A Guide to Analyzing Medicare Premium Support
Premium support is a reform option that has been proposed as a way to improve Medicare’s financial condition. Medicare, the federal program providing health insurance to virtually all Americans 65 and older as well as many younger individuals with long-term disabilities, is currently inadequately financed to sustain the program for the long term. In addition, over time it will impose larger financial demands on both beneficiaries and the federal budget.

This guide is intended to help voters understand what premium support is and the potential implications of shifting Medicare to a premium support program.
What is premium support?

Under a typical premium support approach, Medicare beneficiaries would receive a government contribution (sometimes referred to as a voucher) to apply toward the premium of a health plan of their choice, perhaps with the traditional Medicare program being one of the choices. Beneficiaries choosing a plan with a premium greater than the government contribution would be responsible for paying the difference. The federal government contribution could change over time, for example in accordance with inflation or average premium growth.

How would premium support change the structure of the current Medicare program?

Medicare beneficiaries today can choose to enroll either in the traditional fee-for-service (FFS) Medicare program or in a private Medicare Advantage (MA) plan. In Medicare Advantage, plans submit bids based on the same benefits that are available in the FFS program. Bids reflect each plan’s expected cost of providing these benefits. Government payments to plans are tied to benchmarks that reflect costs under the FFS program. Plan bids are compared to the benchmarks. If an MA plan’s bid exceeds the benchmark, beneficiaries choosing that plan must pay an additional premium. If an MA plan’s bid falls below the benchmark, a portion of the difference is provided to the plan to fund benefits in addition to those provided by traditional Medicare.

The Medicare program today essentially follows a defined benefit approach. In other words, the government pays whatever is needed to cover a defined benefit package and bears the risk of health spending growth. Premium support proposals would change the nature of the Medicare program from a defined benefit approach to what is considered a defined contribution approach. Under a defined contribution approach, depending on how the federal contribution is defined, government spending may be capped and beneficiaries could bear the risk of health spending growing faster than the cap.

Advocates of premium support reforms argue that capping the government contribution could encourage insurers to develop and beneficiaries to choose more cost-effective health plans. Opponents of premium support have argued that rather than reducing overall Medicare spending, premium support may shift costs to beneficiaries and make coverage less affordable.

Are there any premium support-type approaches currently used for health insurance?

The current Medicare Part D prescription drug program contains elements of a premium support approach. In particular, it uses a competitive bidding approach to determine how much the government will contribute toward the plan premiums. Private prescription drug plans submit bids that reflect the expected premiums they require to provide prescription drug benefits to Medicare beneficiaries. The government contribution toward these plans is approximately 75 percent of the average premium bid for basic coverage.\(^1\) Beneficiaries who choose

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\(^1\)Plan bids and enrollee premiums are based on a standardized population. Government payments to plans, however, are risk-adjusted to reflect enrollee characteristics and health conditions that can affect their prescription drug spending.
plans with higher premiums or benefits beyond basic coverage pay higher premiums. Beneficia-
ries who choose plans with below-average bids pay lower premiums.

Under the Affordable Care Act, insurance coverage in state health insurance exchanges also will contain elements of a premium sup-
port approach. In particular, premium subsi-
dies will be available for low- and moderate-
income individuals and families, and these subsidies will be based on the second-lowest-
cost silver tier plan available in the geographic rating area. Participants choosing plans with higher costs would have to pay the difference.

Some employer-based health insurance coverage also can have premium support elements. There are employers who offer multiple plan options to their employees, but set a fixed employer premium contribution cap regardless of the plan chosen. Employees choosing higher-cost plans would have to pay higher premiums. The health plan for fed-
eral government workers is one example.

**What details matter most when designing a Medicare premium support program?**

There are different ways to design a premium support program. How the details are devel-
oped will affect how beneficiaries fare and whether Medicare costs are contained.

**HOW THE GOVERNMENT CONTRIBUTION IS SET AND HOW IT GROWS OVER TIME**

Under a premium support program, not only would an initial government contribution need to be determined, but also how that contribu-
tion grows over time. One option would be to set the initial contribution at the estimated average per-beneficiary government cost under the current Medicare program. Another option would be to use competitive bidding to deter-
mine the government contribution (e.g., set the government contribution at some percent-
age of the average premium bid). Under either option, depending on the premiums for plans offered in the premium support program, beneficiary premiums could be greater or less than those they would have paid under the current Medicare program.

Perhaps even more important than how the initial government contribution would be set is how it would increase over time. Over the past several decades, spending on health care services has increased faster than general infla-
tion and the economy as a whole. Indexing the government contributions to general infla-
tion, the economy, or some other index that doesn’t keep pace with health spending growth could put pressure on insurance plans to con-
tain costs. But if the government contribution does not increase at least as much as the health spending underlying the plan premiums, then a greater share of Medicare costs would be shift-
ed to beneficiaries over time, either in the form of higher premiums or in the form of higher cost sharing if they choose less generous plans. Increased cost sharing likely would result in reduced health care utilization, but also could result in beneficiaries foregoing needed care, particularly lower-income beneficiaries. Tying the government contributions to the increases in the average premium bids would help pre-
vent costs from being shifted to beneficiaries because bids would track better to changes in health spending, yet still would provide an in-
centive for beneficiaries to move to lower-cost plans.
WHETHER THE TRADITIONAL MEDICARE FFS PROGRAM IS RETAINED AS A PLAN OPTION

Under the current Medicare program, beneficiaries have the option of choosing either the traditional FFS plan or one of the available private Medicare Advantage plans. The premium support program could be structured such that the FFS plan remains available to all Medicare beneficiaries, is available only to beneficiaries already enrolled in Medicare at the time premium support is implemented, or is not available to any beneficiaries, including those already enrolled.

Retaining the FFS plan option for all current and future Medicare beneficiaries would provide greater continuity with the current program. Rules may be needed, however, to ensure fair competition between FFS and the private plan options. Allowing only current Medicare enrollees to continue having the FFS option would mean that over time the FFS program would consist of older beneficiaries who would likely have more costly health care needs. That could have negative consequences for the financing of the program unless funds are shifted from the other plans to the FFS program to reflect its higher-cost population. Eliminating the FFS program altogether could have implications for the costs of the private plans. The Congressional Budget Office has estimated that rates paid to health care providers are higher for private health insurance plans than for Medicare. With no FFS plans these higher costs would not be fully offset by savings from greater utilization management in private plans. Depending on local-area market dynamics, the presence of the FFS plan could provide leverage to private plans in their rate negotiations with providers, thus reducing the cost of claims, and therefore premiums, below what they otherwise would be in absence of the FFS option.

HOW THE BENEFIT PACKAGE IS DEFINED

Medicare Advantage plans must cover at least the same benefits offered in the traditional Medicare FFS option. Premium support plans could be subject to these same types of requirements or new standardized or minimum benefit packages could be required.

As an alternative, plans could be provided more leeway in designing their benefit packages. Allowing plan flexibility in benefit designs could allow more timely adoption of innovative benefits and designs. But allowing more flexibility could be confusing for beneficiaries and could also lead to the unintended consequence of plans with benefit packages intentionally designed to avoid appealing to beneficiaries with relatively high-cost health care needs. To mitigate these potential consequences, it would be necessary to implement a risk-adjustment mechanism to ensure that plans are appropriately paid for the risks they bear. Additional requirements also could be considered, such as prohibiting discriminatory plan designs or marketing practices, ensuring an adequate provider network, and developing insurance exchanges to better facilitate the beneficiary decision-making process.

WHETHER THERE IS ADDITIONAL FINANCIAL PROTECTION FOR LOW-INCOME BENEFICIARIES

Low-income individuals especially can be at

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risk for avoiding or delaying health care due to costs. Under the current Medicare program, certain low-income beneficiaries receive premium subsidies and some receive cost-sharing subsidies as well.

A premium support program could be structured to include premium and/or cost-sharing subsidies for low-income beneficiaries. These could come in the form of direct payments to the health plans or as deposits to health savings accounts that are held by the beneficiaries. The degree to which such subsidies would ensure access to affordable care for low-income beneficiaries would depend on their form and amount.

WHEN THE TRANSITION TO PREMIUM SUPPORT TAKES PLACE

Some proposals would implement the transition to a premium support model fairly quickly, within the next few years, and others would delay the implementation for a longer period, for example 10 years. The timing of the transition would affect the plan options available to current and future Medicare beneficiaries as well as which generations share the burden of any lower Medicare spending. A longer transition prior to implementation would allow beneficiaries who eventually would be affected by the change more time to understand and adapt to the new program. Delaying the implementation would shield current beneficiaries and those near retirement from any changes, especially if they can continue in their current plans after the transition. Delaying changes, however, would mean that future Medicare enrollees would be the ones to face any Medicare changes, either positive or negative. And any spending reductions necessary to ensure long-term Medicare solvency and sustainability would need to be greater if borne only by future Medicare enrollees.

OTHER DESIGN DECISIONS

Similar to the current Medicare program, most, if not all, Medicare premium support proposals would prohibit plans from denying coverage or charging higher premiums based on age or health status. To ensure that plans are adequately compensated to reflect the health costs of their enrollee populations, it would be necessary for the government contribution (as opposed to the beneficiary premium) to be risk adjusted so that it varies across plans based on age, health conditions, and other factors that are correlated with health spending.

In addition, decisions would need to be made regarding whether the government contribution would differ by region to reflect geographical variations in health spending. If the government contribution doesn’t vary, then beneficiaries’ premiums would vary not only depending on what plan they choose, but also based on where they live. Another consideration would be whether the government contribution would differ depending on a how a plan rates on quality-related measures.

Would a premium support approach reduce Medicare spending?

The specifics of the premium support approach would affect whether and to what degree it could reduce Medicare spending. Many of these factors are discussed above. Depending on how the government contribution is set, federal Medicare spending could be lower than currently projected. Whether those sav-
ings result in lower overall Medicare savings or instead a shift in costs from the government to Medicare beneficiaries also depends on how utilization management, administrative costs, and provider payment rates under private plans would compare to those under traditional Medicare over time. Ensuring overall Medicare savings rather than just savings to the government may require that plans are structured to facilitate higher quality care and more cost-effective health care payment and delivery systems. In addition, effective incentives for beneficiaries to become more cost-conscious health care consumers may be required.

More information on Medicare

The more you know about how Medicare works, its financial condition, and the options available for reform, the better equipped you will be to evaluate what candidates have to say about the program. You may want to further your understanding with the following Academy publications:

- Medicare’s Financial Condition: Beyond Actuarial Balance
- An Actuarial Perspective on Proposals to Improve Medicare’s Financial Condition
- Revising Medicare’s Fee-For-Service Benefit Structure
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A Guide to Analyzing the Issues: What Voters Should Know About Medicare
Medicare plays a critically important role in ensuring that older and certain younger disabled Americans have access to health care. But the program faces serious, long-term financing problems. As a result, the American Academy of Actuaries believes that policymakers need to take action to restore the long-term solvency and financial sustainability of the program. The sooner such corrective measures are enacted into law, the more flexible and gradual the approach can be.

Due to the importance of the Medicare program and the magnitude of the financial challenges, Medicare-related issues should figure prominently in the 2012 elections.

This guide is intended to help voters understand how Medicare is financed, the financial challenges facing the program, and some of the options available to improve Medicare’s financial condition. Voters can use this information to encourage candidates to advance concrete proposals to improve the program’s fiscal sustainability for current and future generations of Americans.
What Is Medicare?

Medicare is the federal program providing health insurance to virtually all Americans over the age of 65 and many younger long-term disabled individuals. Medicare beneficiaries can access benefits through either the traditional Medicare program or Medicare Advantage (MA) plans offered by private health insurers. Beneficiaries may purchase supplemental coverage (e.g., Medigap) to help fill in the gaps in Medicare coverage.

- The traditional Medicare program provides coverage for inpatient hospital services (Part A), and for physicians and outpatient care services (Part B).
- Medicare Advantage plans are offered by private insurers. The plans must cover at least all of the services that the traditional program covers; however, they may offer extra benefits either at no additional cost or for an additional premium.
- Medicare prescription drug benefits (Part D) are available through private insurers as a stand-alone plan to supplement traditional Medicare or as part of a Medicare Advantage plan.

How Is Medicare Funded?

Medicare is funded through two separate trust funds. The two trust funds support different parts of the Medicare program and are financed in different ways.

- The Hospital Insurance (HI) trust fund covers Part A and is financed largely through earmarked payroll taxes.
- The Supplementary Medical Insurance (SMI) trust fund covers Parts B and D. The SMI trust fund is financed through beneficiary premiums, which cover roughly one-fourth of the cost, and federal general tax revenues, which cover the remaining three fourths of the cost. Both beneficiary premiums and the amount of general revenues allocated to the trust fund are reset annually based on the projected cost for the coming year.
- Medicare Advantage plans are funded through both the HI and SMI trust funds.

How Is Medicare Doing Financially?

Medicare’s current financing is inadequate to sustain the program for the long term, and over time it will place increasing financial demands on both beneficiaries and the federal budget. Medicare has three fundamental long-term financial problems:

1. The payroll tax revenues supporting the HI trust fund are inadequate to fund the HI portion of Medicare benefits. Spending is projected to exceed revenues in all future years, which means the trust fund will have to draw down assets each year to pay benefits. The HI trust fund is projected to run out of assets in 2024. At that point, payroll tax revenues will cover only 87 percent of program costs and even less thereafter. Ensuring that payroll taxes would be sufficient to pay benefits over the next 75 years would require an immediate 47 percent increase in payroll taxes, an immediate 26 percent decrease in benefits, or some combination of the two.

2. Increases in SMI costs will place increasing financial pressures on both beneficiary
household budgets and the federal budget. The SMI trust fund will remain solvent because its financing is reset each year to meet future costs. Projected increases in SMI expenditures, however, will require increases in beneficiary premiums and general revenue contributions. SMI costs are projected to grow from 2.0 percent of Gross Domestic Product (GDP) in 2011 to 4.0 percent of GDP in 2085.

3. Increases in total Medicare spending threaten the program’s sustainability. Overall Medicare spending—including both HI and SMI—is projected to consume an ever-growing share of the nation’s economy, threatening the program’s long-term sustainability. Total Medicare costs are projected to grow from 3.7 percent of GDP in 2011 to 6.7 percent of GDP in 2085.

The sooner corrective measures are enacted, the more flexible and gradual the approach can be.

What’s Causing the Problem?

Both the number of Americans enrolled in Medicare and the cost per enrollee are increasing. Medicare is challenged by the same rising health spending that is affecting the overall health care system. In the case of Medicare, the problem of rising health care costs is compounded by the aging of the population and the retirement of the baby boom generation.

Will the Recent Health Care Reform Law Fix the Problem?

Not fully. The Affordable Care Act (ACA) included a number of provisions designed to reduce Medicare spending, increase Medicare revenues, and develop new health care delivery systems and payment models to improve health care quality and cost efficiency. These have improved projections for Medicare’s financial condition. But, while this was an important first step, it did not go far enough to put Medicare back on a sound financial footing. The financial challenges described above already reflect the anticipated improvements from the ACA.
There is no one solution to Medicare's financial problems; any solution will require policymakers to make difficult choices and will involve a combination of options. Any solution likely will require taxpayers, Medicare beneficiaries, health care providers, and private insurers to share the burden. In simple terms, improving Medicare's financial condition will require:

- Increasing revenues,
- Reducing spending, or
- Some combination of both.

**What Options Are Available for Reforming Medicare?**

A number of specific options for improving Medicare’s financial position have been included in recent debt and deficit reduction proposals but have not been enacted. Some of these are:

- Set spending targets to limit the growth in health spending.
- Expand the authority of the Independent Payment Advisory Board (IPAB).
- Transition to a premium support or voucher program.
- Reform the physician payment system.
- Reduce spending for prescription drugs.
- Revise the traditional Medicare benefit design and cost-sharing requirements.
- Raise the Medicare eligibility age.
- Increase Medicare Part B premiums for some or all beneficiaries.

More information on each of these options is provided below.

**How Do You Decide Which Options Are Best?**

Improving the sustainability of the health system requires slowing the growth in overall health spending, rather than just shifting the costs to from one payer to another. This means that unless system-wide spending is addressed, implementing options to control Medicare spending will have limited long-term effectiveness. And while controlling costs is vital to the sustainability of the program, it is not the only consideration. Slowing the growth in health spending, while maintaining or improving the quality of care, will require provider payment and health care delivery systems that encourage integrated and coordinated care.

To evaluate the various options for reforming Medicare, you should consider:

- How does the reform option affect the cost of the program?
- How does it affect beneficiaries’ access to care?
- How does it affect the quality of care?
- Does it slow the growth in health spending, rather than just shifting costs from one payer to another?
- Does it give providers the incentives to provide, and their patients the incentives to obtain, the kind of integrated and coordinated care that could help control costs and improve quality?

**Options to Reform Medicare**

- **Set Spending Targets to Limit the Growth in Medicare Spending.** Specific spending targets could be established either for
Medicare in particular or for all federal health spending. If spending exceeded the targets, it could trigger specific automatic actions such as benefit reductions or revenue increases. As an alternative, the trigger could be structured to require the president or a commission to submit proposals that would have to be considered by Congress on an expedited basis.

- **Expand the Authority of the Independent Payment Advisory Board.** The ACA created the IPAB to make recommendations to reduce the growth in per capita Medicare spending if that spending exceeds a targeted growth rate. IPAB recommendations would be implemented automatically unless Congress passes legislation that produces comparable savings. The type of recommendations IPAB can make, however, are limited. The IPAB could be given authority to consider a wider range of recommendations, and the expansion of scope could be tied to more ambitious targets for reducing spending growth.

- **Transition to a Premium Support or Voucher Program.** These proposals would change Medicare from a defined benefit plan to a defined contribution plan, meaning government would limit the amount it contributes to Medicare coverage (or private plans). Beneficiaries would pay the difference between plan premiums and the government contribution.

- **Reform the Physician Payment System.** Physician payment rates are governed by the Sustainable Growth Rate (SGR) system, which aims to limit the growth in Medicare spending for physician services. Congress, however, typically overrides the physician fee cuts that the SGR formula would require (this override is known as the “doc fix”). Had Congress not continued to override the fee cuts, physicians would have seen a reduction in payments of almost 30 percent in 2012. Such a large decrease could have threatened beneficiary access to care. One approach to reforming Medicare physician payments would eliminate the SGR, temporarily freeze physician fees at their current level, and replace the SGR with a new physician payment system. Such an option would increase Medicare spending, however, unless it is offset by Medicare spending reductions.

- **Reduce Spending for Prescription Drugs.** Proposals to reduce spending for prescription drugs would require Medicare to negotiate drug prices under Part D, extend drug rebates to individuals who are eligible for both Medicare and Medicaid, or establish a government-run Part D option. Reducing prescription drug prices would lower Part D spending and beneficiary premiums.

- **Revise the Design of Traditional Medicare.** The benefit design for beneficiaries enrolling in traditional Medicare (as opposed to private Medicare Advantage plans) has several shortcomings. The lack of an out-of-pocket maximum leaves beneficiaries unprotected against catastrophic costs; most beneficiaries have supplemental coverage (e.g., Medigap) with low cost-sharing requirements that reduce incentives to seek cost-effective care; and the cost-sharing structure is not ideal for influencing consumer behavior. Updating the traditional
cost-sharing features could help better align beneficiary incentives to seek cost-effective care. Meeting this goal, however, may require changes to supplemental coverage as well. Proposals to update the traditional benefit design would change or combine the Part A and B cost-sharing requirements, add a maximum out-of-pocket limit, and/or eliminate first-dollar coverage in supplemental plans (or apply an additional charge to those plans).

- **Raise the Medicare Eligibility Age.** The current eligibility age for Medicare is 65; the normal retirement age for Social Security has been increased to age 67. There have been proposals to increase the Medicare eligibility age and perhaps even index it to increases in longevity. This would reduce Medicare costs, but the savings would be offset partially by increased federal spending in other areas such as Medicaid and the premium subsidies available through the new health insurance exchanges created by the ACA.

- **Increase Part B Premiums for Some or All Beneficiaries.** Most Medicare beneficiaries pay the standard Part B premium, currently set to cover 25 percent of the average cost of Part B benefits. Higher-income beneficiaries, however, pay between 35 and 80 percent of the average cost. Some proposals would increase Part B premiums for those not already subject to higher premiums or raise them higher for those who are already paying relatively higher premiums. This would increase Medicare revenues by shifting costs to beneficiaries, but would not affect Medicare spending.

### What You Can Do

**Understand that There Is No Silver Bullet**

There is no one, simple solution for shoring up Medicare. Ensuring that Medicare benefits are payable in the future almost certainly will require shared responsibility from Medicare beneficiaries, taxpayers, health care providers, and private insurers. When it comes to reform, sooner is better than later. Improving Medicare’s long-term solvency and sustainability ultimately will require slowing the growth in health spending rather than just shifting costs from one payer to another. Slowing the growth in health spending, while maintaining or improving quality, will require provider payment and health care delivery systems that encourage integrated and coordinated care.

**Learn as Much as You Can**

The more you know about how Medicare works, its financial condition, and the options available for reform, the better equipped you will be to evaluate what candidates have to say about the program. You may want to start with the following Academy publications:

- Medicare’s Financial Condition: Beyond Actuarial Balance (May 2012)
- An Actuarial Perspective on Proposals to Improve Medicare’s Financial Condition (May 2011)
- Revising Medicare’s Fee-For-Service Benefit Structure (March 2012)

**Speak Out**

Encourage candidates for federal office to detail their approaches for putting Medicare on a sound financial footing. Ask Congress and the president to ensure the long-term future of the program.
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When evaluating proposals to improve Medicare's financial condition, it's important to recognize that improving the sustainability of the health system as a whole requires slowing the growth in overall health spending rather than shifting costs from one payer to another. New payment and delivery system models have the potential to control costs and improve quality by better aligning incentives to encourage integrated and coordinated care.

**Additional Resources**


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committee plans to examine many of these options in more detail.

When evaluating proposals to improve Medicare’s financial condition, it’s important to recognize that improving the sustainability of the health system as a whole requires slowing the growth in overall health spending rather than shifting costs from one payer to another. So unless system-wide spending is addressed, implementing options to control Medicare spending will have limited long-term effectiveness.

**Limit the Growth in Medicare Spending**

Some current proposals would set spending targets, either for Medicare in particular, or for federal health spending in total. Exceeding those targets could trigger specific actions, such as automatically reducing benefits or increasing revenues. The trigger, alternatively, could be structured to require the president or a commission to submit proposals that would be considered by Congress on an expedited basis. One approach, for instance, would set target spending for all federal health expenditures at the growth in gross domestic product (GDP) plus 1 percent. If the target is exceeded, the president would be required to submit proposals to reduce spending. Another approach automatically would reduce fee-for-service provider payments by 1 percent if general revenue contributions to Medicare exceed 45 percent of Medicare funding. (As discussed below, the ACA created the Independent Payment Advisory Board, or IPAB, which focuses on reducing Medicare spending if it exceeds a targeted growth rate. As currently structured, the IPAB is somewhat restricted on what options it can recommend.)

**COST:** Medicare savings would depend on how aggressively the spending targets are set. Savings to the health system overall, however, would be offset to the extent that costs are instead shifted to Medicare beneficiaries or other payers.

**ACCESS/QUALITY:** The impact on the access to and quality of care would depend on the specific recommendations made. Depending on how the reductions are structured, reducing provider payment rates could reduce beneficiary access to care and/or the quality of care. Other specific options for reducing benefit costs or increasing revenues are examined in other sections of this paper.

**Transition to a Premium Support or Voucher Program**

Some proposals would transition Medicare to a premium support or voucher program, while others offer such an approach as an option if certain measures to reduce Medicare spending growth are not deemed adequate. These approaches would change the Medicare program from a defined benefit plan to a defined contribution plan.

Under a premium support approach, the
government would limit the amount it contributes toward Medicare coverage, with beneficiaries paying additional premiums to cover any difference between plan premiums and the government contribution. The growth in government contributions would be indexed by inflation or some other factor. Under a voucher-type approach, individuals would receive a voucher to purchase private health insurance. The voucher could be adjusted by various beneficiary characteristics—such as age, health status, geographic location, and/or income—and would be indexed by inflation or some other factor.

**COST:** Moving to a defined contribution approach would shift the risk of health spending growth away from the government and toward beneficiaries. Depending on how the government contribution is set, federal Medicare spending could be lower than currently projected. To the extent that health spending growth exceeds the increase in the government contribution, costs would be shifted to beneficiaries through higher premiums and/or higher cost sharing. As discussed below, increased cost-sharing requirements could lower spending growth due to reduced utilization. The impact of such an approach on overall health spending would also depend on how utilization management, administrative costs, and provider payment rates under private plans would compare to those under traditional Medicare.

**ACCESS/QUALITY:** Access to Medicare or private insurance would depend on the difference between the government contribution and the premium. The greater the share of costs that are shifted from the government to beneficiary premiums, the more likely that beneficiaries will opt for less generous plans. Although this could encourage beneficiaries to seek more cost-effective care, some may forgo needed care. In addition, to bring costs down, care quality might be compromised. Such a system, for instance, might lead to a less-expensive second tier delivery system, which may be much more limited in the types of providers available.

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**Expand the Authority of the Independent Payment Advisory Board (IPAB)**

The ACA created the IPAB, which is similar to the Medicare Payment Advisory Commission (MedPAC). The IPAB is charged with preparing recommendations to reduce the growth in Medicare per capita expenditures if spending exceeds a targeted growth rate. The targets are based on inflation until 2019, and on GDP plus 1 percent thereafter. Unlike MedPAC recommendations, IPAB recommendations would be implemented automatically unless the Congress passes legislation producing comparable reductions. The board is somewhat restricted in its recommendations—it cannot propose to ration health care, raise revenues, increase beneficiary premiums or cost sharing, or otherwise restrict benefits or modify eligibility criteria. In addition, until 2020 most hospital services are excluded from the scope of payment changes that can be recommended.

Provisions included in various fiscal proposals would expand the scope of the IPAB, by eliminating the temporary carve-outs for hospital services, allowing options related to

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1 MedPAC would continue its role as advisor to Congress on issues affecting the Medicare program and would review any IPAB proposals.
2 Section 3403 of the Affordable Care Act: http://docs.house.gov/energycommerce/ppacon.pdf.
cost sharing and benefit design, and giving it authority over all federal health spending. The expansion of scope could be tied to directing IPAB to meet more ambitious spending growth targets.

**COST:** To the extent that the spending growth targets are tightened, additional Medicare cost savings could be achieved, compared to current law. However, total savings would be offset to the extent that costs are shifted to beneficiaries.

**ACCESS/QUALITY:** The impact on the access to and quality of care would depend on the specific recommendations made. Options to revise Medicare’s plan design are examined in more detail below.

### Reform the Sustainable Growth Rate System

The sustainable growth rate (SGR) system was enacted as part of the Balanced Budget Act of 1997 to limit the growth in spending for Medicare physician services. The system compares actual cumulative spending for Medicare physician services to a specified spending target. If actual spending exceeds the target, then physician payment updates are adjusted downward. With the exception of 2002, the first year that physician fee cuts were called for under the SGR formula, the fee cuts have been temporarily overridden each year by Congress (i.e., the “doc fix”). As a result of the cumulative shortfall, physician payment rates will be reduced by nearly 30 percent in 2012, barring another override from Congress.

By putting pressure on physician payment updates, the SGR system might have resulted in slower growth in physician payment updates than would have occurred otherwise. There are calls, nevertheless, to reform or eliminate the SGR system due to concerns regarding beneficiary access to care under large fee cuts, provider frustration regarding the short-term nature of payment fixes, the growing budgetary costs of further overrides, and the way the system’s across-the-board fee cuts poorly target those providers with the highest volume increases. One approach would eliminate the SGR, temporarily freeze physician payments, and develop a new physician payment system. The proposal would pay for the elimination of the SGR by other reductions in Medicare and Medicaid spending.

**COST:** Officially eliminating the SGR would increase Medicare spending over baseline projections including the SGR, unless offset by other spending reductions.

**ACCESS/QUALITY:** Eliminating the SGR could help maintain beneficiaries’ access to care. Depending on how a new physician payment system would be developed, it could better align payments with the provision of high-value care.

### Reduce Spending for Prescription Drugs

Provisions included in various proposals would reduce payments for prescription drugs. One option would be to increase drug rebates by requiring Medicare to use its bargaining power to negotiate drug prices under the Part D program. Another option would extend drug rebates to those eligible

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1Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy (Chapter 4),* March 2011.

2The Congressional Budget Office (CBO) estimates that replacing the SGR with a 10-year physician payment freeze would cost about $250 billion; if payments were increased over time, the cost would be even greater. (*The Budget and Economic Outlook: Fiscal Years 2011 to 2021, January 2011.*)
for both Medicare and Medicaid.

Another approach would establish a government-run Part D option that would be offered alongside Part D private plans. The Centers for Medicare and Medicaid (CMS) would negotiate prices with prescription drug companies. However, as with Medicare Parts A and B, this ultimately could lead to CMS setting prescription drug prices.

**COST:** By reducing the prices paid for prescription drugs, these options would lower Part D spending and reduce its growth rate. To the extent that prescription drug companies can respond by increasing their prices in the private sector, costs would be shifted from Medicare to the private sector.

Lowering Part D spending would also reduce beneficiary premiums for Part D plans. In some cases the copayments for some prescription drugs could also be reduced.

**ACCESS/QUALITY:** Reducing the prices paid for prescription drugs potentially could reduce research and development in the pharmaceutical industry. Introducing a government-run Part D option could lead to some current Part D providers leaving the market, especially if the government-run plan sets drug prices—thereby reducing the choices available to enrollees.

### Revise Medicare’s Fee-For-Service (FFS) Benefit Design and Cost-Sharing Requirements

Medicare, like most other health insurance plans, uses patient cost-sharing requirements (e.g., deductibles, copayments, coinsurance) to help balance plan affordability with the comprehensiveness of coverage. Patient cost sharing directly lowers Medicare spending by shifting a share of medical costs to the beneficiary. In addition, cost sharing can lower spending overall by reducing utilization. Patient cost-sharing requirements ideally align beneficiary incentives with program goals to provide quality and cost-effective care. However, Medicare’s fee-for-service (FFS) cost-sharing requirements are not currently structured to meet these goals. In particular:

- The FFS cost-sharing requirements are skewed more toward less discretionary services, with high deductibles for Part A inpatient services and lower deductibles for Part B physician and outpatient services;
- Most beneficiaries have supplemental policies to fill in most or all FFS cost-sharing requirements, thereby reducing the incentives for beneficiaries to seek cost-effective care;⁶
- The lack of an out-of-pocket maximum under FFS leaves beneficiaries unprotected against catastrophic health costs.

Provisions in various proposals would increase and/or restructure Medicare’s cost-sharing requirements. A number of proposals would combine or restructure the Part A and Part B cost-sharing requirements and add a new maximum out-of-pocket limit. (Medicare Advantage plans have some flexibility on how to structure cost-sharing requirements, and as of 2011, are required to cap out-of-pocket spending.) Some of these proposals would also eliminate first-dollar coverage in Medigap plans and/or prohibit supplemental insurance from covering any new or increased cost-shar-

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⁶MedPAC reports that 89 percent of FFS beneficiaries in 2005 had supplemental coverage: 33 percent had individually purchased Medigap coverage, 37 percent had employer-sponsored coverage, 17 percent had Medicaid, and 2 percent had other public coverage. See *Report to the Congress: Improving Incentives in the Medicare Program* (Chapter 6), June 2009.
ing amounts. Taken together, these changes could help encourage Medicare beneficiaries to seek cost-effective care. A value-based insurance design (VBID) also could encourage the use of cost-effective care. A VBID approach would lower the cost sharing for high-value services and increase the cost sharing for low-value services. The ACA moved Medicare in this direction by covering certain preventive services with no cost sharing. Comparative effectiveness research can facilitate the identification of low- and high-value services.

**COST:** Increasing Medicare’s cost-sharing requirements would reduce Medicare spending by shifting more of the costs to beneficiaries. Savings could also result by lowering utilization, especially if supplemental plans are prohibited from covering the difference. Adding an out-of-pocket cap would offset cost savings. Adjusting cost sharing to align incentives with effective use of services has shown promise in reducing spending in the non-Medicare market—most often for prescription drugs.7

**ACCESS/QUALITY:** A restructuring of Medicare’s cost-sharing requirements could better align beneficiary incentives for high-quality and cost-effective care. In addition, incorporating a maximum out-of-pocket limit would provide the catastrophic protection that the FFS program currently lacks. Such a restructuring would increase out-of-pocket spending for many beneficiaries, but decrease it for those with the greatest health care needs.

Broad increases in cost sharing, rather than targeted increases, have been shown to reduce not only unnecessary care, but also necessary care, especially among the low income and chronically ill. For this reason, some proposals would exempt lower-income beneficiaries from cost sharing increases. In addition, a VBID approach could incorporate lower cost-sharing requirements for chronic treatments.

**Raise the Medicare Eligibility Age**

Since the program began in 1965, beneficiaries have been eligible for full Medicare benefits at age 65, consistent with Social Security’s normal retirement age at that time. Since that time, the normal retirement age for Social Security has been increased to age 67 and there are currently proposals to increase it beyond 67. Similarly, there are proposals to gradually increase the Medicare eligibility age (e.g., to age 67 or 69), and some also would index the eligibility age for increased longevity.

**COST:** Raising the Medicare eligibility age would reduce the cost of the Medicare program and could increase payroll tax revenues by encouraging individuals to work beyond age 65. However, the increased revenues would be offset by increased federal spending to the extent that individuals between age 65 and the new eligibility age receive premium subsidies through the health insurance exchanges or coverage through Medicaid. In addition, some costs would be shifted to employers, states, and individuals.

**ACCESS/QUALITY:** People between age 65 and the new eligibility age would have to find a new source of health insurance—through employer coverage, the individual market or health insurance exchanges, or other public coverage such as Medicaid—or go uninsured. Provisions in the ACA increase the availability of other coverage sources. In particular,

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beginning in 2014, the ACA requires that private health insurance coverage be offered on a guaranteed-issue basis, prohibits preexisting condition exclusions, and limits premium variations by age. Low- and moderate-income individuals may be eligible for premium and cost-sharing subsidies or Medicaid coverage.

Shifting individuals between age 65 and the new eligibility age into private plans would increase average premiums for private plans. This could potentially reduce insurance coverage among younger individuals if their premiums increase as a result.

**Increase Medicare Part B Premiums**

Medicare Part B premiums, initially set at 50 percent of Part B costs, currently are set at 25 percent of costs. Beginning in 2007, premiums for higher-income beneficiaries were raised to between 35 and 80 percent of costs, depending on income. The ACA temporarily freezes the index on income thresholds used to determine the premiums, which means more beneficiaries will be subject to higher premiums over time. Some proposals would increase the Part B premiums for those not already subject to higher premiums or raise them higher for those already subject to higher premiums.

**COST:** Increasing Medicare premiums would increase program revenues by shifting costs to beneficiaries. But it would not reduce Medicare spending (unless some beneficiaries decide to opt out of Medicare Part B due to the higher premiums).

**ACCESS/QUALITY:** Beneficiaries who are unwilling or unable to pay higher Part B premiums may face reduced access to care.

**Next Steps**

This paper provides a brief overview of the various Medicare-related provisions put forward as part of proposals aimed at improving the nation’s fiscal condition. In future work, the American Academy of Actuaries’ Medicare Steering Committee plans to explore in more detail many of these and other options. The focus will be not only on whether an option helps improve Medicare’s financial condition, but also on whether it improves the sustainability of the health system as a whole by slowing the growth in overall health spending.

In addition, the committee intends to examine new programs in the ACA that were included to jumpstart reforms to the health care delivery system. The Medicare Shared Savings Program, for instance, will facilitate the creation of Accountable Care Organizations (ACOs). The newly created Center for Medicare and Medicaid Innovation (CMI) will identify and test new models of health care delivery and payment and speed the expansion of successful models. By better aligning incentives to encourage integrated and coordinated care, ACOs and other new payment and delivery system models have the potential to control costs and improve quality.
August 31, 2011

Dear Senator/Representative:

As you begin the challenging work of the Joint Select Committee on Deficit Reduction, I urge you to use this opportunity to develop sound public policy proposals to improve the long-term solvency and sustainability of the Medicare program.

With Medicare’s critical role of ensuring access to health care for Americans age 65 and older and certain younger adults with permanent disabilities, we as a nation cannot afford to have this important program continue on its current financial path. Rising health care spending threatens not only the sustainability of the Medicare program and the overall health system but also the nation’s fiscal health.

As you consider potential Medicare reforms in the context of deficit reduction, it is important to evaluate the impact those reforms could have on the viability of the Medicare program including cost, access, and quality of care. In addition, improving Medicare’s long-term sustainability requires slowing the growth in overall health spending—not simply shifting costs from one payer to another.

Medicare’s sustainability is a core issue for the American Academy of Actuaries1 and, as one of our highest public policy priorities, we would welcome the opportunity to be of assistance to you as you consider reforms that would affect Medicare and/or the health system as a whole. We are committed to providing objective actuarial information and analysis related to Medicare and other health-related issues. To orient you to some of our ongoing work, our Medicare Steering Committee has issued several recent publications that we commend to your attention, including:

- Presentation from a recent Capitol Hill briefing the Academy hosted that break down some of the trustees’ key findings as well as outlining several options for reforming the program. [http://www.actuary.org/pdf/health/MedicareTrusteesBriefing_Presentation_110527.pdf](http://www.actuary.org/pdf/health/MedicareTrusteesBriefing_Presentation_110527.pdf)

In addition to these documents, we have a number of other publications on our website that address payment and delivery system reforms, which have the potential to control costs and improve quality

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1 The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
through better alignment of incentives to encourage integrated and coordinated care. All of these publications can be found at http://www.actuary.org/issues/health_reform_implementation.asp.

If you have any questions or if you would like to discuss in more detail any implications various reforms may have on the Medicare program, please contact Heather Jerbi, the Academy’s senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

Edwin C. Hustead, MAAA, FSA, EA
Chairperson, Medicare Steering Committee
American Academy of Actuaries

Cc: Mark Prater, Staff Director, Joint Select Committee on Deficit Reduction
Medicare’s Financial Condition: Beyond Actuarial Balance

Each year, the Boards of Trustees of the Federal Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds report to Congress on the Medicare program’s financial condition. Medicare plays a critically important role in ensuring access to health care among Americans age 65 and older and certain younger adults with permanent disabilities. The program is operated through two trust funds. The HI trust fund (Medicare Part A) pays primarily for hospital services. The SMI trust fund includes accounts for the Medicare Part B program, which covers physician and outpatient hospital services, and the Medicare Part D program, which covers the prescription drug program.

The trustees’ report is the primary source of information on the financial status of the Medicare program, and the American Academy of Actuaries proudly recognizes the important contribution that members of the actuarial profession have made in preparing the report and educating the public about the important issues surrounding the program’s solvency and sustainability.

The projected financial condition of Medicare as identified in the 2013 Medicare trustees’ report has improved compared with the projections from the 2012 report. The year in which the HI trust fund is projected to be depleted is now 2026, two years later than projected last year. The 75-year HI deficit decreased from 1.35 percent of taxable payroll in last year’s report to 1.11 percent of taxable payroll in the 2013 report. This improvement is due to...
more recent data and technical changes in projection methods. HI expenditures are projected to exceed HI revenues in most years of the 75-year projection period. Total Medicare expenditures will make up an increasing share of federal outlays and the gross domestic product (GDP).

As required by statute, the trustees’ projections of Medicare’s financial outlook are based on benefits and revenues scheduled under current law. The trustees acknowledge, however, that these estimates likely understate the seriousness of Medicare’s financial condition. In the Statement of Actuarial Opinion that accompanies the trustees’ report, Paul Spitalnic, the acting chief actuary of the Centers for Medicare & Medicaid Services (CMS), specifically notes that actual Medicare expenses are likely to exceed the current-law projections. He states, “the financial projections shown in [the] report for Medicare do not represent a reasonable expectation for actual program operations in either the short range…or the long range…” In particular, the trustees and the acting chief actuary point to scheduled reductions in provider payments that are unlikely to occur. Currently scheduled physician payment reductions in accordance with the sustainable growth rate (SGR) mechanism are considered likely to be overridden by Congress (i.e., the Medicare “doc fix”). In addition, current law requires downward adjustments in payment updates for most non-physician providers to reflect productivity improvements; these adjustments might not be sustainable in the long term.

At the request of the trustees, the CMS Office of the Actuary developed an alternative analysis that provides an illustration of the potential understatement of current-law Medicare cost projections if the physician payment reductions are overridden, the productivity adjustments are phased down, and there are no savings from the Independent Payment Advisory Board (IPAB). Although the illustrative alternative projections are not intended to be interpreted as the official best estimates of future Medicare costs, they do, as noted in the alternative analysis, “help illustrate and quantify the potential magnitude of the cost understatement under current law.” This issue brief presents projections based on both current law and the illustrative alternative projections.

The trustees conclude: “The projections in this year’s report continue to demonstrate the need for timely and effective

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1 Both the 2013 Medicare Trustees Report and the CMS Office of the Actuary’s illustrative alternative scenario analysis are available at: http://www.cms.gov/ReportsTrustFunds/.
action to address Medicare’s remaining financial challenges—including the projected depletion of the HI trust fund, this fund’s long-range financial imbalance, and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare cannot be sustained, then these further policy reforms will have to address much larger financial challenges than implied by the current-law projections.”

This issue brief more closely examines the findings of the trustees’ report with respect to program solvency and sustainability. The American Academy of Actuaries’ Medicare Steering Committee concurs that the Medicare program faces serious financing problems. As highlighted in the 2013 Medicare trustees’ report and its accompanying illustrative alternative analysis:

- The HI trust fund is projected to be depleted in 2026, two years later than projected in last year’s report.
- The HI trust fund faces serious long-term funding challenges. HI expenditures are expected to exceed HI revenues in most future years. In the year that the trust fund is projected to be depleted—2026—tax revenues would cover only 87 percent of program costs.
- The projected HI deficit over the next 75 years is 1.11 percent of taxable payroll. Eliminating this deficit would require an immediate 38 percent increase in standard payroll taxes or an immediate 22 percent reduction in benefits—or some combination of the two. Delaying action would require more drastic tax increases or benefit reductions in the future.
- Under the illustrative alternative scenario, the HI trust fund would be depleted a few months earlier in 2026 and the 75-year HI deficit would be 2.17 percent of taxable payroll.
- The SMI trust fund is expected to remain solvent because its financing is reset each year to meet projected future costs. Projected increases in SMI expenditures will require significant increases over time in beneficiary premiums and general revenue contributions. Under current-law projections, SMI spending is expected to grow from 2.0 percent of GDP in 2012 to 4.0 percent of GDP in 2085. Under the illustrative alternative scenario, SMI spending is expected to reach 5.6 percent of GDP in 2085.
- Total Medicare expenditures also are projected to increase as a share of GDP, thereby threatening Medicare’s long-term sustainability. Under current-law projections, total Medicare spending as a share of GDP is expected to grow from 3.6 percent in 2012 to 6.5 percent in 2085. Under the illustrative alternative scenario, total Medicare spending is projected to reach 9.6 percent of GDP in 2085.

Because Medicare plays a critically important role in ensuring that older and certain disabled Americans have access to health care, the American Academy of Actuaries’ Medicare Steering Committee

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2 The current HI payroll tax rate is 1.45 percent of taxable earnings, payable by both employees and their employers for a total of 2.90 percent. Self-employed individuals pay both shares. Beginning in 2013, earnings exceeding $200,000 for individuals and $250,000 for married couples filing jointly are subject to an additional HI tax of 0.9 percent.
urges action to restore the long-term solvency and financial sustainability of the program. The sooner such corrective measures are enacted, the more flexible the approach and the more gradual the implementation can be. Failure to act now will necessitate far more drastic actions later.

**MEDICARE FINANCING PROBLEMS**

The Medicare program has three fundamental long-range financing challenges:

1. Income to the HI trust fund is not adequate to fund the HI portion of Medicare benefits;
2. Increases in SMI costs increase pressure on beneficiary household budgets and the federal budget;
3. Increases in total Medicare spending threaten the program’s sustainability.

Each of these problems is discussed in more detail below.

**Medicare HI Trust Fund Income Falls Short of the Amount Needed To Fund HI Benefits**

Like Social Security, Medicare relies on trust funds to account for all income and expenditures. The HI and SMI programs operate separate trust funds with different financing mechanisms. General revenues, payroll taxes, premiums, and other income are credited to the trust funds, which are used to pay benefits and administrative costs. Any unused income is required by law to be invested in U.S. government securities for use in future years. In effect, the trust fund assets represent loans to the U.S. Treasury’s general fund. The HI trust fund, which pays for hospital services, is funded primarily through earmarked payroll taxes.

The projections of Medicare’s financial outlook in the trustees’ report must be based on current law. Under these current-law projections, the financial condition of the HI trust fund has improved since the 2012 trustees’ report. This improvement results from more recent data and technical changes in projection methods. The projected trust fund exhaustion date is two years later than in last year’s report, and the 75-year HI deficit decreased from 1.35 percent of taxable payroll to 1.11 percent.

- HI expenditures currently exceed HI revenues. The gap is projected to narrow over the next few years, becoming a surplus for a few years before HI expenditures are expected to exceed revenues, including interest income, for the remainder of the 75-year projection period. The HI trust fund assets, therefore, will need to be redeemed. If the federal government is experiencing unified budget deficits, funding the redemptions will require that additional money be borrowed from the public, thereby increasing the federal deficit and debt.

- The HI trust fund is projected to be depleted in 2026. At that time, tax revenues are projected to cover only 87 percent of program costs, with the share declining to 71 percent in 2050. In 2085, payroll tax revenues are projected to cover 73 percent of program costs. There is no current provision for general fund transfers to cover HI expenditures in excess of dedicated revenues.

- The projected HI deficit over the next 75 years is 1.11 percent of taxable payroll. Eliminating this deficit would require an immediate 38 percent increase in standard payroll taxes or a 22 percent reduction in benefits—or some combination of the two. Delaying action would require more drastic changes in the future.

Current-law projections, however, likely underestimate the fiscal challenges to the Medicare HI trust fund. In particular, the scheduled reductions in provider payment rate updates to reflect productivity adjustments may not be sustainable in the long term. At the request of the trustees,
the CMS Office of the Actuary provided an illustrative alternative analysis that phases down the productivity adjustments gradually over 15 years, beginning in 2020, from about 1.1 percent to 0.4 percent and assumes no savings from IPAB.

Under the illustrative alternative scenario, the HI trust fund also would be depleted in 2026, but the projected deficit over the next 75 years would be 2.17 percent of taxable payroll—compared to 1.11 percent under current-law projections. Eliminating this deficit would require an immediate 75 percent increase in standard payroll taxes or a 36 percent reduction in benefits—or some combination of the two.

**Increases in SMI Costs Increase Pressure on Beneficiary Household Budgets and the Federal Budget**

The SMI trust fund includes accounts for the Medicare Part B program, which covers physician and outpatient hospital services, and the Medicare Part D program, which covers the prescription drug program. Approximately one-quarter of SMI spending is financed through beneficiary premiums, with federal general tax revenues covering the remaining three-quarters.

The SMI trust fund is expected to remain solvent because its financing is reset each year to meet projected future costs. As a result, increases in SMI costs will require increases in beneficiary premiums and general revenue contributions. Increases in general revenue contributions will put more pressure on the federal budget.

Premium increases similarly will place pressure on beneficiaries, especially when considered in conjunction with increasing beneficiary cost-sharing expenses. The average beneficiary expenses (premiums and cost sharing) for Parts B and D combined currently are 23 percent of the average Social Security benefit. These expenses will increase to 40 percent of the average Social Security benefit by 2085. These expenses do not include cost sharing under Part A.

The 2013 trustees' report projects that under current law, SMI spending will continue to grow faster than GDP, increasing from 2.0 percent of GDP in 2012 to 3.1 percent of GDP in 2030, and to 4.0 percent of GDP in 2085.

As acknowledged by the Trustees, the current-law projections likely underestimate the increases in Part B spending. Given that SGR-related physician payment reductions have been overridden every year since 2003, it is considered unlikely that future scheduled reductions will take effect in full. In addition, the scheduled reductions in non-physician provider payment rate updates to reflect productivity adjustments might not be sustainable in the long term. The CMS Office of the Actuary’s illustrative alternative analysis sets physician payment updates to 0.7 percent per year throughout the short range projection period (the average update for the last 10 years), thereafter phasing down to the growth in per capita national health expenditures. In addition, the alternative analysis phases down the productivity adjustments gradually over 15 years, beginning in 2020, from about 1.1

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3Part B beneficiaries pay monthly premiums covering approximately 25 percent of program costs; general revenues cover the remaining 75 percent of costs. Part D premiums are set at approximately 25 percent of Part D costs. Because of low-income premium subsidies, however, beneficiary premiums will cover only approximately 14 percent of total Part D costs in 2013. State payments on behalf of certain beneficiaries will cover approximately 12 percent of costs and general revenues will cover the remaining 74 percent of costs.

4The sustainable growth rate (SGR) system was enacted as part of the Balanced Budget Act of 1997 to limit the growth in spending for physician services. The system compares actual cumulative spending to a specified spending target. If actual spending exceeds the target, then physician payment updates are adjusted downward. A cumulative reduction of 25 percent is estimated for next year.
percent to 0.4 percent, and assumes no savings from IPAB. The alternative scenario projections assume no changes to the current-law Part D projections.

Under the illustrative alternative scenario projections, SMI spending would increase from 2.0 percent of GDP in 2012 to 3.3 percent of GDP in 2030, and to 5.6 percent of GDP in 2085.

**Table 1: SMI Expenditures as a Percent of GDP**

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2013 Report (current law)</th>
<th>2013 Alternative Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>2020</td>
<td>2.2</td>
<td>2.3</td>
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<tr>
<td>2030</td>
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<td>3.3</td>
</tr>
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<td>2040</td>
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</tr>
<tr>
<td>2085</td>
<td>4.0</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Sources: 2013 Medicare Trustees’ Report, CMS Office of the Actuary

**Increases in Total Medicare Spending Threaten the Program’s Sustainability**

A broader issue related to Medicare’s financial condition is whether the economy can sustain Medicare spending in the long run. To help gauge the future sustainability of the Medicare program, we examine the share of GDP that will be consumed by Medicare. Because Medicare spending is expected to continue growing faster than GDP, greater shares of the economy will be devoted to Medicare over time, meaning smaller shares of the economy will be available for other priorities.

According to the current-law projections, Medicare expenditures as a percentage of GDP will grow from 3.6 percent of GDP in 2012 to 6.5 percent of GDP in 2085. Under the CMS Office of the Actuary alternative scenario, however, total Medicare expenditures would increase to 9.6 percent of GDP in 2085.

**Table 2: Total Medicare Expenditures as a Percent of GDP**

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2013 Report (current law)</th>
<th>2013 Alternative Projection</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
<td>3.6</td>
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<td>2020</td>
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</tr>
<tr>
<td>2085</td>
<td>6.5</td>
<td>9.6</td>
</tr>
</tbody>
</table>

Sources: 2013 Medicare Trustees’ Report, CMS Office of the Actuary

**CONCLUSION**

The Affordable Care Act (ACA), enacted in 2010, contains numerous provisions designed to reduce Medicare costs, increase Medicare revenues, and develop new health care delivery systems and payment models that improve health care quality and cost efficiency. Additional steps need to be taken, however, to solve the long-term financial challenges to Medicare.

The HI trust fund is projected to be depleted in 2026, and Medicare spending will continue to grow faster than the economy—increasing the pressure on beneficiary household budgets and the federal budget and threatening the program’s sustainability.

In addition, Medicare’s financial challenges are likely to be much more severe than projected in the trustees’ report. The report’s Medicare spending projections are considered
understated to the extent that currently scheduled reductions in physician payments are expected to be overridden by Congress, as they have been every year since 2003, and the ACA’s provisions for downward adjustments in provider payment updates to reflect productivity improvements are unsustainable in the long term. If Medicare projections are calculated using assumptions that the physician payment reductions are overridden and the productivity adjustments are phased down, Medicare’s financial condition is shown to be even worse than under current-law projections.

The American Academy of Actuaries’ Medicare Steering Committee continues to have significant concerns about Medicare’s financing problems, even under the current-law projections, and strongly recommends that policymakers implement changes to improve Medicare’s financial outlook.

We concur with the 2013 trustees when they say:

_The Board of Trustees believes that solutions can and must be found to ensure the financial integrity of HI in the short and long term and to reduce the rate of growth in Medicare costs through viable means. Consideration of such reforms should occur in the near future. The sooner the solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations. Congress and the executive branch must work closely together with a sense of urgency to address these challenges._

And we wish to underscore this call for action.

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**Medicare Provisions in the Affordable Care Act**

The Affordable Care Act (ACA), enacted into law in 2010, includes many provisions designed to reduce Medicare costs, increase Medicare revenues, and develop new health care delivery systems and payment models that improve health care quality and cost efficiency. Major provisions include:

- **Reductions to provider payment updates.** The annual updates for fee-for-service provider payment rates are adjusted downward to reflect productivity improvements.

- **Basing Medicare Advantage plan payments on fee-for-service rates.** Medicare Advantage plan payments are being reduced gradually relative to fee-for-service costs.

- **Health care payment and delivery system improvements.** Pilot programs, demonstration projects, and other reforms are being implemented to increase the focus on delivering high quality and cost-effective care. These include initiatives on bundled payments and accountable-care organizations.

- **Increases in Medicare revenues.** Provisions to increase Medicare revenues include: increasing the HI payroll tax for earnings above an unindexed threshold, temporarily freezing the income thresholds for Part B income-related premiums, and increasing Part D premiums for higher-income beneficiaries.

- **Creation of the Independent Payment Advisory Board (IPAB).** Beginning in 2014, the board will submit recommendations to make changes to provider payments if Medicare spending exceeds a target per capita growth rate. Unless legislative action overrides the recommendations, they will be implemented automatically.
Revising Medicare’s Fee-For-Service Benefit Structure

Improving the quality and cost-effectiveness of care under the Medicare program is a key health policy challenge. Many Medicare reform proposals in recent years have focused on realigning financial incentives in Medicare’s provider payment and delivery system. However, a comprehensive package of reforms to improve Medicare sustainability also should consider better aligning incentives on the beneficiary side. To accomplish this, there have been calls to update the program’s traditional fee-for-service (FFS) benefit design (i.e., its cost-sharing features) and to address other issues related to beneficiary incentives. Such changes could deal with some of the shortcomings of the current benefit structure, including its lack of a cost-sharing maximum, and could help encourage Medicare beneficiaries to seek more cost-effective care. This brief expands upon the analysis of potential changes to the Medicare FFS benefit design included in the American Academy of Actuaries’ Medicare Steering Committee issue brief, An Actuarial Perspective on Proposals to Improve Medicare’s Financial Condition, including a brief examination of value-based insurance design (VBID).

Current Medicare Fee-For-Service Benefit Design

Like most other health insurance plans, Medicare uses patient cost-sharing requirements, such as deductibles, copayments, and coinsurance, to help balance the cost of the program with the comprehensiveness of the benefits provided (see Text Box 1). Patient cost sharing directly lowers Medicare spending by shifting a share of medical costs...
to the beneficiary. In addition, cost sharing can lower spending overall by reducing health care utilization.

While Medicare’s patient cost-sharing requirements perform the same basic functions as similar requirements in other health insurance programs, their structures vary greatly. Medicare’s hybrid nature—which combines a mandatory hospital insurance program with voluntary coverage for physician and outpatient services as well as voluntary prescription drug coverage—is directly reflected in the structure of the Medicare fee-for-service benefits. Whereas private health insurance programs typically have integrated benefit structures that are designed to manage hospital and non-hospital expenses in a coordinated fashion, the Medicare Part A (hospital) and Part B (physician and outpatient) benefits are structured very differently from each other—and the patient cost-sharing provisions are not coordinated between the two. This lack of coordination in the design of Medicare’s FFS benefits has important consequences for both beneficiaries and taxpayers.

In an ideal situation, patient cost-sharing requirements align beneficiary incentives with program goals to provide high-quality and cost-effective care. Medicare’s current FFS cost-sharing requirements, however, are not well structured to meet these goals and have other drawbacks. In particular:

- **MEDICARE DOES NOT PLACE AN ANNUAL LIMIT ON BENEFICIARY COST-SHARING LIABILITY.** The lack of an annual limit on cost sharing under the FFS option leaves beneficiaries unprotected against catastrophic health costs.

- **MOST MEDICARE BENEFICIARIES HAVE SUPPLEMENTAL POLICIES.** Because there is no cost-sharing limit, supplemental coverage is a necessity for beneficiaries who desire protection against the costs associated with catastrophic illness. Most Medicare benefi-

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**Selected Part A and Part B Cost-Sharing Requirements**

**PART A**

<table>
<thead>
<tr>
<th>Service</th>
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<tr>
<td>Hospital stay:</td>
<td>$1,156 deductible for days 1–60 per benefit period</td>
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<tr>
<td></td>
<td>$289/day copayment for days 61–90</td>
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<tr>
<td></td>
<td>$578/day copayment for days 91–150</td>
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<tr>
<td>Skilled nursing facility stay:</td>
<td>$0 for the first 20 days each benefit period</td>
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<tr>
<td></td>
<td>$144.50 per day for days 21–100 each benefit period</td>
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<tr>
<td></td>
<td>All costs for each day after 100 each benefit period</td>
</tr>
</tbody>
</table>

**PART B**

<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible:</td>
<td>$140</td>
</tr>
<tr>
<td>Physician services:</td>
<td>20 percent coinsurance</td>
</tr>
<tr>
<td>Outpatient hospital services:</td>
<td>20 percent coinsurance (up to hospital deductible of $1,156)</td>
</tr>
</tbody>
</table>

Note: See [www.medicare.gov](http://www.medicare.gov) for cost-sharing requirements for additional Medicare covered services.
Hospitals have supplemental coverage that also fills in the FFS cost-sharing requirements for non-catastrophic illnesses, which reduces the incentives for beneficiaries to seek cost-effective care.

**THE FFS DEDUCTIBLES ARE HIGHER FOR INPATIENT CARE.** Cost-sharing requirements aim, in part, to influence consumer behavior. Medicare’s cost-sharing provisions, however, are not structured in an ideal way to do this. Part A inpatient stays, which are less likely to be influenced by cost-sharing requirements, require fairly high deductibles—$1,156 in 2012 and additional copayments for hospital stays lasting beyond 60 days. In contrast, Part B physician and outpatient services, which are more likely to be influenced by cost-sharing requirements, require a fairly low annual deductible of $140 in 2012. Thereafter, a 20 percent coinsurance is required on most Part B services.

In contrast to traditional Medicare FFS plans, Medicare Advantage plans have some flexibility on how to structure cost-sharing requirements—and very few use the FFS cost-sharing structure. In addition, all Medicare Advantage plans now are required to provide an annual cost-sharing limit, which in 2012 can be no more than $6,700.

**Restructuring the Fee-For-Service Benefit Design**

To address the problems with the current FFS benefit design, proposals have been developed that would combine a new cost-sharing limit with a unified Part A and Part B deductible. The copayment and coinsurance requirements also could be restructured. These changes would result in more coordinated Part A and B cost-sharing requirements and would bring the FFS benefit design more in line with the structure of private health insurance programs.

Unifying the Part A and B deductibles has the potential to better align beneficiary incentives designed to reduce unnecessary care and promote more cost-effective care. But, as discussed in more detail below, the majority of Medicare beneficiaries have supplemental coverage that can limit the effectiveness of the incentives in Medicare’s cost-sharing requirements. In addition, beneficiaries need more access to price and quality information to better facilitate more cost-effective beneficiary behavior. And perhaps most important, provider incentives need to be consistent with beneficiary incentives and more information regarding treatment effectiveness is needed.

Adding an annual cost-sharing limit could be a significant benefit enhancement that would, absent other changes, increase the cost of the program. When combined with the introduction of a unified Part A and B deductible, however, such a restructuring could be achieved in a budget neutral way. In other words, the out-of-pocket limit and combined deductible could be chosen so that costs to the Medicare program would be the same under the new structure as they are projected currently. As an alternative, this restructuring can be done in a way that reduces (or increases)

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**Beneficiary Cost-Sharing Liability vs. Out-of-Pocket Costs**

Medicare beneficiaries who receive medical services are responsible for meeting any applicable cost-sharing requirements. These beneficiary cost-sharing liabilities, however, may not reflect what a beneficiary actually pays out of pocket to meet those requirements. For instance, beneficiaries with supplemental coverage (e.g., Medigap, employer-sponsored retiree health coverage) have all or a portion of their cost-sharing liabilities covered. A full accounting of how a change in the Medicare FFS plan design would affect beneficiary out-of-pocket costs (including premiums for supplemental coverage) therefore would need to incorporate not only the specific changes to the benefit design, but also whether and how changes in Medicare supplemental coverage are required and whether and how beneficiaries change their supplemental coverage purchases and health care utilization in response to the changes.

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1Even with a cost-sharing limit, beneficiaries would remain responsible for all costs associated with benefits that are not covered by Medicare.
Medicare costs. An annual out-of-pocket limit would reduce cost-sharing for those beneficiaries with the highest health care spending. In any year, however, even if the plan design changes are made to be budget neutral, the majority of beneficiaries who have lower health care spending would face higher cost-sharing amounts.\(^2\)

A recent report from the Medicare Payment Advisory Commission (MedPAC) provides insights on the effects of adding a catastrophic limit on cost sharing and combining the Part A and B deductibles, assuming other cost-sharing requirements remain unchanged (Table 1). Under current law, which does not include a cap on cost sharing, a combined deductible of $595 would have been required in 2011 to remain budget neutral compared with the separate plan deductibles. Under this approach, 6 percent of Medicare beneficiaries would have experienced a reduction in out-of-pocket spending of $50 or more and 28 percent would have experienced an increase in spending of $50 or more. About two-thirds of beneficiaries would have experienced no change or a change of $50 or less.

Implementing a cap on cost sharing would require higher combined deductibles to remain budget neutral. The lower the cost-sharing cap, the higher the combined deductible and the more likely it is that beneficiaries would experience an increase in out-of-pocket costs. For instance, a $3,000 cap on cost-sharing would have required a $1,635 combined deductible and 36 percent of beneficiaries would have faced increased out-of-pocket costs of $50 or more. Nevertheless, the increased catastrophic protection would result in large savings for many of those exceeding the cap.

With a combined deductible and a cap on cost sharing, beneficiaries who are more likely to face increased cost sharing include those with no hospitalizations and high Part B spending, but not enough to exceed the catastrophic cap, since the combined deductible exceeds the current Part B deductible. Beneficiaries who are more likely to face a reduction in cost sharing are those with hospitalizations and spending exceeding the cap.

Note that this analysis reflects the change in cost-sharing liability over a one-year period only. Over a longer time period, it is likely that beneficiaries would have some years during which they are hospitalized and would incur a lower cost-sharing liability under a combined deductible and cost-sharing cap, and some years during which they would have a lower cost-sharing liability under the current FFS

### Table 1. Level of Combined FFS Deductible Required to Hold Constant Medicare Program Spending in 2011

<table>
<thead>
<tr>
<th>Catastrophic limit on cost sharing</th>
<th>Combined deductible required to break even</th>
<th>How FFS beneficiaries’ out-of-pocket spending would differ from baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Nonspenders</td>
</tr>
<tr>
<td>None—current law</td>
<td>$595</td>
<td>5%</td>
</tr>
<tr>
<td>$7,000</td>
<td>960</td>
<td>5</td>
</tr>
<tr>
<td>$5,000</td>
<td>1,170</td>
<td>5</td>
</tr>
<tr>
<td>$4,000</td>
<td>1,328</td>
<td>5</td>
</tr>
<tr>
<td>$3,000</td>
<td>1,635</td>
<td>5</td>
</tr>
</tbody>
</table>

**Notes:** Out-of-pocket spending includes only cost-sharing amounts paid by the beneficiary. It excludes spending paid by supplemental coverage as well as premiums for Medicare and supplemental coverage. Changes in out-of-pocket spending incorporate changes in utilization due to the revised cost-sharing requirements, but not any changes in supplemental coverage. Categories may not sum to 100 percent due to rounding.

**Source:** Actuarial Research Corporation (as published by MedPAC in *Report to the Congress: Medicare and the Health care Delivery System*, June 2011, Chapter 3).

\(^2\)Setting the unified deductible below the “budget neutral” level would reduce the number of beneficiaries who would face higher cost-sharing requirements, but would increase the cost of the Medicare program unless offset by other spending reductions or revenue increases.
plan design. In other words, using a one-year basis to estimate the change in cost sharing understates the value to beneficiaries of adding a cost-sharing cap on a budget neutral basis.

When adding a cost-sharing limit along with a unified deductible, other cost-sharing requirements could remain unchanged. As an alternative, service-specific copayment and coinsurance requirements could be replaced with a uniform coinsurance rate for all services. Or, flat copayments, which are more typical among Medicare Advantage plans, could be used. Moving toward flat copayments in FFS Medicare could have the advantage of being more understandable and predictable to beneficiaries than coinsurance, in which cost sharing varies depending on the cost of the service. Depending on the copayment levels set, however, moving toward copayments rather than coinsurance could require higher unified deductibles to stay budget neutral. Although not the focus of this issue brief, the costs of adding a cost-sharing limit could be offset in ways other than increasing other cost-sharing requirements, such as through premium increases.³

An issue that would need to be addressed if Part A and B deductibles are combined is how to treat beneficiaries who sign up for Part A coverage but not Part B coverage (or vice versa). Applying the combined deductible would allow Part A-only beneficiaries to meet a lower deductible, but they would not be subject to potentially higher cost sharing under Part B. Moreover, allowing Part A-only beneficiaries to benefit from the addition of a cost-sharing limit could create equity concerns. An alternative would be to maintain the current higher Part A deductibles for beneficiaries choosing to enroll only in Part A and not allow them to benefit from the cost-sharing limit.

**Impact on Medicare Trust Funds and Part B Premiums**

A redesign of the Medicare FFS benefit package that is budget neutral still could have important implications for the funding of the Medicare program. This would occur, for instance, if a combined deductible and cost-sharing cap shifts costs between Parts A and B. In turn, this could affect not only the trust fund finances, but also Part B premiums.

For instance, a combined deductible that is less than the Part A deductible and greater than the Part B deductible could mean that Medicare spending (net of cost sharing) would shift from Part B to Part A. How costs shift between the two parts is complicated by the cost-sharing cap, which could change the distribution of net costs between Part A and Part B.

In addition, issues arise regarding the timing of claims during a year. If a beneficiary has physician care early in the year and inpatient care later in the year, the deductible first would apply to the physician care, with any remaining deductible applicable to the inpatient care. This would result in different net spending in the Part A and Part B programs than if inpatient care was received earlier in the year with the deductible first applying to that care. With hospital stays early in the year, which are usually accompanied by physician services, it may be difficult to determine how to split the deductible between Part A and Part B. Which services are received after the cost-sharing cap is reached, rather than before, similarly could affect the distribution between Part A and Part B spending. It may be appropriate for CMS to perform a retrospective adjustment at the end of the year to redistribute spending between Parts A and B to better reflect the true split between Part A and B spending, rather than the timing of claims.

If the implementation of a combined deductible and a cost-sharing cap results in a net shift in Medicare spending from Part B to Part A, then Part B premiums, which are set at a percentage of Part B costs, would be lower than they are under current law. If a plan design change were to shift costs from Part A to Part B, however, Part B premiums would be higher. The Part A trust fund exhaustion date also could be affected.

An increase in Part B premiums could result in a decrease in Part B enrollment. Part B is a voluntary program, and, although the vast majority of Medicare Part A enrollees also enroll in Part B, participation rates have been de-

³In addition, cost-sharing requirements could be increased without moving to a unified deductible.
clining somewhat over the years. The Medicare trustees project that participation rates will continue to fall due to the higher premiums that apply to higher-income beneficiaries as well as the younger aged who are still working and have coverage from an employer. Nevertheless, Part B participation rates are projected to exceed 90 percent throughout the current 75-year projection period.

If Part B participation rates decline more substantially, Part B premiums could increase even further, assuming that those enrolling would have higher health care needs than those who forgo coverage. At some point, it might be appropriate to consider additional measures to increase participation. Such measures could include increasing the penalty for those forgoing coverage, mandating Part B coverage, or allowing individuals to choose higher cost-sharing requirements in return for lower premiums. The latter approach, which also could allow individuals to choose lower cost-sharing requirements in return for higher premiums, in effect could combine FFS plan design changes with a premium support approach.

Aside from any potential shifts in costs between the Medicare Part A and Part B programs associated with changing the FFS cost-sharing requirements, it is also important to consider any interactions between Medicare and Medicaid. Although changing the Medicare cost-sharing requirements likely would have little or no direct effects on beneficiaries dually eligible for Medicare and Medicaid, there is a potential shift in costs between the two programs.

**Medicare Supplemental Insurance**

Because Medicare imposes significant cost-sharing requirements, most beneficiaries have some type of supplemental coverage to fill in the gaps. According to data compiled by MedPAC, 89 percent of FFS beneficiaries in 2007 had supplemental coverage: 43 percent had employer-sponsored coverage; 29 percent had individually purchased Medigap coverage; 16 percent had Medicaid, and 1 percent had other public coverage. Supplemental coverage can remove the financial incentives for beneficiaries to control their health spending, and some research suggests that filling in Medicare’s cost-sharing gaps results in higher Medicare spending than would have been incurred otherwise. As a result, there have been calls to limit the extent to which Medigap plans are allowed to cover Medicare’s cost-sharing requirements. For instance, the ACA directs the secretary of HHS to request the National Association of Insurance Commissioners to include nominal cost sharing for Medigap plans that provide first dollar coverage. Some proposals would place further limitations on Medigap plans. Others would levy an excise tax on Medigap plans or a Part B premium surcharge for beneficiaries with Medigap plans with low cost-sharing requirements. Such an excise tax or Part B premium surcharge would be a way for Medicare to recoup some of the costs of higher utilization among beneficiaries with Medigap plans and would encourage beneficiaries to choose plans that fill in less of Medicare’s cost-sharing requirements. If changes to the FFS plan design are implemented, insurance products that coordinate with Medicare may need to be modified so that they do not limit the desired impact of any FFS restructuring. For instance, Medigap plans could be prohibited from covering the higher deductibles. Or, the cost-sharing caps could be implemented on a true out-of-pocket basis, meaning that beneficiary cost sharing covered through supplemental coverage would not count toward the cost-sharing limit.

Reducing the richness of Medigap plans available to beneficiaries, either directly through legislative/regulatory changes or indirectly through levying a Medigap excise tax or Part B premium surcharge, could result in an increased understanding among beneficiaries of their benefit choices, lower insurance premiums (due to reduced plan generosity

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4See Table III.A3 of the 2011 Medicare Trustees Report.
5Percentages calculated from Figure 3-1 in MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2011.
6Although much research agrees that Medicare spending is higher among beneficiaries with supplemental coverage, there is less agreement regarding whether this difference is due to cost-sharing differences or other factors, such as the tendency of beneficiaries with higher health care needs to obtain supplemental coverage. For a review of the literature, see MedPAC *Report to the Congress: Aligning Incentives in Medicare* (Chapter 2, June 2010).
and increased administrative and marketing efficiencies), and a reduction of unnecessary utilization. Reducing the share of costs that Medigap plans can cover would shift costs at the point of service to beneficiaries, increasing the incentives to seek more cost-effective care and avoid unnecessary care. This has the potential to lower both Medicare and beneficiary costs, but the extent to which costs would decline is unclear. Changes in the rules governing Medigap plans should be structured carefully to avoid unintended consequences. Research suggests that broad increases in cost sharing, rather than targeted increases, reduce not only unnecessary care, but also necessary care, especially among the low income and chronically ill. Preventive care could be exempted from any new cost-sharing requirements, and additional protection for low-income and/or chronically ill beneficiaries who are not eligible for Medicaid should be considered.

Other issues that should be addressed when considering changes to Medigap plan requirements include:

- Policymakers would need to decide whether required changes in Medigap plans would apply to new coverage purchases only or to all existing policies as well. Medigap benefits are contractually guaranteed and cannot be cancelled for reasons other than premium non-payment. Besides the potential legal issues that may arise due to a violation of the contractual agreement, customer and insurer issues arise from changes to existing policies. A consumer’s premiums collected to date might have reflected prefunding for future services. Accordingly, insurers have accounted for this prefunding in the form of reserves. If changes are made to policies already in force, a clear transition plan to maintain fairness to insureds and reserve adequacy for insurers would need to be developed.

- Many Medicare beneficiaries may be enrolling in Medigap plans to make their cost sharing more predictable and to avoid the inconveniences and complexities associated with paying providers directly. Any changes to Medigap plans, and to Medicare cost-sharing requirements more broadly, should incorporate ways to minimize beneficiary inconvenience or confusion as well as additional administrative burdens on providers for payment collections.

- Medigap plans are only one source of private supplemental coverage. Even more beneficiaries are covered by employer-sponsored supplemental policies. While employer-sponsored plans typically do not provide first dollar coverage, it still may be appropriate to consider the role of employer-sponsored plans in supplementing Medicare and whether changes are needed. Note that employer-sponsored supplemental plans often include drug coverage and take the place of Part D as well as supplementing Parts A and B.

- The addition of a cost-sharing limit for the traditional FFS program in itself could reduce the demand for supplemental coverage. Reducing the ability of supplemental plans to provide first dollar coverage further could reduce enrollment in these plans. Lower enrollment in supplementary coverage would mean that more beneficiaries would face the financial incentives inherent in the FFS benefit design, without those incentives being limited by supplemental coverage that fills in cost-sharing requirements.

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7 The RAND Health Insurance Experiment found that although the reduction in services resulting from higher cost sharing did not lead to poorer health outcomes for the average person, low-income individuals in poor health were more likely to suffer poorer health outcomes. See Joseph P. Newhouse and the Health Insurance Experiment Group Free for all? Lessons from the RAND Health Insurance Experiment. Cambridge, Mass: Harvard University Press (1993). More recently, Amitabh Chandra et al found evidence that the savings associated with raising cost sharing for physician visits and prescription drugs is offset modestly by increased hospital utilization. The offsets are more substantial, however, for the chronically ill. See “Patient Cost-Sharing and Hospitalization Offsets in the Elderly,” American Economic Review 100(1): 193-213 (2010).

8 In the same manner, it may be appropriate to consider the role of Medicare when it is the secondary payer to other coverage, such as employer coverage for active workers aged 65 and older. In these instances, Medicare coverage in effect supplements other coverage. There are limits, however, as to how much Medicare will pay, and therefore, the extent to which Medicare fills in cost-sharing requirements. For instance, if the primary plan already pays more for a service than Medicare does, then Medicare would pay nothing more.
Value-Based Insurance Design

Redesigning the FFS benefit structure could be a step in the direction of better aligning beneficiary incentives to seek cost-effective care. As discussed earlier, broad changes in cost sharing, however, will not necessarily target reductions in unnecessary or ineffective care. In the longer-term, moving to a value-based insurance design (VBID) could structure beneficiary financial incentives more effectively. A VBID approach would lower the cost sharing for high-value services and increase the cost sharing for low-value services. The ACA moved Medicare in this direction by covering certain preventive services with no cost sharing.

Adjusting cost sharing to align incentives with effective use of services has shown promise in reducing spending in the non-Medicare market—most often for prescription drugs. Comparative effectiveness research can provide more guidance to help distinguish low-value and high-value services. Although lowering cost sharing for high-value services could gain widespread acceptance, it likely would be more difficult to implement higher cost-sharing requirements for treatments deemed of lower value. One potential way to increase cost sharing for lower-value services is to use reference pricing. Under reference pricing, Medicare would pay the costs of the lowest-price option when multiple treatment options achieve similar results. Beneficiaries choosing a higher-cost option would pay the difference.

Conclusion

The current Medicare FFS benefit design has several drawbacks. It lacks a cap on cost sharing, making supplemental coverage a necessity if beneficiaries are to be protected against the costs associated with catastrophic illnesses. Since most beneficiaries have supplemental policies to cover their FFS cost-sharing requirements, their incentives to seek cost-effective care are reduced. In addition, the Medicare FFS cost-sharing requirements are skewed toward less discretionary services. Restructuring the FFS benefit design by unifying the Part A and B deductibles and adding a cost-sharing limit would provide protection against catastrophic health costs and has the potential to encourage beneficiaries to seek cost-effective care.

Restructuring the FFS benefit design could be done in a budget neutral manner, or it could be done in a way that reduces Medicare spending overall. For Medicare to achieve savings beyond the amounts shifted to beneficiaries, the plan design changes would need to encourage beneficiaries to take a more active role in their health care, seek care when necessary, and learn more about the cost and expected outcomes of their care. Restructuring, however, will affect only the few beneficiaries who do not have supplemental coverage, unless insurance products that coordinate with Medicare are modified so that they do not limit the desired effects of any FFS restructuring. In addition, provider incentives need to be consistent with beneficiary incentives and more information regarding costs, quality, and treatment effectiveness is needed.

Redesigning the FFS plan design is more of a short-term solution, with transitioning to a VBID a longer-term approach. Even under a VBID approach, however, a more comprehensive restructuring of not just the benefit design but also the payment and delivery systems is needed to move Medicare toward a more integrated, coordinated, and cost-effective system.