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ASOP 6 and Medicare Payments Projections

by Wes Edwards

I welcome the ASOP 6 as an addition to the practice standards and the literature on valuing retiree group medical and life benefits. While I will not soon throw out the ACG 3, I recognize that it differed in form and content from an ASOP and that an ASOP was warranted for the sake of consistency in treatment by the standards.

One aspect of retiree medical that is addressed somewhat vaguely in the compliance guideline and is perhaps equally vaguely addressed by most practicing actuaries is the impact of Medicare, both in the valuation base year and to a greater extent in future years. The potential for understatement of the post-retirement benefit obligation from this source is large. For this reason, I hope to see a productive dialogue on projecting Medicare payments per beneficiary under the scenario prescribed by applicable accounting and actuarial standards.

Health actuaries are generally well versed on the historic impact of Medicare cost shifting. The sources of impact on private paid medical expenditures include decreases in Medicare reimbursements to providers and Medicare HMO plans, increasing part A deductible and the growth in cost of services not covered, including Rx, private duty nursing, skilled nursing facility in excess of \$101.50 per day, custodial care, etc. The reimbursement decreases have led to an increase in providers refusing to

accept Medicare assignment, providers seeking to increase billed charges for non-Medicare covered services and for non-Medicare eligible patients. A shrinking number of participating providers being compensated a smaller proportion of eligible charges by Medicare has meant that private paid trends per capita have been higher than overall trend. The degree of cost shift from Medicare covered services onto non-Medicare covered services for Medicare beneficiaries versus that shifted to services for other patients is difficult to measure. However, many providers, due to geography, specialty, existing patient base and contracted rates for private pay patients, have less opportunity to shift costs onto non-Medicare patients than their Medicare patients.

What do the standards say about the impact of Medicare?

ACG 3 section 5.5 quotes paragraph 35 of SFAS 106: "an employer's share of the expected future post-retirement health care cost for a plan participant is developed by reducing the assumed per capita claims costs at each age at which the plan participant is expected to receive benefits under the plan by (a) the effects of coverage by Medicare and other providers of health care benefits..." Section 5.6 addresses the health care cost trend rate (HCCTR) that is applied to the per capita claim costs (PCCC) described in 5.5. In 5.6.3, the compliance guideline states "The HCCTR is defined as the rise in gross eligible charges before Medicare reimbursement. Erosion or increase in relative Medicare reimbursements can leverage incurred claims costs faster or lower than the underlying HCCTR."

The new ASOP 6 clearly states in 3.8.1(a), "The actuary should consider separate trend rates for major cost components such as hospital, prescription drugs, other medical services, *Medicare integration* and administrative services."

It is the author's observation that actuaries practicing in the retiree medical valuation area have frequently approached this issue in a cavalier fashion. That is, the practice has been the use of the simple assumption that Medicare will offset a constant percentage of the gross per capita claim amount. This assumption would seem to fly in the

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face of the general acceptance of Medicare cost shifting as a historical fact, a present condition and a significant future probability.

What can we expect of the future for Medicare?

Of course, the accounting standards as promulgated require that no future anticipated changes in Medicare programs should be recognized.¹ The state of existing Medicare as evidenced by the 2002 Medicare Trustee’s Reports is such that Medicare Part A fund will bankrupt in 2030 under the intermediate economic assumptions.² Centers for Medicare & Medicaid Services (CMS) recently produced updated national health expenditure projections through 2011 when converted to per capita values and compared for each year from 2002 through 2001 (see Table 1). These projections include Medicare payments by type of service and expected Medicare beneficiaries.³ They also, when converted to per capita values and compared for each year from 2002 through 2011, show a trend in Medicare per capita payments that is below the norm observed by the author for retiree medical select period trend assumptions. It is also below recently released CMS projections for increases in private insurance paid per capita personal health expendi-

tures (PHE) net of dental and prescription drugs (services largely not covered by Medicare) through 2007 (see Table 2). After 2007, the CMS numbers show that Medicare payments per capita increase at a rate faster than private insurance payments per capita for PHE. This sounds like a “reverse cost shift” onto Medicare, which would be welcome news.

The “reverse cost shift” in 2002 CMS projections in years 2008-2011 is something most of us have not experienced. However, before we get too excited, we should look closely at the recent history of the CMS projections of national health expenditures. Both tables show a side-by-side comparison of the March 2002 and March 2001 projections where we can recognize that the date this reverse shift is to occur was pushed back from 2006 in the 2001 NHE projections to 2008 in the current 2001 NHE projections. Given the state of the Medicare HI Trust Fund, I find it hard to believe that Medicare will in the near future be in a position to increase per capita payments at a rate faster than private sources. At this point, I would invite any CMS actuary familiar with this data to help us better interpret these projections.

Perhaps there is an “out” in ASOP 6, section 3.8 where the standard reads, “With respect to any

| Year | March-02 | | | | March-01 |
|------|------------------------|---------------------------|----------------------|--------------------------|----------|
| | Paid PHE (\$ billions) | Beneficiaries (thousands) | Paid Per Beneficiary | Increase per Beneficiary | |
| 2000 | \$217.0 | 38,239 | \$5,675 | 4.7% | |
| 2001 | 238.2 | 38,654 | 6,162 | 8.6% | 6.2% |
| 2002 | 251.4 | 39,013 | 6,444 | 4.6% | 5.8% |
| 2003 | 261.4 | 39,393 | 6,636 | 3.0% | 5.6% |
| 2004 | 277.7 | 39,847 | 6,969 | 5.0% | 4.7% |
| 2005 | 296.0 | 40,325 | 7,340 | 5.3% | 5.7% |
| 2006 | 314.9 | 40,874 | 7,704 | 5.0% | 5.5% |
| 2007 | 334.4 | 41,563 | 8,046 | 4.4% | 5.2% |
| 2008 | 357.2 | 42,404 | 8,424 | 4.7% | 5.1% |
| 2009 | 381.6 | 43,266 | 8,820 | 4.7% | 5.1% |
| 2010 | 407.8 | 44,084 | 9,251 | 4.9% | 5.3% |
| 2011 | 437.3 | 45,058 | 9,705 | 4.9% | - |

Table 2

| Year | Insurance Paid PHE Net Of Rx and Dental | | | |
|------|---|----------|------------|----------|
| | March-02 | | March-01 | |
| | per capita | Increase | per capita | Increase |
| 2000 | \$1,085 | 4.6% | \$1,094 | 6.8% |
| 2001 | \$1,154 | 6.4% | \$1,179 | 7.8% |
| 2002 | \$1,244 | 7.8% | \$1,279 | 8.5% |
| 2003 | \$1,330 | 6.9% | \$1,379 | 7.8% |
| 2004 | \$1,421 | 6.8% | \$1,476 | 7.0% |
| 2005 | \$1,510 | 6.3% | \$1,562 | 5.8% |
| 2006 | \$1,596 | 5.7% | \$1,637 | 4.8% |
| 2007 | \$1,670 | 4.6% | \$1,699 | 3.8% |
| 2008 | \$1,741 | 4.3% | \$1,757 | 3.4% |
| 2009 | \$1,817 | 4.4% | \$1,818 | 3.5% |
| 2010 | \$1,890 | 4.0% | 1,880 | 3.4% |
| 2011 | \$1,963 | 3.9% | - | - |

particular measurement, each economic assumption selected by the actuary should be consistent with every other economic assumption selected by the actuary to be used over the measurement period. The actuary should reflect the same general economic inflation component in each of the economic assumptions selected by the actuary. The relationships among economic assumptions should be reasonable relative to the underlying economic conditions expected throughout the projection period.” NHE projections are based on demographic and macroeconomic assumptions from the intermediate scenario in Medicare trustees reports. Projected growth in Medicare spending reflects the assumption that there will be no alterations to current law (this assumption is required by law for the Medicare trustees report).⁴

There is latitude for projections using different economic scenarios. However, I believe an actuary should be able to defend and describe any alternative economic scenario and explain the impact of it on results produced. If the actuary chooses a scenario similar to the CMS “high cost” scenario, this will generally cause the post-Medicare age retiree medical liability to increase. To choose a scenario similar to the CMS “low cost” scenario might produce favorable results but must be defended. While CMS produces projections under three scenarios, shareholders and other audiences of

retiree medical valuation reports generally expect a number rather than a range under various scenarios as the result. The constraint of a single expense estimate required under accounting standards would seem to require that the result must be defensible under a best estimate of future conditions.

What is a best estimate for Medicare for the practicing actuary?

I believe a best estimate for every valuation of medical benefits covering a Medicare eligible population should have a Medicare trend that is less than the HCCTR, unless clear documentation is presented to defend the projection of Medicare payment increases at a rate equal to or greater than the HCCTR. The determination of the degree of difference between the HCCTR and Medicare trend rate at each year will be difficult. However, the magnitude of the difference is so large that ignoring the impact of this difference cannot be within accepted actuarial practice. ❏

Footnotes

- 1) SFAS 106, par. 40.
- 2) www.hcfa.gov/pubforms/tr/2002/secib.htm
- 3) www.hcfa.gov/stats/NHE-Proj/proj2001/default.htm
- 4) For more information on assumptions in the intermediate scenario see www.hcfa.gov/pubforms/tr/2002/secic.htm.



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