

# Medicare Spending Projections: Transition from Short-Run to Long-Run

John Shatto  
Office of the Actuary, CMS

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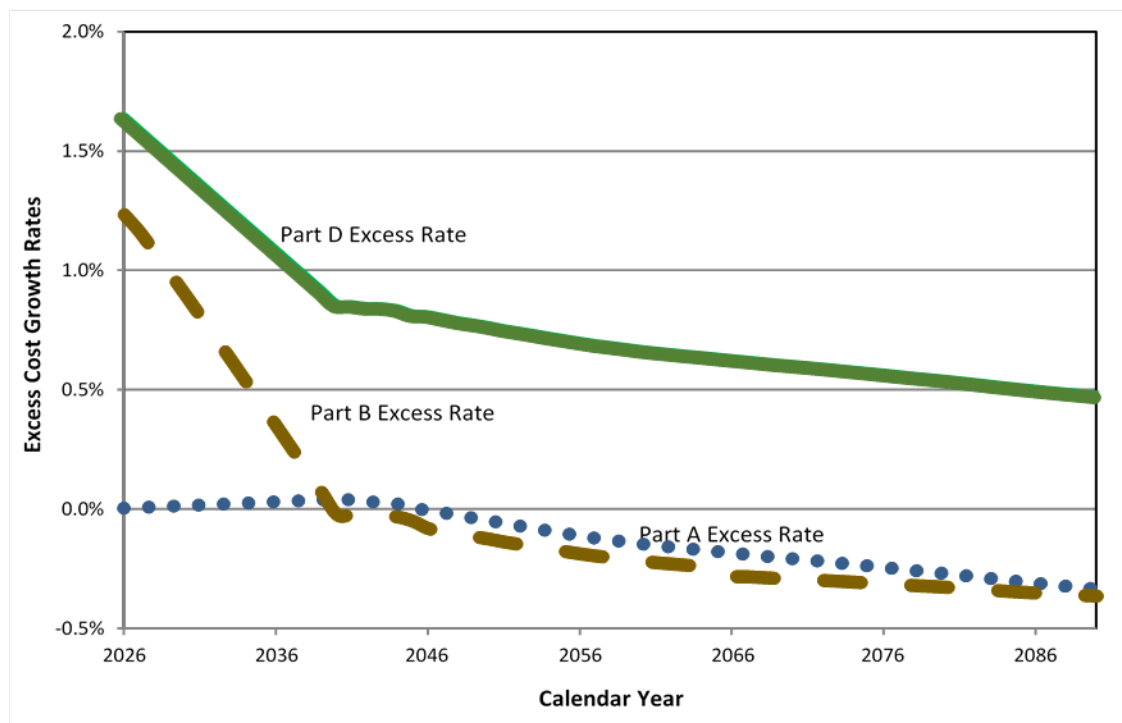
# Current Method

- Similar conceptual approach used for Parts A and B (since early 1990s) and for Part D (since mid-2000s).
  - In practice, modeling specifics are different. (For instance, Part D doesn't separate price and volume & intensity (V&I) in years 1-10, and Part A service splits are maintained for 25 years.)

	<b>Price</b>	<b>V&amp;I</b>
<b>Years 1-10</b>	Current law	Actuarial trend assumptions
<b>Years 11-25</b>	Current law	Linear transition
<b>Years 26-75</b>	Current law	NHE factors model

# Current Method, cont.

**Chart 3—Medicare Projected Excess Cost Growth  
Current Law  
2026-2090**

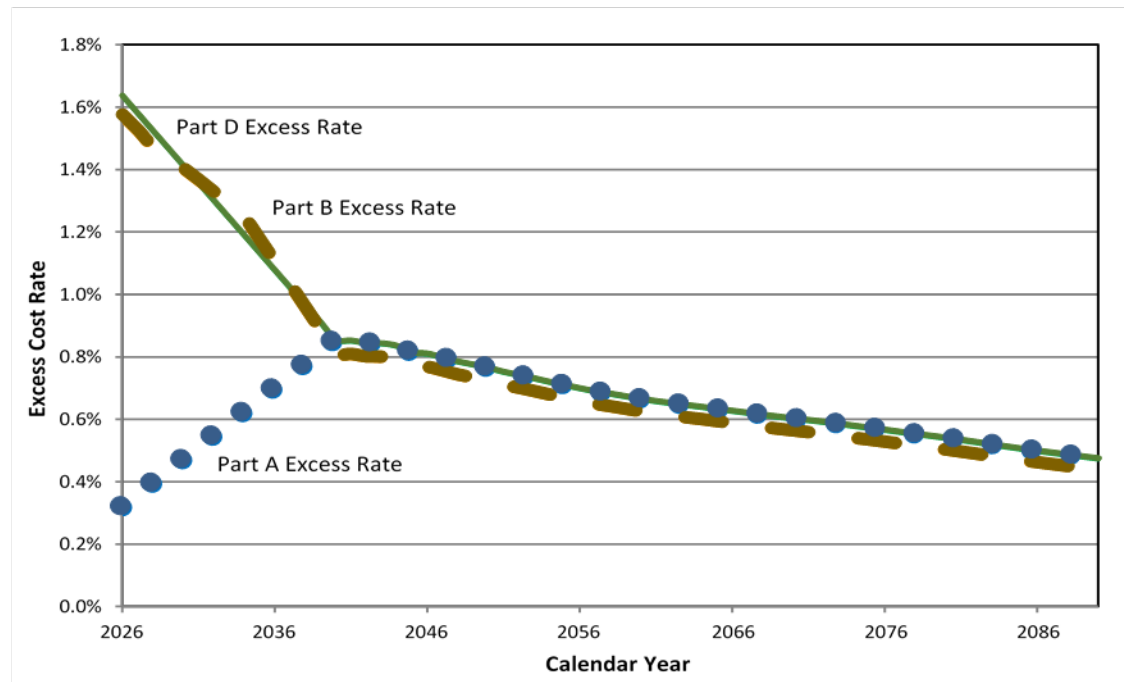


**Source: Centers for Medicare and Medicaid Services, Office of the Actuary.**

NOTE: An excess cost growth is the rate of change in per enrollee costs relative to the growth in per capita GDP. The chart displays projected long-term excess cost growth for Medicare Subparts A, B, and D under the current law. Under this scenario each of the subparts has its own unique series of excess cost growth through the end of the 75-year projection horizon due to the different applicable current law payment provisions. Excess cost growth displayed here do not include additional spending changes attributable to factors such as age and gender composition of the Medicare population, IPAB impacts.

# Current Method, cont.

**Chart 4—Medicare Projected Excess Cost Growth  
Illustrative Alternative  
2026-2090**



**Source: Centers for Medicare and Medicaid Services, Office of the Actuary.**

NOTE: An excess cost growth is the rate of change in per enrollee costs relative to the growth in per capita GDP. The chart displays projected long-term excess cost growth for Medicare Subparts A, B, and D under the illustrative alternative. Under this scenario each of the subparts converges to a similar rate of excess cost growth through the end of the 75-year projection horizon. Excess cost growth displayed here do not include additional spending changes attributable to factors such as age and gender composition of the Medicare population, IPAB impacts.

# Prior Technical Panel Findings

1991

It is reasonable that growth gradually tapers off so that only the effects of changing age/sex composition are shown after year 25.

2000

It is reasonable that both HI & SMI, despite using different underlying projection methods, similarly define the short-range (10 years), intermediate-range (years 11-25), and long-range (years 26-75) periods.

2004

N/A

2010-2011

N/A (Some stated a preference for no transition.)

# Why Use a 15-year Transition Period?

- It creates a smooth path, avoiding difficult-to-explain jumps/drops between years and large revisions between reports.
- There is general acceptance that only over the long-run will the various parts of the health sector growth similarly (NHE=Medicare).
- Evolution of long-range modeling:
  - Part A was projected by type of service for 10 years and then transitioned to only age-sex adjustments for years 26+ (GDP+0).
  - 1991 Panel recommends extending Part B projections to 75 years.
  - 2000 Panel recommends more than just age-sex adjustments for years 26+ (GDP+1).
  - Models that refined GDP+1 were based on historical average, macro relationships that were intended to apply to long-run, stable assumptions.

# Possible Alternatives

- Shorter transition
  - No transition
    - Medicare V&I = NHE Factors Model V&I starting in year 11.
    - Creates large cliffs between years 10 and 11.
      - In 2016 Trustees Report, Part A excess cost growth (ECG) = GDP+0 in 2025 and GDP+0 in 2026.
      - Hypothetical with no transition
        - In 2016 report, Part A ECG = GDP+1 in 2026.
        - In 2017 report (when 2026 is within 10 years), Part A ECG = GDP+0.
    - OACT is concerned that the factors model used to derive NHE V&I is not developed or validated for use so close to the short-range period.
  - 5-year transition? 10-year transition?
    - Rationale?
    - Improvement over using 15-year period?

# Possible Alternatives, cont.

- Longer transition
  - 20-year transition? 50-year transition?
    - Rationale?
    - Is it reasonable that all parts of the health sector will grow at different rates for extended periods?



# CBO's Long-Run Projections

- 2016 Long-Term Budget Outlook
  - 20-year transition.
  - Starts in 2027, and move linearly so that by 2046 all parts of the Federal health system (Medicare, Medicaid, private insurance) grow at the same rate.
- 2015 Long-Term Budget Outlook
  - 15-year transition.
  - Starts in 2026 and proceeds linearly so that by 2040 it matches the path implied by the linear transition from 2014 (assumed to be the average of 1985-2013) to the ultimate assumption.

# Considerations

- The current projection approach uses bottom-up methods for the short-range period and top-down methods for the long-range period.
- Is an intermediate period needed to transition between the short range and long range?
- If a transition is warranted, what is a logical time period? Is a linear transition appropriate?
- If there is no transition between short-range and long-range modeling, how can incongruities between years 10 and 11 and between reports be handled and explained?