Premium Support In Medicare: A Way Forward

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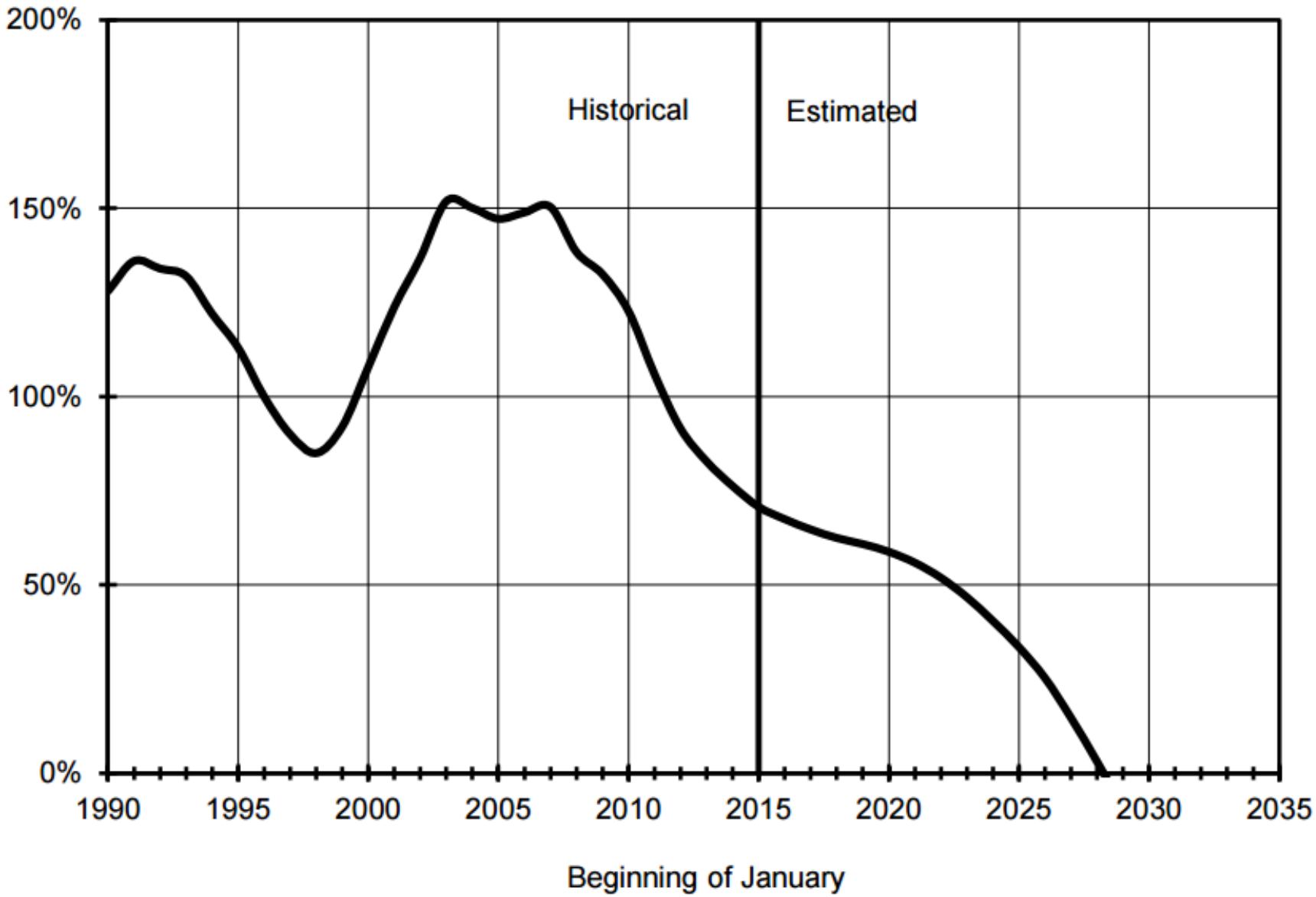
Medicare Today

- Not just one program
- ACOs, HRRP, BPCI, and many other acronyms are new additions that alter the way that the program pays for various services
- Core structure is unchanged from the 20th century
  - Siloed payment sources – IPPS for inpatient; ASP+6 for outpatient drugs; RBRVS for physician services; Part D for retail drugs etc.
  - No OOP limit, different cost sharing for Parts A & B
  - Runs counter to modern-day insurance structure

Figure II.E1.—HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures



Reform is Coming

- The sooner, the less drastic the change
  - Part A (HI Fund): closing 75-year actuarial deficit requires immediate 25% increase in payroll tax or 16% cut in expenditures (2016 Medicare Trustees Report)
  - Part B & D (SMI): share of revenues going to SMI expected to reach 21% in 2030, up from 13.5% in 2015
- Another case for reform – value to beneficiaries
  - Medicare's weak incentives for care coordination
  - No differentiation between high quality vs low quality providers

Reform is Coming (ctd.)

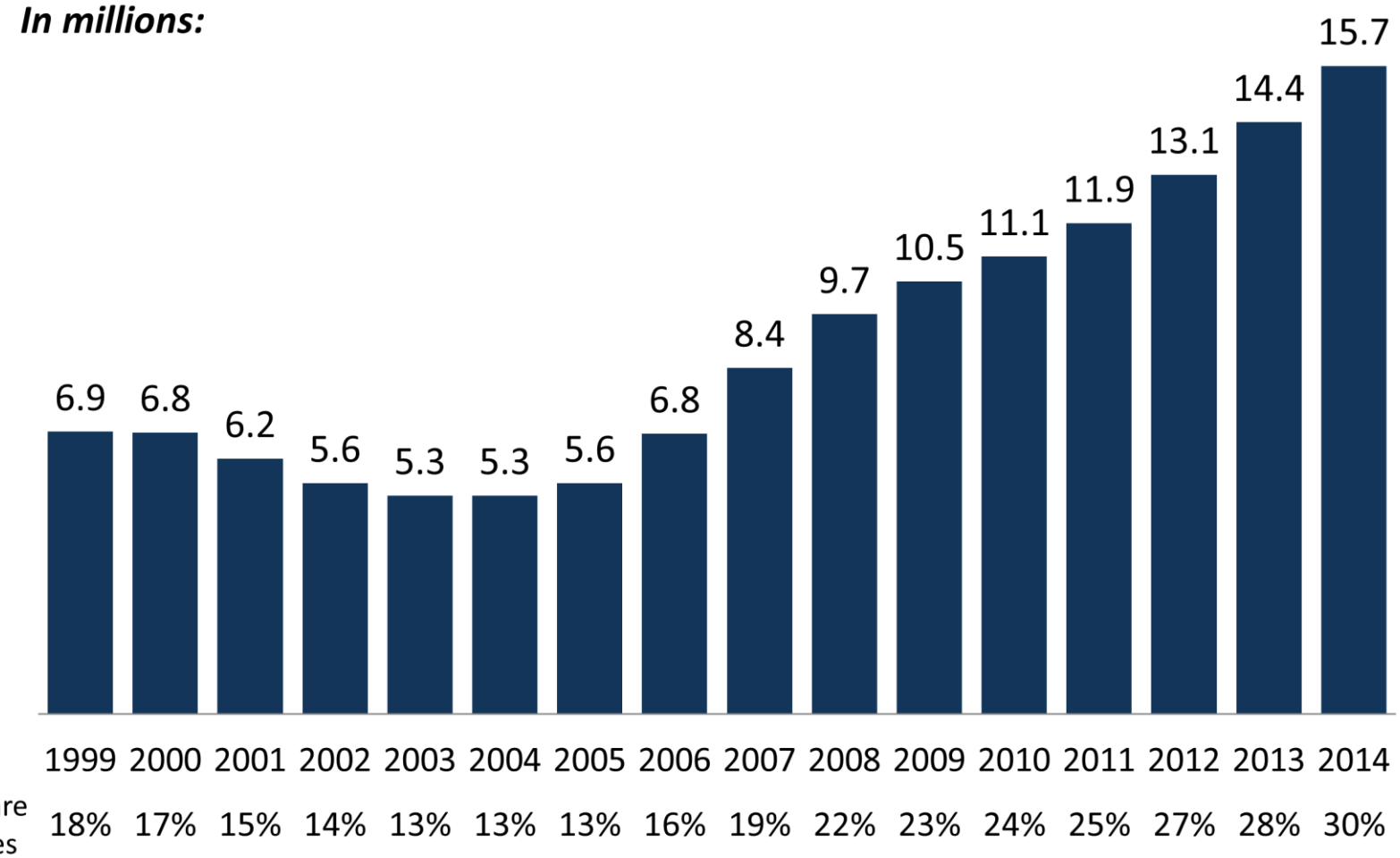
- Broad goals under a new administration
  - Deregulate, reduce spending, shift to defined contribution
- Specific goal: make Medicare look more like a private market
  - Approach – premium support. Already favored by Speaker Ryan; likely to appeal to other Republicans in Congress

Medicare Advantage: An Overview

- Beneficiaries have a choice: coverage through FFS or private plans (MA)
- ~50% of MA plans offer coverage for no additional premium
  - Many include prescription drug coverage as well (for a Part D premium)
- Required to cap OOP burden (max is $7,150 in 2017)
  - Can vary benefit design – use networks, copays, & other utilization management
- Enrollment close to 1/3 of total Medicare population
- Issuers bid to offer coverage, paid based on administrative benchmark
  - If bid>benchmark: enrollees pay premium
  - If bid<benchmark: issuer receive rebate to offer additional benefits

Exhibit 1

Total Medicare Private Health Plan Enrollment, 1999-2014



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2014, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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Premium Support: Premise

- Premium support relies on MA to work
- Medicare benefits can be provided at lower cost than FFS
- Make enrollees responsible for higher-cost choices
- Incentivize more efficient utilization and spending
- MA payments are inefficient: pay plans more than necessary (when bid<benchmark)

Premium Support: Structure

- Beneficiary received $$$ to enroll in a plan
- When cost of the plan>$$$ beneficiary pays extra cost
  - Note: Similar to structure of ACA exchanges
- Plans are paid what they bid, not administrative benchmark

Premium Support: Details Matter!

- Conceptually, premium support is simple
- But the devil is in the details
  - How is $$$ value determined?
  - Does FFS remain an option?
  - What benefits are covered?
  - Rebates to beneficiaries?
  - Dual-eligible participation?

Premium Support: One Potential Approach

- Voucher tied to 2nd-lowest-cost MA plan
- MA plans compete with FFS
- Benefits actuarially equal to FFS
- Beneficiaries choosing lower-cost plan pay lower premiums
- Beneficiaries who enroll in benchmark plan pay single, national premium
- Dual-eligibles excluded

Premium Support: Cost Effects

- Reduce 10-year spending by $275B (CBO, 2013)
- 30% higher premiums (if beneficiaries don't switch); OOP costs would be lower (CBO 2013)
- Overall, less enrollment in FFS more in MA (magnitude depends on many assumptions)
- Spillover effects:
  - MA plans' use of managed care reduces intensity of care → lower FFS spending
  - 10% increase in MA penetration → 4.5% to 9% decrease in FFS spending
  - CBO did not factor this into analysis
- MA pays hospitals less (Baker et al 2016, not in CBO analysis)

Premium Support: Quality Effects

- MA beneficiaries have more appropriate use of various screenings, lower ED use, fewer hospital days (cited in McGuire et al 2014)
- Spillovers studies also find lower LOS for FFS patients
- MA beneficiaries have better care coordination, less intense PAC use

Caveat!!!

Findings have all been under benchmark-based payment system. Dynamics can change under premium support

Premium Support: Critics' Concerns

- Practical
  - Major change to structure of Medicare. Hard to predict actual effects.
  - Adds complexity: more difficult for seniors to navigate the system.
  - Potential for adverse selection against FFS
  - Higher costs for (some) beneficiaries
- Moral/Philosophical
  - Moves away from defined benefit structure of Medicare
  - Can private insurers adequately provide Medicare benefits?

Thank you!

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