MILLIMAN WHITE PAPER

Premium support models for Medicare: Practical considerations

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As Baby Boomers turn 65 and the government continues its struggle to control costs, the focus is once again on reforms to reduce, or limit the rate of increase of, federal spending on Medicare. Medicare premium support is among the concepts often discussed in policy circles to achieve this goal. In concept, premium support programs attribute to each Medicare beneficiary a set dollar-amount federal contribution, which the beneficiary uses to buy an allowed Medicare option. Today, Medicare could spend different amounts on the same beneficiary depending on that person's choice in a region—between Medicare Advantage or traditional Medicare—and this suggests that Medicare would save money by encouraging beneficiaries to choose options that are lower cost for Medicare. The prominent proposal, which we discuss in this paper, would make the options that are low cost for the beneficiary the same as the low-cost options for the Medicare program. The federal contribution would be tied to a low-cost option, and if the cost to Medicare for the plan elected by the beneficiary were higher, the beneficiary would pay an extra premium.

This paper describes some of the key financial and insurance issues involved in premium support proposals for Medicare Parts A and B. We discuss the potential advantages and disadvantages of such an approach. Implementation would likely require acts of Congress, not just changes from the Medicare Administrator.

Introduction to premium support for Medicare Parts A and B

Currently, Medicare Part A requires no premium contribution from most beneficiaries.[1] Medicare beneficiaries must pay the Part B premium to receive Part B benefits, whether they enroll in Medicare Advantage or traditional Medicare. The Part B premium may be subsidized by Medicaid for low-income individuals. Each year the Part B premium is set at 25% of projected average per capita Part B program costs for aged beneficiaries.[2] Overall, beneficiaries also bear about 20% cost sharing for covered Medicare expenses, which may also be subsidized by Medicaid for some individuals. Not counting beneficiary cost sharing, the Medicare trust funds pay all Part A expenses and 75% of Part B expenses.

Under a typical premium support model, a total dollar value or price would be assigned to each qualified Medicare option within each geographic area, including traditional Medicare as one option. In this paper we use the term "price" to represent the estimated cost to the plan, or to Medicare in the case of traditional Medicare, of providing the covered benefits. Based on these prices, the federal contribution would be set or fixed to represent the amount that the Centers for Medicare and Medicaid Services (CMS) would pay for Medicare benefits, without regard to which option is chosen by the beneficiary.

The federal contribution would likely be set to cover all or a share of a low-priced option. If the beneficiary chooses an option that has a higher price than the federal contribution, the beneficiary would pay the difference. This creates an incentive for the beneficiary to choose a lower-priced option.

Under the current funding rules, benefits under Medicare Advantage plans and traditional Medicare can cost the Medicare trust fund different amounts for the same beneficiary. In some areas, Medicare Advantage plans are less expensive to the Medicare trust fund than the average cost of traditional Medicare, and in other areas they are more expensive.[3] A premium support system would provide beneficiaries with a direct incentive to choose the lowest-cost option available to them. Some beneficiaries would have to pay higher premiums for traditional Medicare, which is not currently the case. By linking the federal contribution to a low-cost option, Medicare would save money.

Medicare Advantage plans have become popular, with 31% of beneficiaries electing Medicare Advantage in 2016,[4] so changes

1 CMS (November 3, 2015). Original Medicare (Part A and B) Eligibility and Enrollment. Retrieved September 7, 2017, from https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol/.

2 Davis, Patricia A. (August 4, 2016). Medicare: Part B Premiums. Congressional Research Service. Retrieved September 7, 2017, from https://fas.org/sgp/crs/misc/R40082.pdf.

3 Biles, B., Casillas, G., & Guterman, S. (January 28, 2016). Does Medicare Advantage Cost Less Than Traditional Medicare? The Commonwealth Fund. Retrieved September 7, 2017, from http://www.commonwealthfund.org/publications/issue-briefs/2016/jan/does-medicare-advantage-cost-less.

4 Kaiser Family Foundation (May 11, 2016). Medicare Advantage: Fact Sheet. Retrieved September 7, 2017, from http://kff.org/medicare/fact-sheet/medicare-advantage/.

to the system could cause millions of beneficiaries to change their choice of plans. Creating a level playing field between traditional Medicare and Medicare Advantage would be an intense issue given the significant enrollment in each.

Important considerations for a premium support program

As with any new policy, the devil is in the details. These details would have a substantial impact on the cost of care for both Medicare beneficiaries and the Medicare trust fund.

- *How would traditional Medicare be treated?* Most premium support proposals would consider traditional Medicare as a competing plan because its own price would compete with other coverage options offered by private health plans. Traditional Medicare competing with Medicare Advantage plans would create fundamentally new dynamics in the Medicare program.
- *What are the bidding areas?* Currently, Medicare Advantage rates can vary by county, but that may not make the most sense from a provider contracting perspective. There are a number of metropolitan areas throughout the country that cross multiple counties. Bidding areas could extend to encompass multiple counties or metropolitan statistical areas (MSAs), some of which cross state lines. Given that substantial variation in the federal contribution could exist across geographic areas, it will be important to consider how the size and orientation of the bidding areas may influence such variation.
- *What is the level at which the federal contribution would be set?* Medicare would need to determine an appropriate federal contribution level for beneficiaries to use to purchase their Medicare plans. The level of this contribution is one of the most important financial considerations in implementing a premium support program, as it directly implicates not only the cost of the program to Medicare but also the cost to the beneficiary of purchasing coverage. Some proposals envision that the federal contribution would be set at the second-lowest-priced plan, similar to the low-income subsidy for eligible individuals in the Patient Protection and Affordable Care Act (ACA) marketplace. This would assure that there would be at least one option that was free to beneficiaries after paying the Part B premium. Other proposals suggest setting the federal contribution at the average price. Others recommend that the federal contribution be set based on the average cost of traditional Medicare coverage in the service area.
- *How much should be done to mitigate large premium increases year over year?* In years of rapidly increasing healthcare costs, the resulting prices would reflect similar increases. This raises the question of whether the federal contribution should be limited. If the federal contribution is set equal to the price of one of the plans or the average, then the contribution would increase as plan costs increase. If the federal contribution does not keep pace with the increase, the beneficiary contribution to achieve the same coverage would increase over time and may become unmanageable. What would happen to beneficiaries who can no longer afford any of the available plans with the defined federal contribution?
- *Would Medicare Advantage plans and traditional Medicare be required to offer the same standard benefit designs?* Currently, Medicare Advantage bids must cover at least traditional Medicare benefits, but the actual Medicare Advantage product designs are very different. However, in the ACA marketplace, plans must offer benefits that fall into platinum, gold, silver, or bronze definitions, which enables shoppers to more easily compare competing plans. The challenge with any premium support arrangement is the ability of buyers to evaluate the available plans and effectively choose the one that is best for them. A lack of standardization makes informed decisions more challenging, which may negatively affect the ability of beneficiaries to choose the most cost-effective plan for their individual situation. Furthermore, if a standard benefit design is not mandated, the potential for cheaper, bare-bones plans could emerge for those beneficiaries that have little or no resources to devote to purchasing more generous coverage that could come with larger premiums. This could bifurcate the market into two strata, with one program competing solely on minimizing costs (which could be to the detriment of the quality of the coverage if minimum requirements are not enforced).
- *How would the Medicare Supplement or Medigap market need to change?* Around one in four traditional Medicare beneficiaries purchase supplemental Medigap coverage to cover their cost sharing.[5,6] However, such policies are not allowed for beneficiaries in Medicare Advantage. If Medicare Advantage and traditional Medicare offered the same plans, should Medigap continue to be allowed? Should it be allowed in conjunction with some Medicare Advantage plans?
- *Would traditional Medicare introduce out-of-pocket limits like Medicare Advantage?* Out-of-pocket spending for Medicare Advantage beneficiaries is limited to no more than $6,700 for Medicare Parts A and B. However, traditional Medicare has no out-of-pocket spending limits.[7] Therefore, high-cost beneficiaries can incur much larger out-of-pocket

5 Cubanski, J., Swoope, C., Boccuti, C. et al. (March 20, 2015). A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers. Kaiser Family Foundation. Retrieved September 7, 2017, from **http://kff.org/report-section/a-primer-on-medicare-what-types-of-supplemental-insurance-do-beneficiaries-have/**.

6 Jacobson, G., Neuman, T., & Damico, A. (April 13, 2015). Medigap Enrollment Among New Medicare Beneficiaries: How Many 65-Year-Olds Enroll in Plans With First-Dollar Coverage? Kaiser Family Foundation. Retrieved September 7, 2017, from **http://www.kff.org/medicare/issue-brief/medigap-enrollment-among-new-medicare-beneficiaries/**.

7 Jacobson, G., Gold, M., Damico, A., Neuman, T., & Casillas, G. (December 3, 2015). Medicare Advantage 2016 Data Spotlight: Overview of Plan Changes: Limits on Out-of-Pocket Spending. Kaiser Family Foundation Issue Brief. Retrieved September 17, 2017, from **http://kff.org/report-section/medicare-advantage-2016-data-spotlight-overview-of-plan-changes-limits-on-out-of-pocket-spending/**.

expenses than they would with a Medicare Advantage plan. If traditional Medicare were to introduce out-of-pocket limits, the cost to Medicare would increase, the need for Medigap policies would be reduced, and cost sharing for high-cost beneficiaries would be limited.

- *Should traditional Medicare be subject to quality targets the way Medicare Advantage is subject to star ratings?* If traditional Medicare in a region is low quality and low cost, should beneficiaries be discouraged from enrolling in it? Discouraging beneficiaries from enrolling in traditional Medicare seems unlikely, but if traditional Medicare is competing with Medicare Advantage plans, shouldn't it be held to the same standards with regard to quality?
- *How would variation in population risk affect payments in the program?* Currently, payments to Medicare Advantage plans are based on the risk scores of enrolled beneficiaries. Under a premium support program, the federal contribution would need to be adjusted for the risk score of the enrolled beneficiaries. An unadjusted federal contribution could lead to plans targeting low-risk-score individuals or high-risk individuals being priced out of the market because the difference between the plan price and the unadjusted federal contribution would be too large.
- *Which beneficiaries would be included in the program?* When a premium support program is initially rolled out, Medicare could implement the program for all current beneficiaries, or it could only include beneficiaries who become Medicare-eligible after a certain date. Rolling the program out only to newly eligible beneficiaries may ease some concerns current beneficiaries have about changes in their benefit structure. This decision could implicate how quickly any potential cost savings could be achieved.

Potential implications of premium support

A premium support model has the potential to fundamentally change the way Medicare benefits are provided to eligible individuals. Such a model would substantially influence both beneficiary and federal spending far into the future.

Financially, the possible implications of some premium support models have been scored by the Congressional Budget Office (CBO) to demonstrate the level of savings or costs to the federal government and affected beneficiaries. Under the options examined, the CBO found that net federal spending for Medicare would decrease in 2024 relative to current law by $84 billion (a 9% decrease) in the second-lowest-bid option (where the federal contribution is set at the second-lowest bid), and by $41 billion (a 4% decrease) in the average-bid option (where the federal contribution is set at the average bid). However, it is worth noting that the CBO projected an increase in spending by beneficiaries on their own premiums and care in the second-lowest-bid option.[8]

From a beneficiary perspective, the design of any premium support model would be under pressure to demonstrate that beneficiaries would have access to comprehensive coverage for an affordable price. Without sufficient information on the similarities and differences among various plans, beneficiaries may be at a disadvantage in terms of their ability to identify plans that best meet their needs. Financially, beneficiaries are at risk of incurring an increasing percentage of the cost of these plans if the federal contribution is less than the cost of the plans. In the second-lowest-bid option that was scored by the CBO, beneficiaries' spending was projected to increase by 18% (including both premiums and other out-of-pocket costs) in 2024 relative to the amount projected under current law, which represents a substantial increase in out-of-pocket costs for the same level of care.[9]

Testing premium support in a select population may be possible

Because of the complex decisions needed for premium support, reformers may want to roll out premium support in a measured way, testing it in a subset of the Medicare population before rolling it out to all beneficiaries. One approach might be to require a premium support program only for subsidized populations, such as dual eligibles, where state Medicaid programs purchase Part B premiums and may subsidize beneficiary cost sharing. Dual eligible beneficiaries would have their choice of the less expensive options (between traditional Medicare and Medicare Advantage), and states could save money. The implications of such a model on the cost to beneficiaries and quality of care would be heavily influenced by the considerations discussed above.

8 CBO (October 2017). A Premium Support System for Medicare: Updated Analysis of Illustrative Options.

9 CBO, ibid.

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