ISSUE GUIDE

A Guide to Analyzing Medicare Premium Support

American Academy of Actuaries

A GUIDE TO ANALYZING THE ISSUES: MEDICARE PREMIUM SUPPORT

Premium support is a reform option that has been proposed as a way to improve Medicare's financial condition. Medicare, the federal program providing health insurance to virtually all Americans 65 and older as well as many younger individuals with long-term disabilities, is currently inadequately financed to sustain the program for the long term. In addition, over time it will impose larger financial demands on both beneficiaries and the federal budget.

This guide is intended to help voters understand what premium support is and the potential implications of shifting Medicare to a premium support program.

The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

What is premium support?

Under a typical premium support approach, Medicare beneficiaries would receive a government contribution (sometimes referred to as a voucher) to apply toward the premium of a health plan of their choice, perhaps with the traditional Medicare program being one of the choices. Beneficiaries choosing a plan with a premium greater than the government contribution would be responsible for paying the difference. The federal government contribution could change over time, for example in accordance with inflation or average premium growth.

How would premium support change the structure of the current Medicare program?

Medicare beneficiaries today can choose to enroll either in the traditional fee-for-service (FFS) Medicare program or in a private Medicare Advantage (MA) plan. In Medicare Advantage, plans submit bids based on the same benefits that are available in the FFS program. Bids reflect each plan's expected cost of providing these benefits. Government payments to plans are tied to benchmarks that reflect costs under the FFS program. Plan bids are compared to the benchmarks. If an MA plan's bid exceeds the benchmark, beneficiaries choosing that plan must pay an additional premium. If an MA plan's bid falls below the benchmark, a portion of the difference is provided to the plan to fund benefits in addition to those provided by traditional Medicare.

The Medicare program today essentially follows a defined benefit approach. In other words, the government pays whatever is needed to cover a defined benefit package and bears the risk of health spending growth. Premium support proposals would change the nature of the Medicare program from a defined benefit approach to what is considered a defined contribution approach. Under a defined contribution approach, depending on how the federal contribution is defined, government spending may be capped and beneficiaries could bear the risk of health spending growing faster than the cap.

Advocates of premium support reforms argue that capping the government contribution could encourage insurers to develop and beneficiaries to choose more cost-effective health plans. Opponents of premium support have argued that rather than reducing overall Medicare spending, premium support may shift costs to beneficiaries and make coverage less affordable.

Are there any premium support-type approaches currently used for health insurance?

The current Medicare Part D prescription drug program contains elements of a premium support approach. In particular, it uses a competitive bidding approach to determine how much the government will contribute toward the plan premiums. Private prescription drug plans submit bids that reflect the expected premiums they require to provide prescription drug benefits to Medicare beneficiaries. The government contribution toward these plans is approximately 75 percent of the average premium bid for basic coverage.[1] Beneficiaries who choose

[1]Plan bids and enrollee premiums are based on a standardized population. Government payments to plans, however, are risk-adjusted to reflect enrollee characteristics and health conditions that can affect their prescription drug spending.

plans with higher premiums or benefits beyond basic coverage pay higher premiums. Beneficiaries who choose plans with below-average bids pay lower premiums.

Under the Affordable Care Act, insurance coverage in state health insurance exchanges also will contain elements of a premium support approach. In particular, premium subsidies will be available for low- and moderate-income individuals and families, and these subsidies will be based on the second-lowest-cost silver tier plan available in the geographic rating area. Participants choosing plans with higher costs would have to pay the difference.

Some employer-based health insurance coverage also can have premium support elements. There are employers who offer multiple plan options to their employees, but set a fixed employer premium contribution cap regardless of the plan chosen. Employees choosing higher-cost plans would have to pay higher premiums. The health plan for federal government workers is one example.

What details matter most when designing a Medicare premium support program?

There are different ways to design a premium support program. How the details are developed will affect how beneficiaries fare and whether Medicare costs are contained.

HOW THE GOVERNMENT CONTRIBUTION IS SET AND HOW IT GROWS OVER TIME

Under a premium support program, not only would an initial government contribution need to be determined, but also how that contribution grows over time. One option would be to set the initial contribution at the estimated average per-beneficiary government cost under the current Medicare program. Another option would be to use competitive bidding to determine the government contribution (e.g., set the government contribution at some percentage of the average premium bid). Under either option, depending on the premiums for plans offered in the premium support program, beneficiary premiums could be greater or less than those they would have paid under the current Medicare program.

Perhaps even more important than how the initial government contribution would be set is how it would increase over time. Over the past several decades, spending on health care services has increased faster than general inflation and the economy as a whole. Indexing the government contributions to general inflation, the economy, or some other index that doesn't keep pace with health spending growth could put pressure on insurance plans to contain costs. But if the government contribution does not increase at least as much as the health spending underlying the plan premiums, then a greater share of Medicare costs would be shifted to beneficiaries over time, either in the form of higher premiums or in the form of higher cost sharing if they choose less generous plans. Increased cost sharing likely would result in reduced health care utilization, but also could result in beneficiaries foregoing needed care, particularly lower-income beneficiaries. Tying the government contributions to the increases in the average premium bids would help prevent costs from being shifted to beneficiaries because bids would track better to changes in health spending, yet still would provide an incentive for beneficiaries to move to lower-cost plans.

WHETHER THE TRADITIONAL MEDICARE FFS PROGRAM IS RETAINED AS A PLAN OPTION

Under the current Medicare program, beneficiaries have the option of choosing either the traditional FFS plan or one of the available private Medicare Advantage plans. The premium support program could be structured such that the FFS plan remains available to all Medicare beneficiaries, is available only to beneficiaries already enrolled in Medicare at the time premium support is implemented, or is not available to any beneficiaries, including those already enrolled.

Retaining the FFS plan option for all current and future Medicare beneficiaries would provide greater continuity with the current program. Rules may be needed, however, to ensure fair competition between FFS and the private plan options. Allowing only current Medicare enrollees to continue having the FFS option would mean that over time the FFS program would consist of older beneficiaries who would likely have more costly health care needs. That could have negative consequences for the financing of the program unless funds are shifted from the other plans to the FFS program to reflect its higher-cost population. Eliminating the FFS program altogether could have implications for the costs of the private plans. The Congressional Budget Office has estimated that rates paid to health care providers are higher for private health insurance plans than for Medicare. With no FFS plans these higher costs would not be fully offset by savings from greater utilization management in private plans.[2] Depending on local-area market dynamics, the presence of the FFS plan could provide leverage to private plans in their rate negotiations with providers, thus reducing the cost of claims, and therefore premiums, below what they otherwise would be in absence of the FFS option.

HOW THE BENEFIT PACKAGE IS DEFINED

Medicare Advantage plans must cover at least the same benefits offered in the traditional Medicare FFS option. Premium support plans could be subject to these same types of requirements or new standardized or minimum benefit packages could be required.

As an alternative, plans could be provided more leeway in designing their benefit packages. Allowing plan flexibility in benefit designs could allow more timely adoption of innovative benefits and designs. But allowing more flexibility could be confusing for beneficiaries and could also lead to the unintended consequence of plans with benefit packages intentionally designed to avoid appealing to beneficiaries with relatively high-cost health care needs. To mitigate these potential consequences, it would be necessary to implement a risk-adjustment mechanism to ensure that plans are appropriately paid for the risks they bear. Additional requirements also could be considered, such as prohibiting discriminatory plan designs or marketing practices, ensuring an adequate provider network, and developing insurance exchanges to better facilitate the beneficiary decision-making process.

WHETHER THERE IS ADDITIONAL FINANCIAL PROTECTION FOR LOW-INCOME BENEFICIARIES

Low-income individuals especially can be at

[2]Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan," April 5, 2011 (revised April 8, 2011). Available at: http://cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf.

risk for avoiding or delaying health care due to costs. Under the current Medicare program, certain low-income beneficiaries receive premium subsidies and some receive cost-sharing subsidies as well.

A premium support program could be structured to include premium and/or cost-sharing subsidies for low-income beneficiaries. These could come in the form of direct payments to the health plans or as deposits to health savings accounts that are held by the beneficiaries. The degree to which such subsidies would ensure access to affordable care for low-income beneficiaries would depend on their form and amount.

WHEN THE TRANSITION TO PREMIUM SUPPORT TAKES PLACE

Some proposals would implement the transition to a premium support model fairly quickly, within the next few years, and others would delay the implementation for a longer period, for example 10 years. The timing of the transition would affect the plan options available to current and future Medicare beneficiaries as well as which generations share the burden of any lower Medicare spending. A longer transition prior to implementation would allow beneficiaries who eventually would be affected by the change more time to understand and adapt to the new program. Delaying the implementation would shield current beneficiaries and those near retirement from any changes, especially if they can continue in their current plans after the transition. Delaying changes, however, would mean that future Medicare enrollees would be the ones to face any Medicare changes, either positive or negative. And any spending reductions necessary to ensure long-term Medicare solvency and sustainability would need to be greater if borne only by future Medicare enrollees.

OTHER DESIGN DECISIONS

Similar to the current Medicare program, most, if not all, Medicare premium support proposals would prohibit plans from denying coverage or charging higher premiums based on age or health status. To ensure that plans are adequately compensated to reflect the health costs of their enrollee populations, it would be necessary for the government contribution (as opposed to the beneficiary premium) to be risk adjusted so that it varies across plans based on age, health conditions, and other factors that are correlated with health spending.

In addition, decisions would need to be made regarding whether the government contribution would differ by region to reflect geographical variations in health spending. If the government contribution doesn't vary, then beneficiaries' premiums would vary not only depending on what plan they choose, but also based on where they live. Another consideration would be whether the government contribution would differ depending on a how a plan rates on quality-related measures.

Would a premium support approach reduce Medicare spending?

The specifics of the premium support approach would affect whether and to what degree it could reduce Medicare spending. Many of these factors are discussed above. Depending on how the government contribution is set, federal Medicare spending could be lower than currently projected. Whether those sav-

ings result in lower overall Medicare savings or instead a shift in costs from the government to Medicare beneficiaries also depends on how utilization management, administrative costs, and provider payment rates under private plans would compare to those under traditional Medicare over time. Ensuring overall Medicare savings rather than just savings to the government may require that plans are structured to facilitate higher quality care and more cost-effective health care payment and delivery systems. In addition, effective incentives for beneficiaries to become more cost-conscious health care consumers may be required.

More information on Medicare

The more you know about how Medicare works, its financial condition, and the options available for reform, the better equipped you will be to evaluate what candidates have to say about the program. You may want to further your understanding with the following Academy publications:

- A Guide to Analyzing the Issues: What Voters Should Know About Medicare
- Medicare's Financial Condition: Beyond Actuarial Balance
- An Actuarial Perspective on Proposals to Improve Medicare's Financial Condition
- Revising Medicare's Fee-For-Service Benefit Structure

AMERICAN ACADEMY *of* ACTUARIES

Mary Downs, *Executive Director*
Craig Hanna, *Director of Public Policy*
Cori Uccello, *Senior Health Fellow*
Heather Jerbi, *Assistant Director of Public Policy*
Charity Sack, *Director of Communications*

Members of the Health Practice Council Communications Task Force:
Thomas F. Wildsmith, MAAA, FSA, chairperson; Mark J. Jamilkowski, MAAA, FSA; Darrell D. Knapp, MAAA, FSA; Donna C. Novak, MAAA, ASA, FCA; David A. Shea, Jr., MAAA, FSA; Cori E. Uccello, MAAA, FSA, FCA, MPP; Shari A. Westerfield, MAAA, FSA.

For further information, contact us at:

AMERICAN ACADEMY *of* ACTUARIES
1850 M Street NW, Suite 300
Washington, DC 20036-5805
Telephone 202 223 8196
Facsimile 202 872 1948
WWW.ACTUARY.ORG