost and use of health care services. In view of the complexity and scope of these changes, estimates of their financial and other effects are necessarily very uncertain. As the Affordable Care Act provisions are finalized through regulations, and as providers, employers, and individuals respond to the requirements and opportunities in the legislation, we will continue to monitor developments and to update our estimates for Medicare, Medicaid, CHIP, and total national health expenditures as necessary.

I hope that the information presented here is of value to policy makers, and I pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine optimal solutions to the financial challenges associated with health care in the U.S. I would be happy to answer any questions you might have.