AMERICAN ACADEMY of ACTUARIES

Ms. Anne Mutti
National Bipartisan Commission on the Future of Medicare
Adams Building - Room 144
101 Independence Ave., SE
Washington, DC 20540-1998

February 17, 1999 **Hand Delivered**

Re: Proposed Changes to Medicare and Medicare Supplement Insurance Benefits

Dear Ms. Mutti:

This letter is submitted to the staff of the Medicare Commission on behalf of the American Academy of Actuaries' Health Practice Council. The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession.

I am writing in response to the questions you have raised regarding possible changes to the current Medicare benefit structure as well as modifications to the coverage requirements for Medicare supplement insurance (Medigap). I have restated your questions below along with our comments.

The responses in this letter were prepared by a work group of Academy volunteers with health actuarial practice expertise. In addition to myself, members of the work group are: Dwight Bartlett, III, Tony Hammond, Donna Novak, Julia Philips and Harry Sutton. The information in this letter is based on our professional experience and readily available health data.

As an initial matter, I would like to set out several general caveats to the comments which we have provided in this letter. As you are aware, Medicare beneficiaries and those individuals covered by Medigap policies have their own specific health needs and patterns of utilization of medical services which are different from the general population. While it is helpful to look at data from other sources, such as information showing the cost of medical services in the employer group health insurance market, care should be taken when applying this information to individuals covered by Medicare or the subset of those with Medigap coverage.

It is also important to consider the relationship between the various benefit components which make up Medicare and the Medigap market. Any modifications which might be made to one part of Medicare will usually impact the entire Medicare system and Medigap market. In addition, you

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need to look at the potential impact of state laws, such as requirements for the guaranteed issue of Medigap policies. It is also important to remember that any changes to the requirements for Medicare supplement insurance policies will be prospective and will not impact existing policyholders. In addition, changes to the coverage requirements in Medigap policies do not directly affect employer group health retiree coverage.

Finally, in preparing this letter, we did not have sufficient time or resources to undertake a thorough analysis of your proposed modifications to Medicare and to the Medicare supplement insurance market. Other organizations may have data available and, therefore, be better prepared to provide you with more specific estimates of the impact of your proposals. We are available to continue working with the Medicare Commission staff on a formal or informal basis to discuss any additional questions you might have in the future.

Questions/Answers:

We would like to make a few observations about the specific questions which you raised. You have based your questions assuming Medigap plans with a prescription drug benefit (Rx benefit) that is "actuarially equivalent" to a $600 annual premium. As you are aware, there are regional variations in medical costs and rates of utilization of medical services.

In order to provide a prescription drug benefit with a $600 premium to each Medicare beneficiary throughout the country, such coverage would have to be defined as a set dollar amount with a yearly maximum. Alternatively, a prescription drug benefit defined in terms of similar, or actuarially equivalent benefits nationwide could be offered, but the actual premiums may vary considerably.[1] In addition, you must recognize that state laws frequently require insurers to underwrite Medigap policies on a state-by-state basis which does not permit the nation wide pooling of Medigap risks.

In answering the following questions we considered four new Medigap plans proposed by the commission staff. Note that the "standard" prescription drug benefit was not defined.

(1.) Plan A:

Deductible/Copayment: None specified
Rx Benefit: Standard benefit, but actuarially equivalent to $600 annual premium.
Other Benefits: None.

[1]The Medicare Commission might also examine the impact of other prescription drug benefit designs, such as higher copayments or coverage only for certain types of "basic" drugs such as those regulating high blood pressure.

(2.) Plan B:

Deductible/Copayment: $1,500 deductible on Rx benefit.
Rx Benefit: Standard benefit with full coverage after deductible.
Other Benefits: None.

(3.) Plan C:

Deductible/Copayment: $10 Copayment.
Rx Benefit: Standard benefit with $10 copayment.
Other Benefits: Current Plan F benefits, but excluding combined Parts A and B deductible of $380.

(4.) Plan D:

Deductible/Copayment: None specified.
Rx Benefit: Standard benefit.
Other Benefits: Current Plan F benefits, including combined Parts A and B deductible of $380.

1. *Assume the new Medigap Plan* A *outlined above is issued in year 2000 and assume the drug benefit is actuarially equivalent to a benefit with a premium of $600 per member per year (pmpy) for the average Medicare recipient. What would the year 2000 premiums be? What would the premiums be for the next 4 years?*

The benefits provided under the new Medigap plan would have to be carefully defined to ensure that the prescription drug benefit would have a $600 annual premium. If Rx benefits were limited to a specific dollar amount or annual maximum, premiums could be reasonably close to the desired $600 annual premium. For example, if the Rx benefit is described as paying the first $540 in drug costs in a year and the cost of that benefit averages $480 pmpy (average cost is less than $540 because every insured does not incur $540 of drug costs), and assuming a 20% administrative load (0.2 x $600 = $120), the premium would be $600 pmpy or $50 per member per month (pmpm). The premium amount would remain $600 pmpy unless the benefits were indexed or otherwise increased.

However, if the benefit were described as 50% of all covered drug costs above a $500 deductible, because it was found that such a benefit would equal a $600 annual premium in year 2000 for the average Medicare beneficiary, the Rx benefit may cost more or less than $600 pmpy depending on geographic area, the population enrolled and other factors. The premium would be $600 pmpy ($50 pmpm) only if an average Medicare population were to enroll in the Medigap plan in an

average cost area of the country. It is more likely that premium rates would range from 70% of the average rate to more than 150% of the average rate just for area differences alone.[2]

What would premium rates look like over the next 4 years? Assuming the premium starts at $50 pmpm in year 2000 and assuming an average trend of 15%, the estimated monthly premium per member for 2001 would be $57.50 (=1.15 x $50.00). The estimated premium for 2002 would be $66.13 (=1.15 x $57.50); the premium for 2003 would be $76.05 (=1.15 x $66.13); and the premium for 2004 would be $87.46. If the cost and utilization trend were higher, for example, 25%, premiums would be $62.50 in 2001, $78.13 in 2002, $97.66 in 2003 and $122.07 in 2004.

2. *Are there other actuarial considerations to implementing the proposed Medigap plans?*

We would expect risk segmentation within the market to increase if the proposed Medigap plans were offered. Risk segmentation is the tendency for health plans to attract enrollees with higher or lower than average health costs. In general, plans offering more benefits or a greater choice of options or providers tend to attract higher risk enrollees, and vice versa. Since the proposed plans offer Rx coverage that may not be available elsewhere, plans without Rx coverage would tend to attract lower risk populations while the proposed plans may attract higher risk populations.[3]

The increased cost of the drug benefits for the proposed plans could drive some purchasers from the market. If Medicare enrollees can keep their current Medigap plans, a new plan that is similar but adds an Rx benefit, will tend to attract high risk enrollees from the old plan. If higher risk enrollees are allowed to enroll in the new plan, the per capita cost under the old plan will decrease below the previous average, while the per capita cost in the new plan will increase above the previous average per capita cost.

For a given population, people who do not have to spend their own money on services will have a tendency to use more of those services. That is, the Medigap population tends to use more services than a similar population not covered by Medigap. This tendency, called induced demand, increases the Medicare cost for the Medigap population.

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[2]A William M. Mercer study of their managed pharmacy practice client data base showed cost and utilization trends (annual percentage increase in per capita cost) of from 7 to 22 percent in 1998. Other actuaries and consultants have reportedly observed trends as high as 25 percent and more on some prescription drug plans. While Pharmacy Benefit Managers (PBMs) can control some trend increases by modifying Rx plan benefits and the prices paid for drugs, some of the factors contributing to the current increases in Rx benefit costs are outside of the control of the PBM - - such as technological advances, the rate of approvals for new drugs by the Federal Drug Administration and the impact of the direct advertising of brand-name drugs.

[3]The impact of some of these problems would be moderated if <u>all</u> Medigap policies were required to provide Rx coverage. The key issue would be how long of a transition period there would be until all individuals with Medigap policies had Rx coverage since you could not require existing policies (i.e. those sold before the law changed) to provide such pharmacy benefits.

There is some evidence that individuals with coverage under Medigap policies tend to use more services under Medicare. However there is no evidence that adding an additional benefit to Medigap coverage, such as prescription drug coverage, will increase or decrease the cost to Medicare.

The Medigap market may already be showing signs of what we call an assessment spiral. An assessment spiral occurs when enrollment in a plan keeps decreasing as costs per capita (per member) keep increasing. Adding a prescription drug benefit to all Medigap plans could exacerbate the tendency toward an assessment spiral and attendant risk segmentation. Coverage for prescription drugs would increase premiums for these plans compared with similar Medigap plans without the Rx benefit and trigger further adverse selection, when healthier enrollees decide to drop coverage because they perceive the cost of coverage to be higher than their expected health care costs. Adverse selection can be a particular problem when states guarantee coverage or require open enrollment; in which case, Medigap-eligibles may wait to purchase coverage until they expect to really need the benefit, increasing benefit costs overall.

3. *What would be the implications of subsidizing low-income (non-dual eligibles) so that they could participate in the proposed Plans A or B?*

Subsidizing the low-income, "non-dual eligible**"** populations may increase the overall cost per member somewhat. These "non-dual eligible" are Medicare beneficiaries who are not eligible for Medicaid coverage because their incomes exceed the applicable limits. However, it is likely that only a fraction of those non-dual eligible would avail themselves of the subsidy and the coverage. A low participation rate may be sufficient to keep any aggregate increases in cost low, but that is by no means certain.

Personal income and Medigap coverage are directly correlated. As an individual's income increases, the probability of purchasing Medigap coverage increases. Likewise, for people with very low incomes, affordability also drives the decision to seek health care or health insurance. Thus, a decision to purchase coverage (assuming coverage is available to those currently enrolled) may be put off until medical problems persist and the out-of-pocket cost for health care exceeds the cost of insurance (i.e., the premium plus copayments).

Unfortunately, some studies suggest that no amount of subsidy will make people with very low incomes proactive, such that they will seek insurance and health care while they are still healthy and have lower health costs. Also, subsidies may be paid to some people who would have bought the coverage without the subsidy. Medicare beneficiaries with marginal incomes may expect to utilize Medicaid if they become sick and thus refuse to enroll in a Medicare plan if premiums are required.

On a more positive note, experience in Minnesota and some other states indicates that the level of publicity and ease of enrollment can increase enrollment and lower the per capita cost of these programs but the total subsidy cost would be higher than it would be with low participation. If one assumes that a federal program would have good publicity and easy enrollment, then the per capita cost could be lower.

4. *Please provide a description of drug benefits that, on a national average and actuarially equivalent basis, would have a premium of $600 per member per year in 2000. (Assume that the benefit doesn't vary by region and assume an 80% loss ratio, i.e., the ratio of claims to premium is 80%?)*

We hesitate to answer this question without more data and sufficient analysis. As stated previously, there are other organizations which have data available and are a more appropriate source for information about the impact of your proposals. We have provided a few examples to illustrate the magnitude of the cost of prescription drug benefits for elderly populations (Attachment 1).

We would like to thank you for the opportunity to assist the staff of the Medicare Commission with these issues. If you have additional questions or would like further clarification of any of the responses in this letter, please feel free to contact any of the members of the work group through Tom Wilder with the American Academy of Actuaries at (202) 785-7875 or wilder@actuary.org.

Sincerely,

James J. Murphy
Vice President, Health

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