American Academy *of* Actuaries

Actuarial Implications for the Medicare Program Under the Health Security Act

October 1994

Monograph Number Fifteen

Monograph Series on Health Care Reform

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comment on proposed federal regulations, and work closely with state officials on actuarial issues.

The Academy's Medicare Work Group, under the guidance of the Health Practice Council, prepared this paper.
The Academy's Health Practice Council formed this work group because actuaries have special expertise
in the practical issues of designing benefits, analyzing provider reimbursements, evaluating delivery systems,
as well as assessing the risk and projecting the cost impacts. Actuaries also have unique perspectives
on potential problems and unintended consequences related to these structure changes.

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INTRODUCTION

Since the inception of the Medicare program (Title XVIII) in 1965, numerous changes have been made in its provisions. By examining the ramifications of these changes, such as revisions in benefit coverages, funding or cost sharing arrangements, and provider reimbursement methods, including the Diagnostic Related Group (DRG)-based payment to hospitals and Resource Based Relative Value Scale (RBRVS)-based payment to physicians, we can better analyze the President's health care reform proposal as it relates to Medicare.

In addition, the Health Care Financing Administration (HCFA) has contracted with private health plans to provide health care services via alternate (managed) delivery systems; they are reimbursed on either a cost or risk basis. Various studies have been done to evaluate the cost effectiveness of these contracting efforts.

The President's proposal would affect the Medicare program in three major ways:

- Medicare Part B would be expanded, for all beneficiaries, to include a prescription drug benefit on January 1, 1996.

- Savings to Medicare would supposedly derive from reductions in provider reimbursement levels and incentives to promote primary care.

- The Medicare program would allow enrollment of beneficiaries in regional health alliances, via state-developed programs.

This paper considers the possible consequences of these changes, from an actuarial perspective.

ISSUES

Prescription Drug Coverage Under Medicare and Its Impact

Key provisions of the President's proposal that pertain to the prescription drug coverage that would be provided to Medicare recipients under the proposal include:

- Beneficiaries would have an out-of-pocket prescription drug cost deductible of $250 each year. They would also pay 20 percent of any prescription drug cost total, during the year, between $250 and $1,000.

- Beneficiaries would pay an additional Medicare Part B premium equal to at least 25 percent of the federal costs of the drug benefit (net of any rebate revenue).

- Manufacturers would be required to pay a rebate for each nongeneric prescription sold to a beneficiary, equal to at least 17 percent of the average manufacturer's price to retail vendors.

- Reimbursement to pharmacists would be capped at 93 percent of the average wholesale price for ingredient costs, plus a $5 dispensing fee per prescription (indexed to inflation).

- The Secretary of the U.S. Department of Health and Human Services (HHS) would require that administrators of the prescription drug benefit perform utilization review for pharmacists and physicians similar to what is required under Medicaid.

In theory, this new benefit would make Medicare coverage consistent with the prescription drug benefit to be provided in the accountable health plans for the population under age 65. There is no doubt that drug coverage would make Medicare more comprehensive. However, it also raises several issues that need to be carefully examined to avoid (or at least minimize) some unintended consequences:

- Proposed financing of prescription drug coverage;
- Projected additional federal expenditure;
- The impact of the manufacturer rebate program;
- The impact of the proposed benefit coverage level for Medicare beneficiaries; and
- Other Issues, such as the impact on MediGap plans and Medicare Risk programs.

Proposed Financing of Prescription Drug Coverage. The President's plan would finance the prescription drug benefit by increasing the Medicare Part B premium and triple-matching this extra premium with funds from general revenues. Thus, the program would be financed largely by general tax revenue, not by beneficiary premiums.

Because of its consequences for the federal budget and how much it might cost the public, accurate and reasonable estimates of the expense entailed in this new benefit are extremely important. However, since the drug premium is redetermined every year in a manner similar to what is done for the current Medicare Part B premium, the drug premium should track the drug expenditures closely. This method has worked well for the Medicare Part B program, and we expect that the financing would still be adequate if a prescription drug benefit were added.

Projected Additional Federal Expenditures. The projected expenditures include both the benefit itself and any associated administrative costs. Several estimates have been presented (including one by HCFA actuaries) ranging from over $74 billion to nearly $100 billion over the next five years. The magnitude of the difference suggests that it is rather difficult to arrive at an accurate estimate without extensive analysis. It also suggests that much more work is needed to determine the cost impact of this new coverage.

Impact of the Manufacturer Rebate Program. The rebate program is intended to prevent excessive reimbursements for prescription drugs. The current Medicaid program includes a rebate program that has been fairly successful. However, it may have had some undesirable effects outside of the Medicaid program itself. Expanding the rebate program to Medicare, which is more generous in its benefits than Medicaid, may have additional unintended consequences. Implementing a rebate program under Medicare would greatly expand the scope of rebate programs. This may encourage new pricing schemes by pharmaceutical companies aimed at recouping (or minimizing) revenues lost because of mandatory rebates on a significantly larger proportion of all prescriptions drugs.

We recognize the need to avoid excessive reimbursements, but policies whose intent is control of reimbursements must be designed to avoid higher payments in the wake of new pricing tactics. The history of Medicare cost control is one of decidedly mixed success.

Impact of Proposed Benefit Coverage Level to Medicare Beneficiaries. Since a substantial number of Medicare beneficiaries (particularly the aged) do not have insurance for prescription drug coverage now, they would welcome this new benefit. It is projected that over 60 percent of the beneficiaries would meet the $250 deductible in 1996 and would be reimbursed for 80 percent of the remaining expenditures with an out-of-pocket limit of $1,000. This benefit is consistent with the benefit required in the President's proposal, for the under-age-65 population. However, since the aged population use prescription drugs so extensively, the proposed Medicare benefit is more like a prepayment plan largely financed by additional federal spending than a plan for insuring against the risk of major loss.

Other Issues. We expect that there will be changes in the patterns of prescription drug use. Physicians will probably write more prescriptions, and many of those prescriptions will be for more expensive drugs, because the cost to the patient would be minimal.

The Medicare prescription drug benefit would replace prescription plans offered by private insurance companies. This could reduce the number of available options under standardized MediGap plans currently available, which in turn would affect the insurance carriers offering prescription drug coverage. The same holds true for state-sponsored prescription drug programs.

Risk contract health maintenance organizations (HMOs) would also be required to cover prescription drugs. Some of these plans already offer such coverage, so this requirement would serve to make the benefit packages offered by the various HMOs more uniform. How drug benefits might affect a Medicare recipient's decision to

join an HMO is unclear, since he/she would already have drug coverage under the traditional Medicare program. The AAPCC (Area Adjusted per Capita Cost), used as the basis of payment to Medicare Risk contractors, would have to rise to cover this extra benefit.

Level of Medicare Reimbursement to Providers and Its Impact

Key Provisions on Projected Savings Affecting Medicare Program. The President's proposal contains provisions designed to reduce the rate of Medicare cost increases. These savings, according to one administration estimate, amount to $124 billion from 1994 through 2000. The key cost saving features would include:

Medicare Part A Proposals

- Reducing hospital payments via: a reduction in the hospital market-basket index updates, a reduction in the indirect medical education adjustment, an adjustment to the inpatient capital payments, a revision of the disproportionate-share hospital adjustment, a moratorium on Prospective Payment System (PPS)-exempt long-term care hospitals, and an extension of the Consolidated Omnibus Budget Reconciliation Act of 1993 (COBRA 1993), to eliminate "catch-up" on the skilled-nursing facility (SNF) update freeze.
- Subjecting all state and local government employees to the Hospital Insurance (HI) payroll tax.

Medicare Part B Proposals

- Reducing physician payments via: a revision to Base Medicare Volume Performance Standard on real gross domestic product (GDP) per capita, establishment of a cumulative growth target for physician services, and a reduction in the Medicare fee schedule conversion factor.
- Eliminating formula-driven overpayment to hospital outpatient departments.
- Establishing competitive contracting of all Part B laboratory services and other supplies.
- Raising Part B premiums for high-income beneficiaries.
- Re-establishing the 20-percent coinsurance for laboratory services.

Medicare Part A and B Proposals

These proposals relate primarily to home health visits: payment levels for home health visits would be lowered, and copayments would be introduced.

Under the President's proposal, savings from the Medicare program are supposed to fund a large portion of the other features of the proposal. These savings come from, or are derived from, two broad segments of the health care community: health care providers and health insurers, including managed care health plans. Savings are also expected from increases in beneficiaries' out-of-pocket expenses.

However, absolute reductions in provider reimbursements may prompt some facilities and physicians to opt out of participation in the Medicare program. Also, reducing reimbursements and imposing copayments may decrease the number of Medicare Supplement insurers, HMO risk plans, and states willing to participate in the Medicare program.

Note that the "savings" referred to here are savings to the total federal budget. Although they may achieve the intended purpose of diminishing growth in Medicare spending, they may not lower total national health care expenditures, since some of the "savings" are in fact derived from tax increases, while other savings entail passing additional costs on to Medicare beneficiaries. Furthermore, lowering provider payments from the Medicare program may result in increased costs to other payers, unless total health care costs can be controlled.

Note too that the various estimates of how much would be saved differ significantly from the administration's original estimate, suggesting that further analysis is warranted.

The proposal's intended savings may have a major impact on the Medicare program, not only because of their effect on health care providers, but also because of the potential consequences for alternate risk-taker HMO risk plans, Medicare Supplement insurers, and (possibly) the willingness of states to participate.

To summarize the strategies for savings under the proposal in order to examine their impact on the various players, it is helpful to group them into two broad categories:

- Reductions in Medicare payments to providers as part of the reimbursement methodology; and
- Transfers of Medicare liability in whole or in part to Medicare beneficiaries or other insurers.

Next, we address these changes and how they affect health care providers and organization sponsors.

Impact on Health Care Providers. In general, health care providers are most affected in two areas by the actions contemplated under the reductions in Medicare payments cited above. First, there is the obvious impact of continued reductions in reimbursement levels. Second, and possibly more important, is the potentially disruptive effect of making ad hoc modifications in what are now perceived as rational and fair reimbursement mechanisms. Both these aspects affect the provider's overall assessment of Medicare's continued viability, and in particular, whether to continue participation in the Medicare program.

For the most part, Medicare operates as the nation's largest fee-for-service system, reimbursing providers per unit of service rendered. In the past, both facility and physician reimbursement mechanisms were open to abuse and, therefore, to inflationary spirals. Congress has responded by passing what seems to be annual ad hoc reductions, limitations, and other restrictions focused on reducing costs.

Absolute reductions in Medicare's payments per unit of service may not represent problems to providers, per se, as long as the reimbursement mechanisms in place provide for fair payment for such services, without significant discontinuity in payment levels. The concern, of course, revolves around the definition of "fair." In addition to fairness, the ideal mechanism would also encourage efficiencies and innovative delivery of care, which would serve to reduce costs further while still ensuring quality care.

PPS introduced for hospitals in 1984, and RBRVS established for physicians in 1992, seemed to represent more equitable reimbursement mechanisms. Also, the PPS furnished a mechanism for encouraging efficient care by providing one fixed payment for all services rendered during a single admission.

Although both mechanisms included provisions for default updating processes, nonetheless, ad hoc reductions and modifications have been made in every year since they were introduced. These changes have ushered in what is, in effect, a global policy change that affects health care providers, implemented principally to achieve budgetary control.

Specifically, the reductions to hospital payments that are under consideration will most likely exacerbate the financial problems of small to medium-sized hospitals. This could lead to closing/merging of hospitals unable to achieve the purchasing and payroll economies necessary to survive. Although reducing the surplus of hospital beds may, in general, be the appropriate direction for U.S. health care policy, achieving such reductions solely through reimbursement methods is likely to result in inadequate care in certain geographic areas. Also, because financial viability is not always consistent with quality of care, it is impossible to determine if the "survivors" among U.S. hospitals are in fact the "best."

For physicians, lower fee updates, coupled with the reorientation toward primary care services that is the intent of Medicare's proposed reimbursement policy, may create problems parallel to those experienced by hospitals. It is not unreasonable to expect that more and more specialists will judge Medicare's payment inadequate and will no longer participate in Medicare, thereby evoking some of the provider shortages that have become endemic to the Medicaid program.

Although it would have relatively minor consequences, compared with the reimbursement reductions, the transfer category savings attributable to copayments on laboratory services is likely to generate additional paperwork for most providers.

Impact on Health Care Organizations/Sponsors. The impact on alternate risk taker HMO risk plans, Supplement insurers, and the states encompasses the effects of lower reimbursement and the introduction of member copayments.

For risk-based HMOs, reductions in Medicare outlays would stem directly from reductions in the AAPCCs, which serve as the current basis for reimbursement, or, possibly, from the use of a totally different mechanism to determine reimbursement levels (e.g., managed competition).

A key attraction that such HMOs use as an inducement to offset restrictions on choice of providers is the elimination (or significant reduction) of member copayments, in conjunction with benefits not offered by Medicare (e.g., prescription drugs). When benefit designs like this are coupled with reductions in reimbursement levels, these plans could be financially weakened. Also, if HMOs are forced to reduce benefits drastically, they may no longer appear attractive as alternatives to Medicare. Although various studies, most notably a recent *Mathematica*[1] study, have questioned the appropriateness of the current risk-based methodology, most (including the *Mathematica* study) have concluded that these delivery systems are viable and desirable alternatives. If fostering managed care is one element in making the health care delivery system more efficient, rendering HMOs less viable for Medicare surely is counterproductive.

[1] "Does Managed Care Work for Medicare," by Randall S. Brown, Jeanette W. Bergeron, Dolores Gunnick Clement, Terrold W. Hill, and Sheldon M. Retichin, 12/93.

For Medicare Supplement insurers, the effect of lower reimbursement levels would likely be favorable since the resulting Part A per day copayments and Part B coinsurance should reflect lower trends. Imposing copayments on home health care and laboratory services will, of course, increase the costs of these policies. It is unclear to what extent these two effects will offset each other. In any case, the introduction of copayments on services that do not now specify copayments will result in higher processing and handling costs to Medicare Supplement insurers, as they begin dealing with many relatively small claim amounts.

The coverage of prescription drugs under the Medicare program would have a great impact on Medicare Supplement insurers. Elderly people who now get their prescription drug benefit through Medicare Supplement plans would find that they now get the benefit from Medicare—with only a minimal contribution.

Finally, the contemplated reductions would affect the potential state players in much the same way as they affect risk-based HMOs. Because AAPCC is used as a payment basis, the requirement to, in effect, duplicate the Medicare program benefits, policies, etc., coupled with the probable continuation of ad hoc budgetary-based reductions in the Medicare program, any state that participates in the program accepts a significant element of uncertainty and risk. Participation will probably decline if states carefully scrutinize all of the pros and cons involved.

Level of State Participation and Medicare Enrollment in Health Alliances

Key Provisions of the Proposal Affecting Other Areas of the Medicare Program. As one of its major features, the President's proposal would establish a National Health Board and authorize the states to form regional health alliances. Regional health alliances would negotiate with willing state-certified health plans to enroll eligible individuals, including Medicare beneficiaries under certain specified conditions. The federal government would pay the regional health alliance a predetermined rate for each Medicare beneficiary enrolled in the alliance. In essence, it would transfer a portion of the current national Medicare program to state programs, as happens now with the Medicaid program.

As noted above, the establishment of the state-run regional health alliances and the provisions that allow Medicare beneficiaries to enroll in a health alliance would bring about a transfer of the current federally run Medicare program to state-run programs. The drawbacks of this change are numerous. We will focus on two:

- The impact on continuity of appropriate health care delivery; and
- The impact on resulting duplication of administrative effort.

Impact on Continuity of Appropriate Health Care Delivery. Several elements of the President's proposal may have an adverse effect on the medical care Medicare beneficiaries receive. Switching from a national to a state-oriented program has several implications. Permitting individual states to elect all or part of the Medicare pool introduces a significant element of program fragmentation into the national Medicare program, which will probably lead to greater burdens on the affected elderly population. A significant portion of the senior population moves from one region to another fairly often. More affluent Medicare members, who travel to southern states for the warmer weather during winter and then go back to the North during summer, will feel the impact of change.

The effect of state's opting to provide benefits through regional health alliances is unclear. The President's proposal specifies many requirements. For example, there must be at least one fee-for-service alternative; there must be a plan that is actuarially equivalent to the costs of Medicare deductibles and premiums. Medicare recipients must also have the opportunity to join any other plan currently available to other individuals in the state.

Will there be problems in areas near state borders (especially in major population centers) if plan provisions vary among neighboring states? If a state chooses to buy into Medicare, will that state be able to manage the task properly? The General Accounting Office (GAO) has been skeptical about states' ability to manage regional health alliances, because many states have no insurance actuaries and have proved unable to audit traditional health carriers properly.

Also, including Medicare beneficiaries in a regional health alliance could prove to be a burden on any insurers not accustomed to dealing with the unique concerns/problems of delivering care and support to an elderly market. This could disrupt health care for the ever-increasing elderly population.

Impact of Resulting Duplication of Administrative Effort. The level of paperwork/certification needed would appear to place a burden on the state regulatory agencies, which would have to duplicate the administration of the current Medicare program at the state level. Consequently, participation would probably be declined by all but the

most aggressive states. The result: the proposal would further subdivide a national Medicare program into a scattering of state-run programs, in addition to a federally run program for all the other states.

How much would the information on each MediGap carrier, to be collected and distributed by the HHS Secretary, cost? The states would be charged back a pro rata portion, but what would the administrative expenses run to? Many states now do something like this already on their own. Would the newly required information be little more than redundant?

A state oriented program may increase total costs to the national Medicare program, unless the state can make administration significantly more efficient than in the current Medicare program.

Potential for Adverse Selection. If the annual open enrollment requirements for regional health alliances extend to every available plan that can exhibit price variation of 300 percent to 400 percent between a typical core plan and a richer benefit plan, and to new enrollees plus those who want to switch from an alliance plan or from a different Medicare Supplement plan, significant antiselection could be introduced. The *Mathematica* study notes that 20 percent of people who joined risk plans dropped out voluntarily within 12 months. If the relatively high percentage of dropouts reflected the number of claimants who were unhappy about the restrictive nature of access to providers (i.e., they already had an illness that required a provider), the degree of antiselection from the group would be magnified.

Medicare Supplement plans will be forced to offer annual open enrollment at all ages, not just at the initial enrollment for Part B. The unit-age rating requirement, coupled with a significant reduction in new entrants, may lead to elevated rate increases and cumulative antiselection in the MediGap market. If rate increases are restricted at the federal or state level, insurance companies could lose money.

What would the future impact be from the many choices still open to the Medicare population? New retirees will be allowed to pick between their existing regional health alliance plan and Medicare. Depending on the relative pricing/benefits schemes of the various alliances and Medicare, there would be antiselection similar to what is observed by HMOs, when multiple plan offerings are available to employees of a single group.

Even though the President's proposal restricts choice to traditional Medicare or the regional health alliance, there may be some interest in Congress in expanding such choice. If the Medicare-eligible population were given the choice between Medicare and the regional alliance health plan, would there be selection against Medicare? Experience has shown that, on average, when a choice is given, individuals select the most advantageous plan. Would it be politically feasible not to allow Medicare eligibles to join an alliance?

Alliances Operation Within the Prescribed Capitation Under Medicare Budget. A review of the history of enrollment in Medicare risk plans is useful. The *Mathematica* study suggests that Medicare may be losing money on Medicare HMOs: the federal government paid 5.7 percent more for HMO enrollees than for the people who stayed in the fee-for-service Medicare program. However, there are several problems with this study. The President's proposal would raise the AAPCC from 95 percent to 100 percent, for the short term. How much higher would AAPCC levels need to have been to encourage more enrollment? How would risk adjusters affect this, if HMOs can in fact secure a better spread of risk?

We suggest a comprehensive study of the true cost of care of Medicare enrollees from fee-for-service to "Medicare Select" to HMO environments, after controlling for the variables of risk and demographic variation. The study should include an analysis of cost variances between people actively working versus other enrollees. For example, it may be worthwhile to review the *Mathematica* conclusion that hospital admission rates were not reduced in a managed-care environment.

A related question: Will states/alliances be able to operate within the prescribed capitation under the Medicaid reimbursements? Also, how have the relevant historical Medicaid expense and AAPCC growth trends compared with the consumer price index?

Impact on MediGap Market. Note that the President's proposal would require revisiting the standardized MediGap plans that are currently authorized by federal and state regulations. For example, mandatory assignment of physician reimbursement would eliminate the Medicare Part B Excess Expense-type benefit currently offered under MediGap plans. Outpatient drug coverage would alter any health plans that now provide prescription drug coverage. New coinsurance for lab services, and certain home health visits, would add new benefit categories that may be offered through MediGap plans.

In addition, in states that elect to move Medicare enrollees into the regional health alliance, MediGap plans may need to be further modified in accordance with the new system of copayments and deductibles. As mentioned above, this system may vary by state.

If alliances can provide benefits equivalent rather than identical to those provided by Medicare, additional antiselection could be generated. The example cited was a copayment alternative to the $250 deductible, 80-percent coinsurance drug benefit. Similarly, proliferation of benefit alternatives runs counter to recent National Association of Insurance Commissioners initiatives to simplify benefit choices for the population aged 65 and older.

Finally, another feature that could introduce significant antiselection into the MediGap market is the requirement for community rating during open enrollment. If the number of new entrants are significantly reduced, there may be increases in average age, leading to a need for substantial rate increases. This could precipitate either cumulative antiselection or necessary increases in premiums—in excess of what is permitted by premium caps.

CONCLUSION

The American Academy of Actuaries is willing to assist in addressing any of the actuarial issues identified in this paper. Given the complexity of health care reform efforts, any comprehensive proposal will raise many actuarial issues. This discussion of the issues should not be interpreted in any way as an endorsement or criticism of the American Health Security Act of 1993 or of any section thereof.