



Seven Reasons to Have an Optimistic View of the Future of Medicare—and ActiveRx

from the Desk of the CEO

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In spite of the polemic debate surrounding Medicare and its impact on our national budget, regardless of the fact that another Baby Boomer turns 65 every seven seconds and that they're living longer, and irrespective of the relatively poor health of the majority of the American population that leads to heightened healthcare expenditures and increases in federal debt, I continue to be optimistic about the future of Medicare as it relates to the ActiveRx business model.

The reality is that Medicare is not going bankrupt. It is not going to cease to exist. And although there will probably be changes to the system over the next decade, I believe that whatever changes occur will most likely enhance our cause rather than detract from it.

It's important to keep in mind that general economic principles, such as the law of supply and demand, still apply to the healthcare industry. Today, there is unprecedented demand for senior rehabilitation services and it will only increase for many years to come.

Therefore (hypothetically speaking), even in the absence of health insurance—like Medicare—there would be no change in the supply of healthcare providers or the demand for their services.

So, it always makes me grin when someone asks me about whether I'm concerned about having a healthcare business model that is focused on Medicare-aged individuals and Medicare reimbursement. My answer is always the same: "No, not really, and let me tell you why..."

This conversation has been part of my daily focus for the past decade—and I'd like to share a summary of the evidence surrounding my outlook. Here are six reasons that I'm optimistic about the future of Medicare and ActiveRx:

#1 The history and need for Medicare – a need that is even greater today.

Medicare was established in 1965 as a federal social insurance program to provide what the private insurance market did not: adequate, affordable health insurance for America's older adult population. Prior to the enactment of Medicare, only about half of persons over age 65 in America had health insurance, and they paid close to three times as much as younger people while having half as much income. Nearly five decades later, Medicare helps pay medical expenses for 39.6 million individuals aged 65 and older and 7.9 million individuals with disabilities.

In general, U.S. citizens or permanent residents are eligible for Medicare benefits if they have worked for at least 10 years in a job that has paid money into the Medicare system. Therefore, it is not a benefit that you are just given when you turn 65. Most of the Baby Boomer generation that is now turning 65 and contributing to Medicare has been paying into the Medicare system for more than 30 years, one paycheck at a time.

Further, according to a survey released in August 2009 by Silverlink Communications and Suffolk University in Boston, more than 94% of Medicare members indicate that they are satisfied with their coverage, with just 6% expressing dissatisfaction. This makes Medicare, arguably, the most beloved federal program in the country among people 65 and older.

Considering that the 60+ demographic controls most of the voting for all elected officials in this country, what do you suppose would happen if anyone in Washington proposed to discontinue Medicare, reduce the coverage or re-privatize the program? You actually don't need to guess—just “Google” the topic and you'll see the backlash that politicians are receiving from the senior community for even suggesting such things.

#2 Not all parts of Medicare are created equal.

Medicare finances are managed through two trust funds, the Hospital Insurance (HI) Trust Fund, which pays for Part A benefits, and the Supplementary Medical Insurance (SMI) Trust Fund, which pays for Part B and Part D benefits.

It is important to note that ActiveRx services are billed thorough Medicare Part B only. This is a part of Medicare that participants must choose and pay out-of-pocket monthly premiums in order to have.

To date, **Medicare Part B has never lost money** because it is funded in a completely different manner from Part A. Part B allows for year-to-year adjustments to maintain its solvency.

Part A of Medicare automatically enrolls individuals age 65 and older if they (or their spouses) are entitled to Social Security benefits and have contributed payroll taxes on their wages for at least 10 years. The Medicare payroll tax is 1.45 percent on the wages of both employers and employees (2.9 percent cumulatively), and is the primary source of funding for

Part A benefits. Unlike Social Security taxes, which are limited to earnings below a certain level, Medicare taxes are collected on worker's entire earnings. In fact, beginning in 2013, the Affordable Care Act (Obama Care) increases Medicare payroll taxes by 0.9% for high-income taxpayers (individuals making more than \$200,000 annually and couples making more than \$250,000 annually). In 2010, payroll tax revenue provided 84.4 percent of the income of the HI Trust Fund, with interest earned on the investments of the Trust Fund and income taxes on a portion of Social Security benefits making up most of the balance.

The SMI Trust Fund consists of two separate parts – one for Part B, which pays for physician and other outpatient health services, such as outpatient rehabilitation, and one for Part D, which pays for outpatient prescription drugs.

Those who choose to participate in Part B or Part D must elect this coverage and pay monthly premiums. Premiums for Part B are required by law to cover 25 percent of SMI expenditures.

In 2011, beneficiaries are paying a monthly premium of \$115.40 for outpatient and other services covered by Part B. Medicare Part D requires an additional premium that averages \$31 per month. Costs of Medicare Part B and D that are not covered by premiums are financed through general revenues such as income taxes paid by taxpayers of all ages.

Medicare participants are also responsible for “cost-sharing” which occurs in the form of deductibles and coinsurance. Additionally, participants must pay for uncovered health services such as routine dental care, eyeglasses, hearing aids, and most long-term services and supports.

#3 The bottom line...

For those of you who like to know the numbers... In 2010, the HI Trust Fund received income of \$215.6 billion and paid out \$247.9 billion in benefits and administrative expenses, leaving a deficit of \$32.3 billion for the year. At the end of 2010, the HI Trust Fund held \$271.9 billion in assets.

Each year, the Trustees Report projects the year that the HI Trust Fund will become insolvent. The HI Trust Fund began running deficits in 2008 and according to the 2011 report, reserves are projected to be depleted by 2024. At that point, if no changes are made, scheduled HI income will cover 90 percent of estimated expenditures.

Put another way, when HI Trust Fund reserves are depleted in 2024, payments to doctors and hospitals can still be made, but only from current payroll tax contributions; it is believed that these tax contributions will only be sufficient to cover 90 cents on the dollar. Congress could make up this gap through direct appropriations.

The estimation of the solvency of the HI Trust Fund is based on a number of economic factors, including changes in demographics and the health care system. Since 1990, estimates of continued HI solvency have ranged from as few as four years to as many as 28 years, with the length of continued solvency averaging 13.7 years. Projections of HI solvency in 2011 fall

just below the average over the last 21 years. HI insolvency has been avoided, in part, because Congress has made frequent adjustments to the program to ensure future spending and resources are in balance.

The SMI Trust Fund, on the other hand, is *always* adequately financed because beneficiary premiums and general revenue contributions are set annually to cover the expected cost of Part B and Part D benefits. However, the rapid rate of growth in program costs will place increasing financial demands on both beneficiaries to pay the premiums and taxpayers to provide the general revenues. In 2010, the SMI Trust Fund had an income of \$270.5 billion and expenditures of \$274.9 billion.

#4 Changes to “entitlement programs” are challenging and very slow to occur.

Medicare was established for a specific purpose; it is adored by the majority of its beneficiaries; it is made up of several parts – Part A, and Parts B/D – which are paid for by completely different trust funds that are never comingled; and, because of this structure we can be assured that the system itself is not at risk for bankruptcy or collapse. Any speculation of the sort is purely hyperbole.

Due to the popularity of Medicare among the population it serves, it is safe to assume that any major changes to it will not only be challenging to get approved, they will have to be phased in changes over a number of years. This would provide ample time for us to adjust the ActiveRx business model accordingly.

I actually welcome such changes. I believe that change can enhance our growth opportunities and propel us further into the limelight as the national leader of the senior rehabilitation industry.

#5 Medicare and other insurers need companies like ActiveRx.

However unsustainable you feel Medicare may be, to abolish it outright would enrage the largest constituency of both parties and be political suicide for legislators hoping to keep their jobs in congress. After all, Medicare is not perceived to be just an “entitlement program”. It’s really thought of as an “earned entitlement program”.

Additionally, it is important to note that the current (and future) demand for both primary care and rehabilitative services, among persons aged 65 years and older, far exceeds the supply of physicians, physical therapists and healthcare professionals who specialize with this population. Therefore, Medicare and other insurers **need** companies like ActiveRx!

I am often blessed with the privilege of being invited to speak about various health-related topics to groups of seniors. Whenever possible, I make an effort to begin my talks with the following remark: “Your attendance at this presentation leads me to assume that you care deeply about your independence, your quality of life, and your ability to remain active and function at your highest level as you age.”

These are the topics that I typically cover in my talks, and as I start, the heads begin to nod, and I will often even get a shout from several in the audience.

My next question is: “So, where do you go to get the support and encouragement you need to accomplish these all-important goals?”

The reality is that, until now, there really hasn’t been a place for them to go that exists for the purpose of serving the needs and desires of older adults. That’s why I typically get blank stares from the audience when I pose the question, and why I lead with it as a way to introduce ActiveRx.

Think about it for a moment. Other than ActiveRx, where would you go? Your doctor, or physical therapist who you need to schedule an appointment with weeks in advance only to get 5-7 minutes of face time when you do arrive, if you are lucky? Your local health club or recreation center may be an option, but what happens if you have a variety of health challenges? Your area senior center is another option, but will you really receive personalized attention from a healthcare provider there?

Herein lies the problem. Until now, there has been no mainstream solution that provides both personalized attention with a healthcare professional for a sufficient amount of time to really make a difference. Interestingly, the problem is the same for the patient, for you, your mom, your dad or loved one, and for the system, including Medicare, other insurers, and the economic system as a whole.

They all need ActiveRx for different reasons.

You know why the patient needs ActiveRx. It may be less obvious why large systems need ActiveRx. To understand this, consider a few more pointed questions: 1) Since ActiveRx clinics are not yet readily available to older adults throughout the country, where are they currently going to get their aforementioned needs addressed? 2) Are the current options making a difference? 3) How many unnecessary doctors visits, hospital visits, and preventable illnesses/injuries occur each year because there is not a readily available proactive healthcare option specifically for older adults? 4) How much money is spent each year on these items? 5) How will this spending affect the U.S. economy if nothing changes?

#6 Medicare will not be discontinued.

In reality, while Medicare may be altered over the next decade, it is certainly not going to be discontinued completely. The economic importance for seniors to have solid healthcare coverage is at an all time high and, therefore, the government will be forced to look for other ways to cover the costs of the Medicare program. Ideas for this generally fall into two categories:

1) Ideas that simply look to pay for the problems, which range from raising payroll tax contributions for younger populations to raising premiums and, or deductibles for Medicare participants, and everything in between;

2) Ideas that include solutions to the problems as part of the plan. This involves elements of the former but also attempts to improve healthcare as a whole by cracking down on fraudulent billing, and rewarding providers who consistently produce outcomes that save the system money. Together, these are thought to be the most practical—and according to most experts—the only realistic solutions for “fixing” the solvency of the Medicare system.

One of our primary objectives for developing the ActiveRx model was to be part of the solution for the Medicare problem.

Why, you may ask would be want to get involved in such a large issue? Well, we figured, someone in healthcare needs to try to do something about it, so why not us...? After all, our mission is to facilitate active aging, through services that improve independence, physical function and quality of life. And, conditions associated with loss of independence and lack of physical activity cost the Medicare system more than anything else. Second to that is fraudulent billing, an absolute epidemic in all of healthcare, especially outpatient rehabilitation.

Therefore, we have made it our business at ActiveRx to set the standard in the industry in both of these areas.

All of our clinics operate in strict accordance with Medicare rules and regulations for billing and charting; our model was founded on evidence from dozens of scientific publications—studies that I personally directed specifically related to rehabilitation, physical function, independence and quality of life with older adults. We have innovated quality control systems to further our standards as we grow; we are committed to producing the best functional outcomes possible; and we’ve been recognized with awards for our efforts.

#7 ActiveRx is part of the solution.

Our system was designed to positively impact the five major chronic conditions for which the Medicare system spends over \$84 BILLION annually. This is our best defense against the corruption that affects the reimbursement rates for the services we provide.

While others may choose to be part of the problem and attempt make as much money as they can while they can by taking advantage of the system, our commitment is to be part of the solution, which I believe will afford us unique opportunities with Medicare and others, regardless of what may happen to the industry as a whole.

We are currently the *only* outpatient healthcare/rehabilitation franchise that is specifically focused on the rapidly growing aging market. This means, we are situated in the most stable industry (healthcare) in a sector (rehabilitative services) that is in incredibly high demand, focused exclusively on a market that is growing like never before—a market that *requires* far more rehabilitative services than any other.

We are also conjoined—for better or for worse—with physicians in how we are reimbursed by Medicare under Part B. There is no specific rehabilitation fee schedule that is separate and

apart from the physician fee schedule, the two are married under Medicare B, which means all changes to fee schedules are experienced by all.

This is another enormous hedge for ActiveRx because medical doctors are probably the second most powerful group to seniors in Washington, and they are governed by an even more powerful group—the American Medical Association (AMA).

Physicians, unlike physical therapists, already believe, by and large, that Medicare does not reimburse them adequately for what they do. Therefore, the likelihood that they are going to stand for any cuts to reimbursement rates is nil. In fact, an alarming percentage of physicians have formed an alliance, backed by the heavy hand of the president of the AMA, and publically threatened to opt out of Medicare if the physician fee schedule is reduced even slightly. The same group is actually calling for increases in payment rates.

The thought of thousands of doctors opting out of Medicare makes both seniors and politicians shudder. Seniors, because they won't be able to get the treatment they need, and politicians because they know that voting for a decrease will cost them their careers. It could also lead to an enormous tsunami of ER/hospital visits among seniors that have been displaced by the loss of their primary care physicians. That it would undoubtedly deplete the HI Trust Fund in no time flat!

In Conclusion

We all know that business success is highly dependent on positioning, timing and execution. I would challenge anyone to find a comparable business model—with comparable start up costs and returns—that is better positioned than ActiveRx.

I am not boasting. The facts are the facts, and our Medicare contract provides a significant advantage over most businesses.

Think about it this way—along with the key market drivers and inherent demand for our services, our model also comes with a built-in government contract—Medicare—something we all know that many businesses strive to attain. This government contract is currently, and will continue to be, a great way to subsidize the expense of ongoing *wellness-oriented rehabilitation*, so that we can stay true to our commitment to “serve the underserved”.

ActiveRx is positioned as part of the solution to some of the biggest problems with Medicare.

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