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Medicare solvency extended ... but with many caveats

In early August, the trustees of the Social Security and Medicare trust funds released their annual report about the current and projected status of the programs.

Normally, the trustees release this report in the spring. However, they decided to delay their 2010 report by several months so they could incorporate into it the effects of the many changes impacting Medicare that were included in the Affordable Care Act enacted in March (formally known as the Patient Protection and Affordable Care Act as amended by the Health Care Reconciliation Act of 2010).

The Hospital Insurance (HI) Trust Fund is now projected to remain solvent until 2029, which is 12 years longer than was projected than last year. This projection is despite the lower revenues from the wage tax that have resulted because of the recession, which finances the HI Trust Fund. To no one's surprise, the Obama administration celebrated this news. But many did not expect the skepticism and questions that others have raised with the reported projections. Even the trustees indicated in the report that their projections are predicated on reductions in payment that may not occur, in which case, actual costs would be greater than those projected. In their introduction, the trustees note that future costs are likely to exceed those shown under current law projections and that the projections should be interpreted as an illustration of what could be achieved if the assumptions underlying current law could actually be met.

The Office of the Actuary went one step further and released a memo that presents an alternative scenario, illustrating and quantifying the potential magnitude of the underestimated spending in Medicare that could result if the current law projections are not realized.

What's the Problem?

By convention, whenever the Office of the Actuary or the Congressional Budget Office make projections, the projections always assume that "current law"—that is, the law as it exists at the time the report is written—will be followed. Normally, this is a reasonable assumption, and in any case, it is not clear what alternative assumption would make sense and be acceptable to both political parties as well as the executive branch and the Congress.

However, current law as embodied in the Affordable Care Act contains some assumptions that few, if anyone, think reflect what will actually occur. Medicare payment rates for physicians have been under pressure each year since 2002 because of the sustainable growth rate, which is designed to ensure spending on physician services continues to grow at the rate of the economy. Each year, other than 2002, when fees were reduced by 4.8 percent, Congress has intervened late in the process and provided a short-term "fix" to keep fees approximately flat. The current such provision is due to expire in December.

Under current law, physician fees are scheduled to be reduced by approximately 30 percent over the next three years—23 percent in December, 6.5 percent in January, and an additional 2.9 percent the following January. Reductions of this magnitude would inevitably cause major problems with access, making it virtually unimaginable that Congress would allow them to occur. Yet they are factored into the Part B estimates

included in the trustees report as though they are a given, because that is current law.

An assumption that is more directly relevant to the HI Trust Fund projections concerns payment reductions that reflect improvements in productivity expected to be achieved in the nonfarm sector of the economy. In its annual update recommendations to Congress regarding payment updates, the Medicare Payment Advisory Commission (MedPAC) often assumes that the healthcare sector should be able to improve its productivity in the same way other sectors of the economy do, and as a result, the rate of increase for its services should be lower than would be expected based on projected increases in inflation. These same types of assumptions were built into the Affordable Care Act and include payments rates across Medicare that incorporate the expected increases in nonfarm productivity for the next 10 years, which amount to approximately a 1.1 percent reduction each year in payment increases over what would otherwise occur.

The problem is that services in general, and healthcare services in particular, have rarely been able to achieve the kind of productivity increases observed elsewhere in the economy. This has been true for all sectors that depend heavily on labor and are less capital-intensive. What MedPAC actually recommended is that the nonfarm productivity assumption be implemented one year at a time so that some adjustment could be made if the productivity assumptions do not occur.

Furthermore, these assumptions of productivity increases for Medicare updates continue out into the future, beyond the first 10 years. The Office of the Actuary estimated in April that the resulting update reductions would produce negative total facility margins for 15 percent of the hospitals, skilled nursing facilities, and home care agencies by 2019, for 25 percent of these organizations by 2030, and for 40 percent by 2050. Presumably, Congress would intervene before this would actually happen, yet the projections assume they will occur.

The Way Forward

Simply reducing payments to the same financially dysfunctional Medicare program, where providers of all types are paid to do increasingly complex services and are not rewarded for quality, should not be confused with Medicare reform. Incentives should be realigned to reward desired outcomes. But that does not occur in the present reimbursement system.

The new law does contain some steps to begin this transformation, such as initiating value-based purchasing for hospitals and nursing homes in 2012 and allowing physicians and hospitals to share in savings produced by accountable care organizations that meet specified quality standards. Mostly, however, these changes will depend on the outcomes of pilots from the new Center for Medicare and Medicaid Innovation, which has yet to be established. Producing changes that improve quality while keeping costs either the same or lower will become increasingly difficult as the productivity increases—and related lower payment increases—are built into future projected spending.

We will have to wait to see what these pilots produce and whether their results can be easily replicated elsewhere in the country before we can assess their value in redesigning the incentives associated with Medicare.

All of these factors make the savings projected by the Office of the Actuary highly uncertain, at best, if not highly unlikely. Unlike the savings, however, the expenditures that these savings are financing—that is the expansions in coverage—are highly likely, if not absolutely certain. This situation should be a cause of some concern. ●

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