



ISSUE BRIEF

AMERICAN ACADEMY of ACTUARIES

Applying the Defined Contribution Concept to Medicare: A Primer

Medicare provides substantial support to older and disabled Americans in meeting their health care needs, and it is a key component of the U.S. health care system. Almost 98 percent of the population age 65 years or older in this country is covered by Medicare. Due to the continually rising cost of health care and the many Americans depending on the Medicare program, public policy-makers continue to debate how Medicare should be funded. Should it retain its current defined benefit approach (similar to that used by traditional retirement plans) or should it be changed to a defined contribution approach (similar to that used by 401(k) retirement plans)? This issue brief provides a primer on these two approaches and what they mean in the context of the debate on Medicare reform.¹

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Basic Definitions

Retirement plans are generally described as either *defined benefit* or *defined contribution* plans. A basic understanding of how the terms have been used in describing retirement plans is helpful in considering the implications of applying the defined contribution concept to health insurance coverage.

Defined benefit (DB): Some employers establish retirement plans that promise employees a specific benefit at retirement — the employer *defines* the *benefit* to be received by the retiree (e.g., a monthly pension of x dollars per year of service with the employer, or y percent of the salary earned in the last year working for the employer). The employer contribution required to properly fund the promised benefit is calculated using various assumptions about what might happen between the present day and the time when benefit payments are actually received.

Typically, these assumptions include the expected investment returns, salary increases, death rates, and termination rates, as well as projected patterns of actual retirement ages. The annual funding requirement changes from year to year due to differences between actual experience and the assumptions used. The benefit obligations, however, generally remain unchanged.

Defined contribution (DC): Some employers make no promises about the level of benefit available to future retirees. Instead, they commit to fund a retirement plan that *defines* a specific *contribution* to be made on behalf of each employee (e.g., a contribution of x dollars each year, or y percent of salary earned in a year). These contributions are invested on behalf of each employee; in many cases, employees are given at least partial control over how the funds are invested. The employee's retirement benefit is whatever he or she can purchase at retirement with the funds accumulated over his or her working lifetime from those employer contributions. Employees are often given projections to illustrate the annuity benefits that they might purchase with their accumulated funds at retirement, but no specific level of retirement income is guaranteed by the employer.

For the employer, the DB approach creates a long-term liability of unknown size, and it requires considerable financial flexibility to manage the changing funding requirements from year to year. The DC approach, in contrast, limits the employer's liability to the contribution promised for each year.

For employees, the DB approach provides more explicit information about their future retirement income than the DC approach. But perhaps the most crucial difference is that with a DB plan, the employer bears all the investment risk (i.e., if contributions to the plan are insufficient to fund the benefits, the employer must make up any difference; on the other hand, if investment earnings are better than expected, the employer's liability is reduced). However, with a DC plan, the investment risk is transferred to the employee (i.e., if contributed funds do not accumulate as rapidly as expected, the employee receives less retirement income; on the other hand, if the investments do very well, the employee receives more retirement income). An analogy may be drawn to personal retirement plans, where an annuity with fixed benefit payments would represent the defined benefit approach; the typical Individual Retirement Account (IRA) or a variable annuity (with a payout based on the performance of an investment account) would represent the defined contribution approach.

Medicare Coverage

Traditionally, health coverage in the United States has been provided using a DB approach. Under this approach, a health insurance contract promises a specific package of health benefits, and the premium, or contribution rate, is calculated based on the expected cost of those benefits. The insurer bears the risk of any funding shortfall. (If the premiums are too low, the insurer is still required to provide the promised benefits.) This is true for Medicare as well, because Congress defines the Medicare benefits and the funding required is determined by the cost of providing those promised benefits to Medicare beneficiaries.

A significant difference between health coverage and retirement programs is that health coverage benefit promises are generally good for one year only, rather than for many years. Because of this, the health plan sponsor can modify the benefit level defined each year so costs (premiums, or contribution rates) are consistent with the level of funding the sponsor views as acceptable.² Thus, the risk involved is primarily a short-term pricing risk (estimating the cost of providing next year's health care benefits) rather than a long-term investment risk. Of course, prudent employers want to ensure that their health plans will be sustainable for more than one year, and the Medicare trustees take a longer-term view than the typical employer health plan. Nonetheless, planning for health benefits does not require looking as far into the future as does planning for retirement benefits, and the nature of the financial risk is significantly different.

In the current Medicare program, Congress defines the premium rate requirement for beneficiaries who participate in Medicare, as well as the payroll tax rates for employers and active workers. Once the required premiums and taxes are paid, Medicare enrollees have a statutory right to the benefits promised by the Medicare program. Premiums and payroll taxes provide part of Medicare's funding. Other funding elements, such as returns on trust fund assets and transfers from general tax revenue, are used to balance available Medicare revenue with the benefits promised by Congress.³

To individual Medicare beneficiaries and employers, the funding appears to be based on the projected cost of the benefits promised. Congress also considers modifying benefits as another tool for keeping Medicare funding and spending in balance, but significant benefit reductions have seldom been used to limit increases in premium and payroll tax rates. (One significant difference between employer-sponsored plans and Medicare is that Congress has somewhat more flexibility in the timing and application of benefit changes.) Instead, by adjusting the fee allowances for hospitals, physicians, and other health care providers, Congress often balances the funding available with the benefits promised under the Medicare program. This minimizes the impact of rising Medicare costs on funding requirements without reducing the benefits promised to beneficiaries. (Congress is able to do this because it effectively controls the price of medical services provided to Medicare enrollees.)

Applying the DC Concept to Medicare

There is no generally accepted definition for a DC Medicare program, nor is there general agreement on the form that such a program might take. The essential element of change would be that Congress would define the level of Medicare funding provided to beneficiaries rather than define the level of benefits provided to them. Conceptually, the program's focus would shift from guaranteeing enrollees a defined set of benefits (with the Medicare trust funds responsible for any funding shortfall)³ toward providing a fixed government contribution that enrollees could use to buy health care coverage (with the enrollee responsible for making up any difference between the government contribution and the cost of the benefits they selected). This concept, as generally described, assumes that traditional, fee-for-service Medicare would still be available.

Medicare+Choice plans already incorporate several DC elements; Congress has defined the contribution the federal government will make on behalf of any beneficiary for a minimum standard Medicare benefit plus additional benefits, with an optional additional cost to the beneficiary. These plans also have DB features; most notably, the benefits provided are required to be at least as great as those provided under the Medicare fee-for-service program.

Possible Implications of a DC Approach to Medicare

Many important issues must be considered when evaluating proposals to move the Medicare program from a DB approach toward a DC approach. These include issues that are specific to Medicare beneficiaries, the federal government (and the financial condition of the Medicare program), and participating health plans, and they will depend heavily on the structure of the reform proposal. The potential implications of a DC approach include the following:

- A DC approach could make future federal outlays for Medicare more predictable and controllable (This is often cited as a primary advantage of using a DC approach).
- A DC approach could be used to try to convey a positive message to the beneficiaries (e.g., announcing that the federal contribution on their behalf was increasing by x percent, rather than announcing required premium increases and benefit changes).
- A DC approach would make no guarantee that government contributions would keep up with increases in the cost of coverage. Regardless of any emphasis on the government's contribution, beneficiaries would be unlikely to be satisfied if the contribution made on their behalf were insufficient to buy meaningful coverage. To ensure that a beneficiary had meaningful coverage options, competitive bidding by carriers might be necessary. If it were an important goal to ensure that benefit options were available to all Medicare enrollees, then it might be necessary for the federal government to offer multiple benefit options in areas where no — or very few — private plans had chosen to operate.
- A DC approach would allow greater emphasis to be placed on cost management through the contribution side of Medicare (with or without including continued or additional limits on allowed provider reimbursement levels).
- A DC approach would enable the federal government to vary the contributions it makes to Medicare on behalf of beneficiaries. This would allow, for instance, for funding that varied by age, facilitating the expansion of the eligible population to lower ages. (A related issue is how the premiums would be allowed to vary for the health plans made available to Medicare beneficiaries. If the government contribution did not vary by the same set of factors as did premiums, some beneficiaries would be forced to bear a higher proportion of the cost of coverage than others.)
- A DC approach would facilitate a transition to increased control by individual Medicare beneficiaries over the benefits they received, and greater personal involvement in the cost of their coverage and the cost of the health care they received. Greater personal responsibility for health care buying decisions could reduce overall spending on health care and ultimately help control the long-term cost of providing coverage to seniors. On the other hand, beneficiaries might see this as placing a significant financial burden on their shoulders and creating barriers that would prevent them from seeking needed care.
- Individual selection of coverage would add a dimension to Medicare that many seniors — particularly older ones — might be unable to manage effectively. As more choices were made available, it would become increasingly important, and difficult, for an individual to compare the different options and

select the most appropriate one. (This concern, and the perceived market problems that prompted it, motivated the standardization of Medicare supplement policies.)

- If a DC approach to Medicare failed to increase efficiency, reduce fraud, improve consumers' health care buying decisions, and enhance competition, the cost of coverage would likely exceed the financial capacity of seniors. In that event, the government would have to increase contribution levels beyond expectations.
- Offering individual enrollees a choice between multiple coverage options, particularly when cost and benefit levels varied significantly between them, would create the potential for adverse selection against one or more of the options. Risk adjustment would be required in order to assure equity among insurers and health care organizations, and some provision for pooled catastrophic coverage would likely to be required.

A Final Note

The intent of this brief is to provide a basic understanding of what the DB and DC concepts mean in the context of Medicare reform. It is not intended to address the broader range of issues associated with Medicare reform, nor is it intended to address the application of a DC approach to health benefits in other contexts.

¹ This issue brief was developed by the American Academy of Actuaries Medicare Steering Committee and addresses the defined contribution concept only in the context of Medicare reform proposals that provide for guaranteed availability of coverage. The Academy's Defined Contribution Health Plans Work Group developed the issue brief *Understanding Defined Contribution Health Plans*, which addresses the defined contribution concept in a broader context, and it is available on the Academy's Web site at www.actuary.org.

² This discussion focuses on programs in which a sponsor, such as an employer or governmental entity, provides health benefits for a group of eligible individuals. Individually purchased health insurance policies are guaranteed renewable, meaning that policyholders can keep their current insurance plan as long as they keep paying the premium. However, it is common for consumers in the individual market to periodically shop for new coverage to keep their premiums affordable as health care costs rise. The insurer can change premiums on a periodic basis. Thus, from the insurer's standpoint, premiums, not benefits, become the balancing item.

³ For a more detailed discussion, see the recent Academy issue brief *How Is Medicare Financed?*, which is available on the Academy's Web site at www.actuary.org.