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Office of the Actuary

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FROM: Solomon M. Mussey

SUBJECT: Estimated Effects of the "Patient Protection and Affordable Care Act," as Amended, on the Year of Exhaustion for the Part A Trust Fund, Part B Premiums, and Part A and Part B Coinsurance Amounts

The "Patient Protection and Affordable Care Act" (P.L. 111-148) was enacted on March 23, 2010 and amended shortly thereafter by the "Health Care and Education Reconciliation Act of 2010" (P.L. 111-152) as enacted on March 30, 2010. In addition to expansions of health insurance coverage, the new legislation includes numerous provisions that will reduce Medicare costs and one that will increase the Hospital Insurance (HI) payroll tax rate by 0.9 percentage point for high-income individuals and families.[1] This memorandum describes the estimated impacts of the health reform legislation on the date of exhaustion for the Medicare Hospital Insurance (Part A) trust fund, on Part B beneficiary premiums, and on the average level of Part A and Part B beneficiary coinsurance. For convenience, the health reform legislation, including amendments, is referred to in this memorandum as the Patient Protection and Affordable Care Act, or PPACA.[2]

We estimate that the aggregate net savings to the Part A trust fund under the PPACA would postpone the exhaustion of trust fund assets by 12 years—that is, from 2017 under prior law to 2029 under the proposed legislation.

The combination of lower Part A costs and higher tax revenues contributes to 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 Part A trust fund. In practice, the improved Part A financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions under the PPACA) and to

[1] The Reconciliation Act also establishes a 3.8-percent "unearned income Medicare contribution" on income from interest, dividends, annuities, and other non-earnings sources for high-income taxpayers. Despite the title of the tax, this provision is unrelated to Medicare; in particular, the revenues generated by the tax on unearned income are not allocated to the Medicare trust funds (and thus have no impact on the Part A exhaustion date or Part B premium).

[2] Detailed estimates of the Medicare savings and costs by provision are available in an April 22, 2010 memorandum by Richard S. Foster titled "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended." This report also includes estimates by the Office of the Actuary for the effects of the health reform legislation on other Federal expenditures, insurance coverage of the U.S. population, and total national health expenditures.

extend the trust fund, despite the appearance of this result from the respective accounting conventions.

The estimated postponement of asset exhaustion for the Part A trust fund does not reflect the relatively small impact on HI payroll taxes due to economic effects of the legislation or the increase in administrative expenses resulting from the HI provisions. As noted in our April 20, 2010 memorandum on the estimated financial and other effects of the PPACA, reductions in Medicare payment updates to Part A providers, based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis. If such reductions were to prove unworkable within the period 2010-2029, then the actual HI savings from these provisions would be less than estimated, and the postponement in the trust fund exhaustion date would be shorter.

The Medicare expenditure reductions under the PPACA will also affect the level of Part B premiums paid by enrollees and the average Part A and Part B beneficiary coinsurance amounts. In addition, as described below, Part B premiums will be reduced as a result of the fees imposed on manufacturers and importers of brand-name prescription drugs. The following table presents these estimated impacts:

CY	Part B Premium Impact (change in monthly premium amount)	Average Coinsurance Impact (change in yearly per capita amount)	
		Part A	Part B
2010	$0.00	$0	$8
2011	−$1.60	−$1	−$9
2012	−$4.40	−$4	−$34
2013	−$6.00	−$8	−$52
2014	−$7.50	−$13	−$70
2015	−$9.40	−$18	−$93
2016	−$11.60	−$23	−$119
2017	−$14.10	−$29	−$145
2018	−$16.00	−$37	−$169

After 2010, there would be steadily increasing savings to Part B and associated reductions in the Part B premium and coinsurance averages. Similarly, the Part A savings under the PPACA would result in lower beneficiary coinsurance payments for inpatient hospital and skilled nursing care. As before, all of these effects are conditional on the continued application of the productivity adjustments to the Medicare "market basket" payment updates.

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 PPACA are not needed to help pay for future benefit costs, 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 PPACA coverage expansions.

The additional revenues from the fees on brand-name prescription drugs represent a special case of the principle described above. Specifically, under section 9008 of the PPACA, these revenues are earmarked for the Part B account in the Medicare Supplementary Medical Insurance trust fund. From the standpoint of the Federal Budget, these amounts are new receipts and serve to reduce the Budget deficit. From a trust fund perspective, the situation is more complicated. 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. With no change to the existing financing, the additional revenues under section 9008 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, it would be reasonable to establish a negative "premium margin," which would reduce 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 above reflect such reductions.

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