Session 38, Actuarial Implications of a Medicare Buy-in Option

Actuarial implications of a Medicare buy-in option

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Agenda

Overview of current healthcare system

Landscape of reform proposals

Case study: Medicare Advantage buy-in option

Key takeaways

Questions

United States healthcare system overview

Overview of United States healthcare programs

Public (government)	• Medicare • Medicaid • Military • Correctional populations • Indian health service (IHS)
Private (commercial)	• Employer group • Individual • Short term limited duration • Association health plans
Public and private	• Medicare Advantage and Part D • Managed Medicaid • Private correctional • Individual market ACA subsidies • Employer group health premiums exempt from taxation
Uninsureds	• Insurance is unaffordable • Insurance is not accessible • Insurance is not perceived to be needed

Healthcare system features

Universal coverage

A system of allocating health care resources in a way that ensures everyone is covered for basic health care services and no one is denied care as long as he or she remains a legal resident in the territory covered.

Single payer

Healthcare system in which the government pays private physicians and hospitals directly.

Socialized medicine

Healthcare system where the government pays and manages physicians and hospitals directly, as employees of the government.

Healthcare system features

Public subsidization

Healthcare program that includes some funding from the government (e.g., through private insurance or direct to consumer).

Comprehensive coverage

Healthcare that covers all medically necessary services.

Uniform pricing

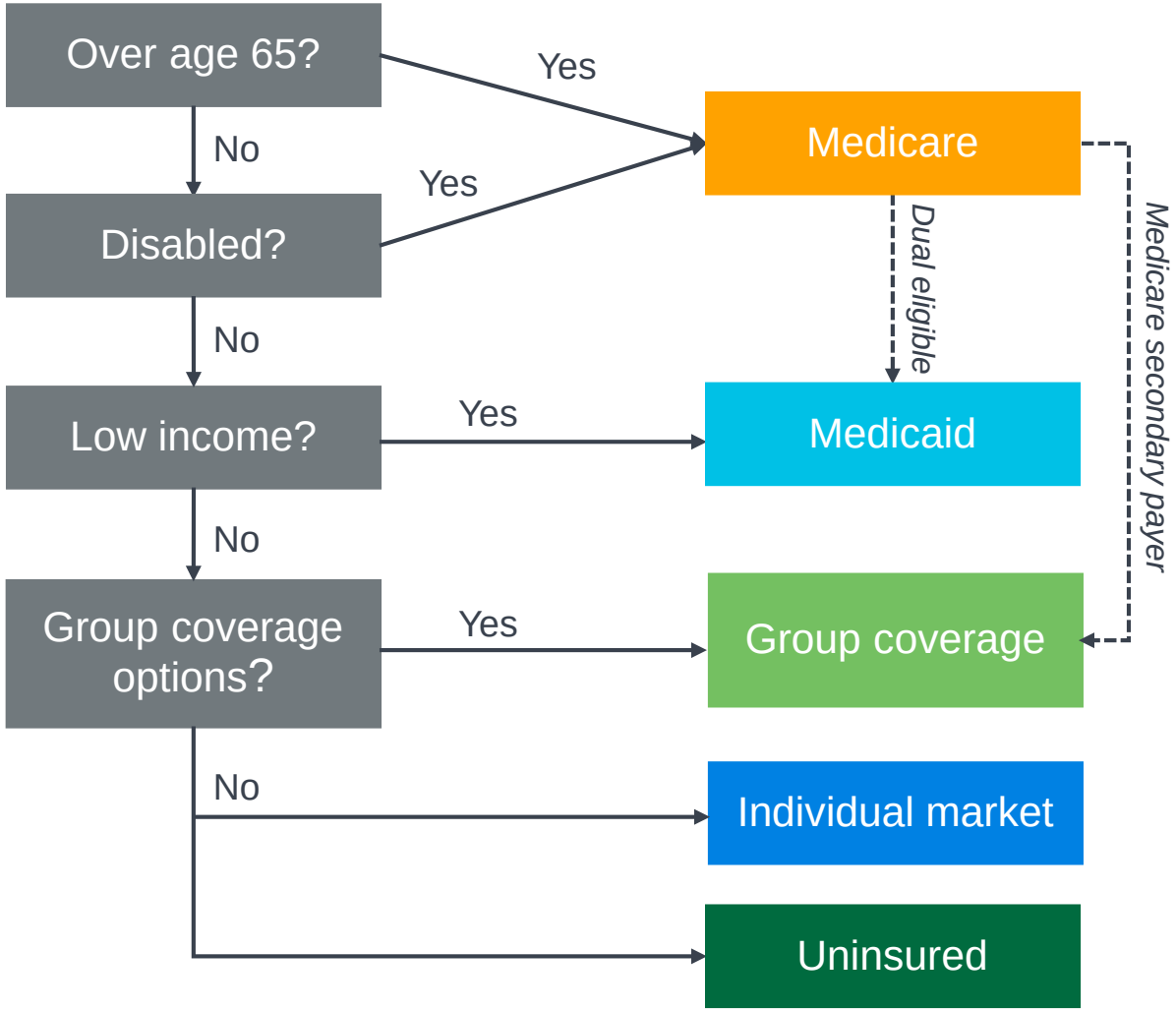
The price paid to physicians and hospitals for a service does not vary by healthcare payer or members within a program

Features of US healthcare programs

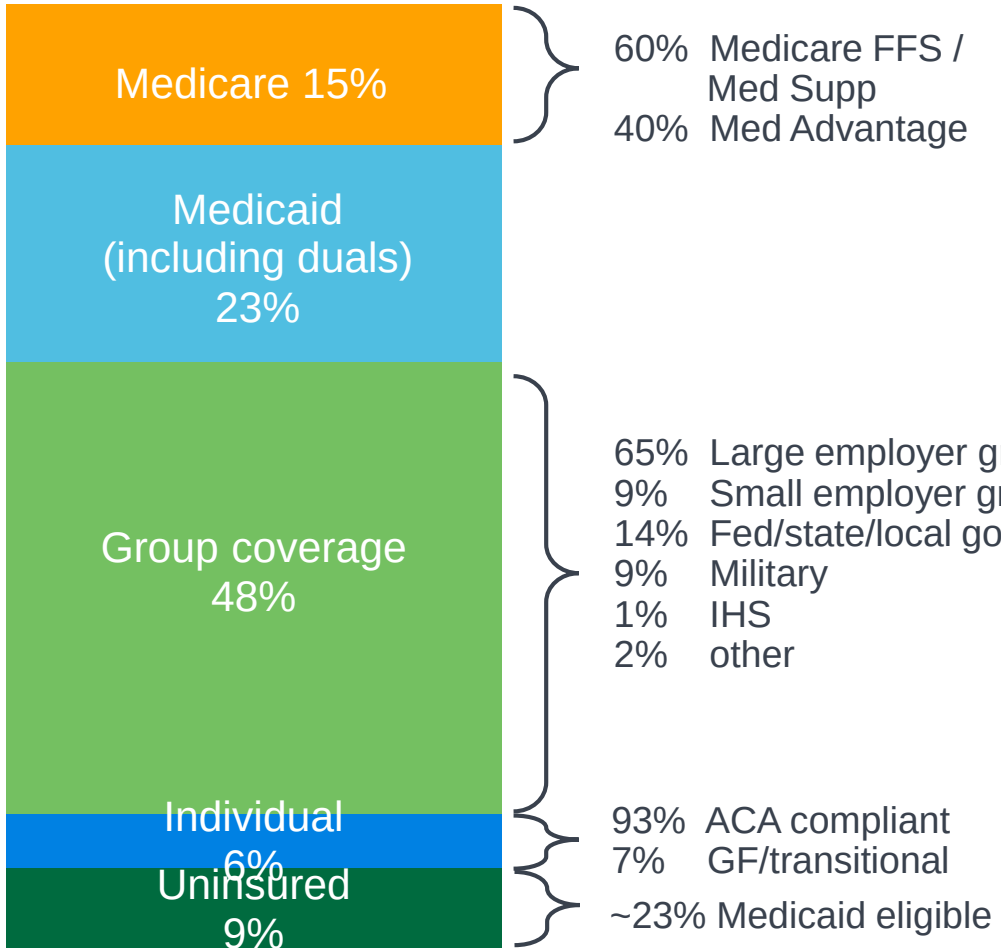
Program	Universal coverage	Single payer	Socialized medicine	Public subsidization	Comprehensive coverage	Uniform pricing
Traditional Medicare		X			X	X
Medicare Advantage and Part D				X	X	
Medicaid Fee-for-Service		X[1]			X	X
Managed Medicaid				X	X	
Military[2] / IHS			X		X	X
Employer group				X[3]	X	
Individual				X	X	
Short term limited duration						
Association Health Plans						

1. Funded jointly by the federal and state governments, so not strictly single payer.
2. The VA and Military Health System (MHS) are government run healthcare systems for retired and active duty military personnel and their dependents. TRICARE (under the Defense Health Agency) combines resources of military hospitals and clinics with civilian health care networks. The Patient-Centered Community Care (PC3) contract allows VA beneficiaries to access and receive payment for care outside of the VA system.
3. Employers' spending on health insurance premiums is exempt from taxation for both employers and employees.

Overview of United States healthcare system



2017 Population[1]



1. Estimates by Charles Gaba | ACASignups.net

Landscape of healthcare reform proposals

US healthcare reform proposals

Public plan option	• Public healthcare plan to compete with private healthcare plans
Medicare buy-in for older adults	• Option for individuals over age 50 to buy-in to the Medicare program
Medicaid buy-in	• Option for individuals to buy-in to state Medicaid programs
Public program with opt out	• Federal healthcare program for all US residents, maintaining employer-sponsored coverage as an option
Single payer "Medicare-for-all"	• Single federal program covering all US residents

Features of US healthcare reform proposals

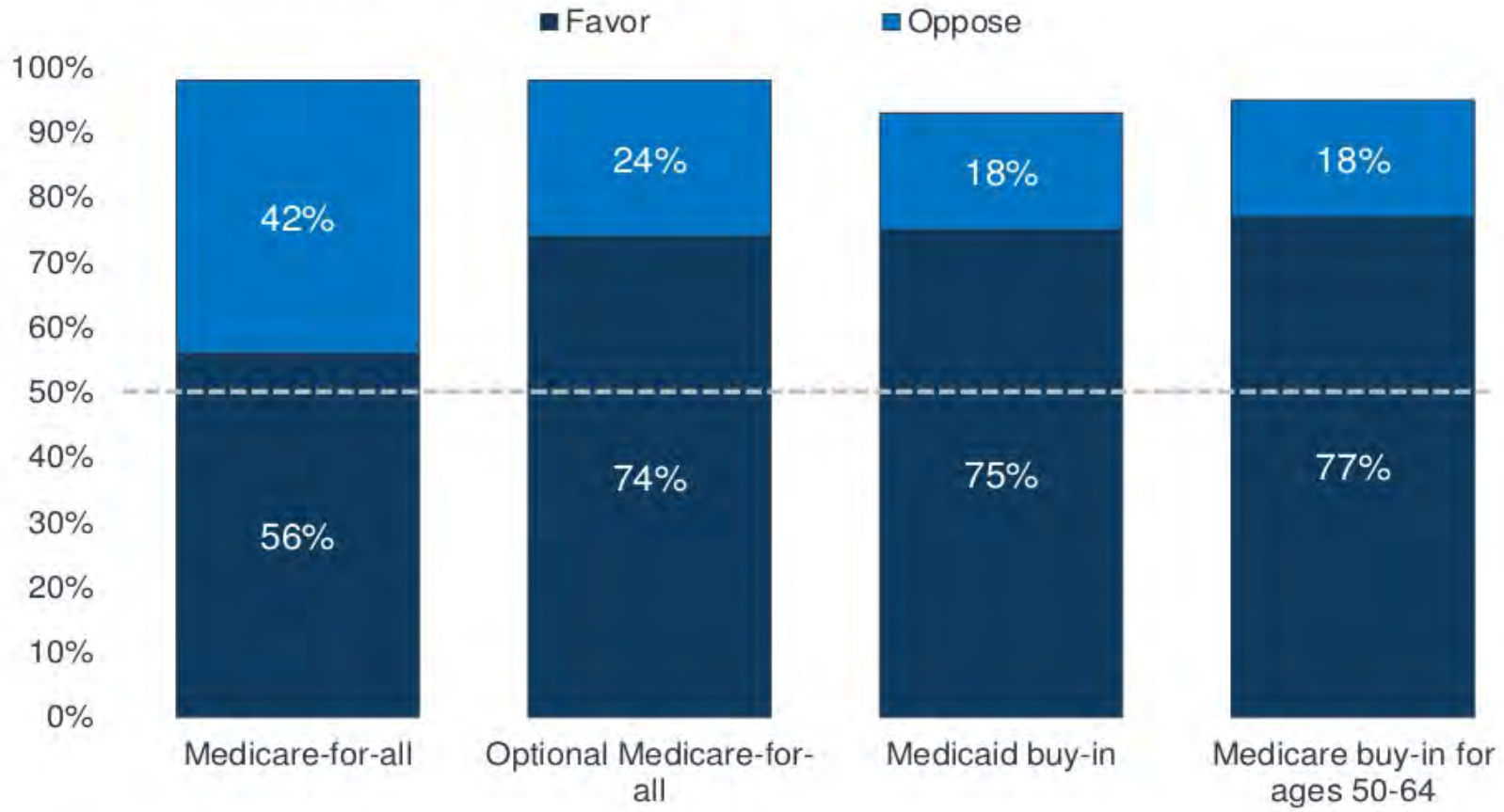
Program	Universal coverage	Single payer	Comprehensive coverage	Socialized medicine	Public subsidies	Uniform pricing
Public option			X		X	X
Medicare buy-in		X*	X		X	X
Medicare Advantage buy-in			X		X	
Medicaid buy-in		X*	X		X	X
Public program w/opt out	X	X*	X			
Medicare for all	X	X	X			X

*Funded through member premium

Figure 3

Broad Support For Proposals To Expand Public Health Insurance Programs

Percent who favor or oppose:



SOURCE: KFF Health Tracking Poll (January 9-14, 2019). See topline for full question wording and response options.

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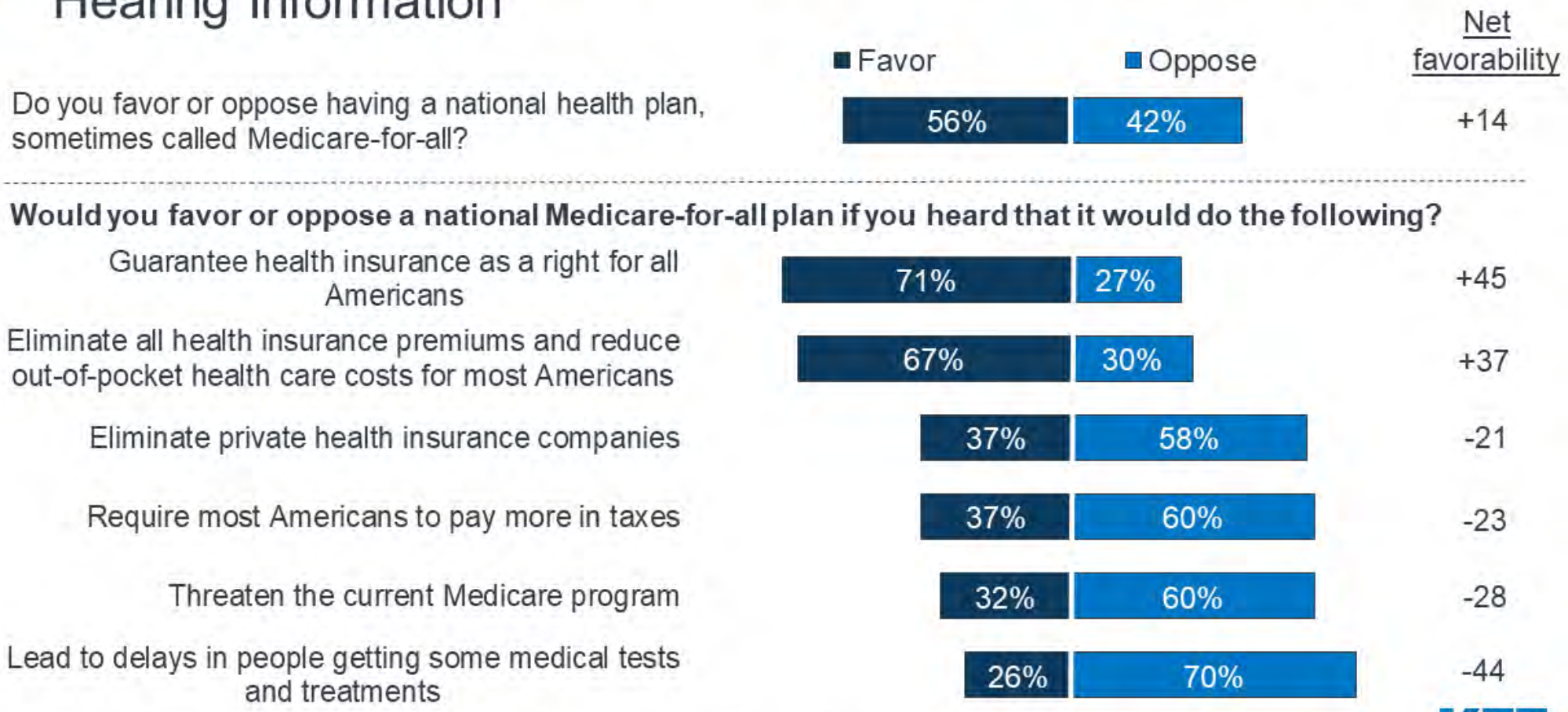
Figure 6

Public's Views Of Medicare-For-All Can Shift Significantly After Hearing Information



SOURCE: KFF Health Tracking Poll (conducted January 9-14, 2019). See topline for full question wording and response options.

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Medicare buy-in for older adults

Program description	• Option for individuals age 50 to 64 to buy-in to Medicare • Option to buy private Medicare Advantage, Part D, or Med Supp plans
Financing	• Funded through new Medicare buy-in trust fund • Financed through premiums
Member premium and cost sharing	• Generally community rated (one bill varies premiums by geography) • Individuals selecting Medicare Advantage would pay any applicable additional premium • ACA premium and cost sharing subsidies generally apply • No OOP limits unless choosing Medicare Advantage, Med Supp, or if eligible for CSRs.
Provider payments	• Provider payment rates set to Medicare fee-schedule • Secretary of Health and Human Services negotiates drug prices for Medicare and buy-in plan
Role of private insurance	• Current sources of private coverage continue

Actuarial implications of a Medicare Advantage buy-in option for older adults

Actuarial considerations

Eligibility requirements

Benefits and cost sharing

Pricing considerations

Financing considerations

Risk mitigation programs for private markets

Subsidies

Interactions with existing markets

Selection considerations

Provider reimbursement

Participation requirements

Case study:

How many members would be eligible for a buy-in option?

How might premium for a Medicare Advantage (MA) buy-in option compare to existing ACA coverage options?

How would existing ACA options change in the presence of an MA buy-in option?

Important note:

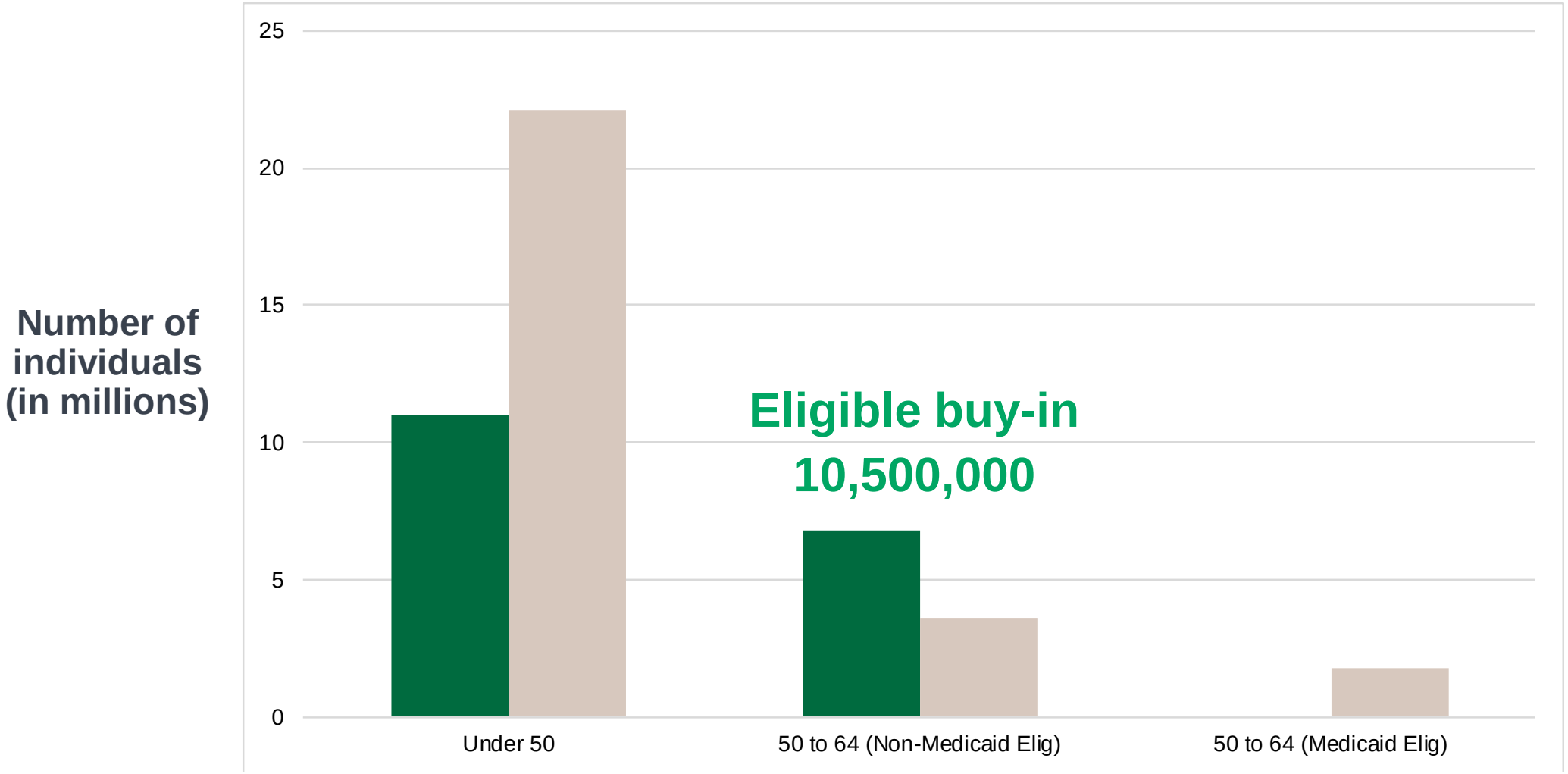
Healthcare system changes may take time (many years) to reach equilibrium. The case study in this presentation assumes rational pricing in a steady state market.

Case study assumptions

Medicare Advantage buy-in option for older individuals

Eligibility	50-64 Not eligible for employer sponsored coverage Not eligible for Medicaid or otherwise eligible for Medicare (e.g., due to disability)

Estimated potential buy-in eligibility (2017 population)



Source: estimated from Charles Gaba | ACASignups.net, US Census data, and Public Use Files (PUF)

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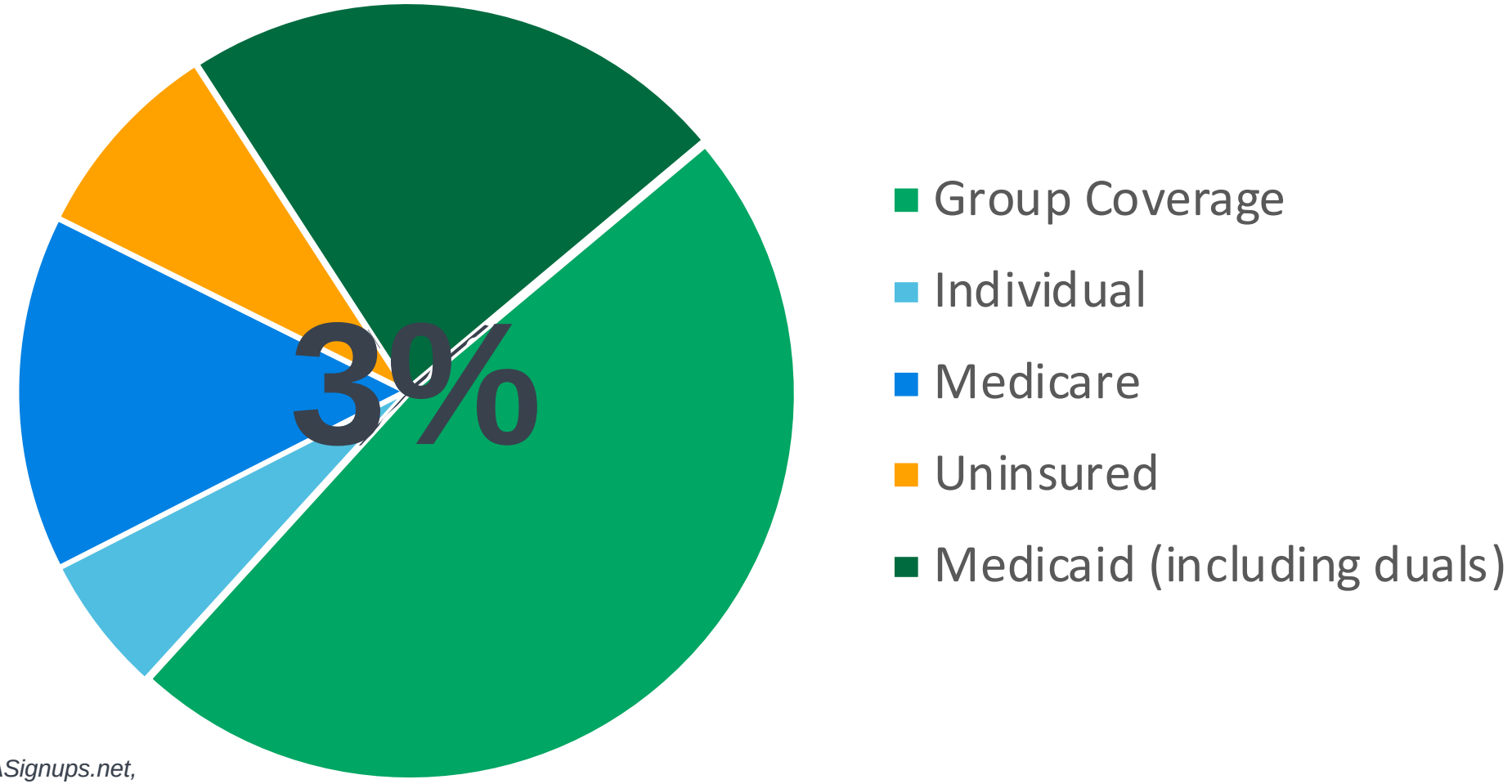
Estimated potential buy-in eligibility (2017 population)



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Case study assumptions

Medicare Advantage buy-in option for older individuals

Eligibility	50-64 Not eligible for employer sponsored coverage Not eligible for Medicaid or otherwise eligible for Medicare (e.g., due to disability)
Risk pools	Buy-in population separately rated from existing MA-PD population Costs funded through member premium and subsidies

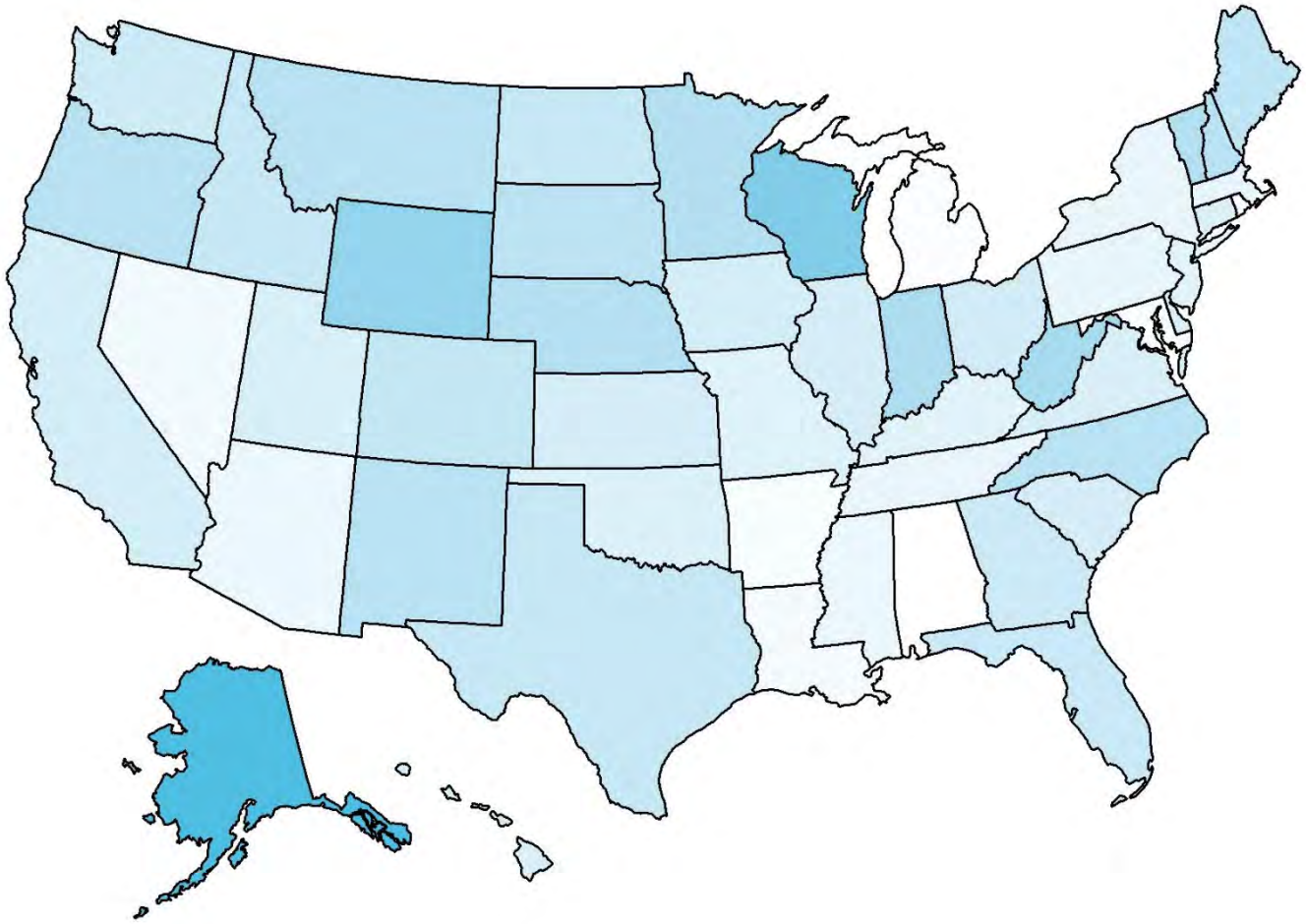
Case study assumptions

Medicare Advantage buy-in option for older individuals

Eligibility	50-64 Not eligible for employer sponsored coverage Not eligible for Medicaid or otherwise eligible for Medicare (e.g., due to disability)
Risk pools	Buy-in population separately rated from existing MA-PD population Costs funded through member premium and subsidies
Fee schedule	Providers accept set rates at 100% of the Medicare fee schedule

Estimated Commercial group provider reimbursement rates as a percent of the Medicare fee schedule (2018)

All services, excluding Rx



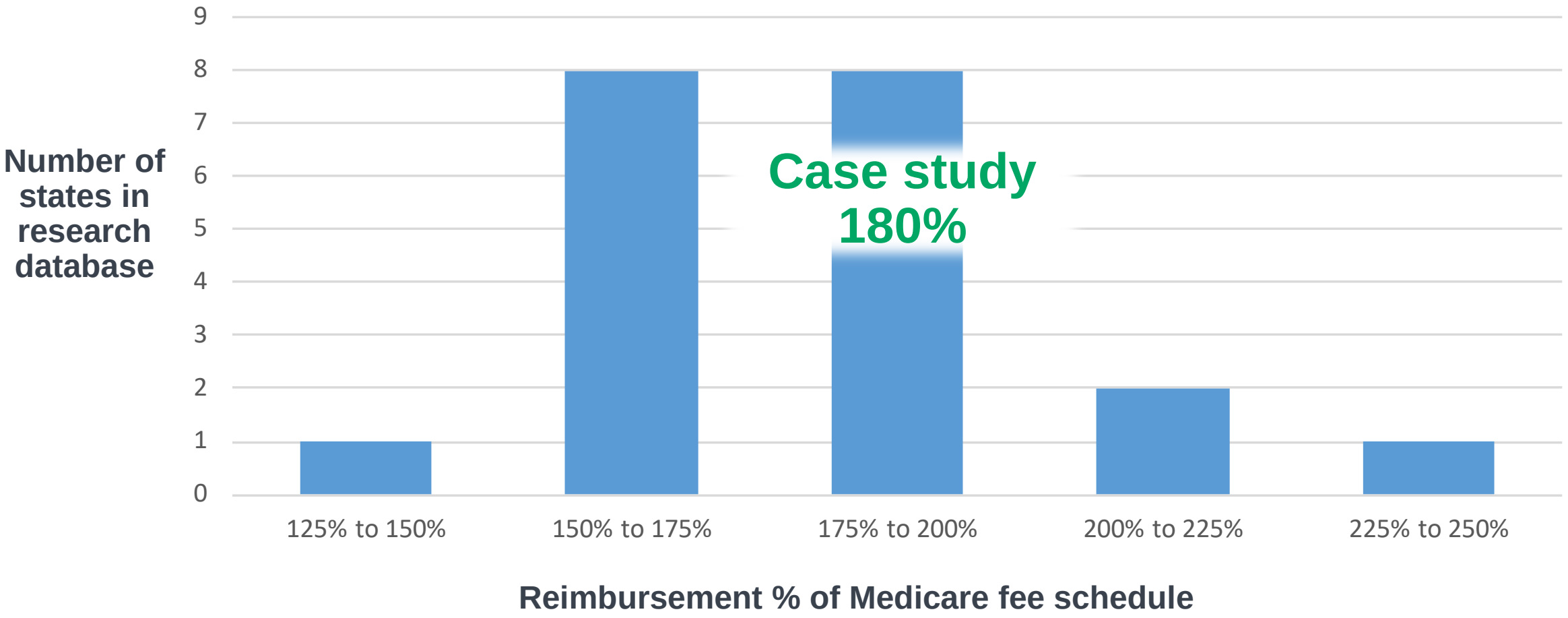
Min: 155%

Median: 195%

Max: 290%

Estimated ACA individual market provider reimbursement rates as a percent of the Medicare fee schedule (2017)

All services, excluding Rx



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Risk pools	Buy-in population separately rated from existing MA-PD population Costs funded through member premium and subsidies
Fee schedule	Providers accept set rates based on the Medicare fee schedule
Benefits and network	Benefits largely similar to a zero-premium Medicare Advantage plan available in the market (actuarial value around 85%)

Case study assumptions

Assumed benefits will be largely similar to a zero-premium Medicare Advantage plan available in the market (actuarial value around 85%)

Benefit requirement	Medicare Advantage	ACA individual market
Covered services	▪ Must cover all Medicare-covered services ▪ Most MA-PD plans include supplemental benefits	▪ Must cover essential health benefits and any state mandated benefits
Member cost sharing	▪ At least as rich as Original Medicare ▪ No annual maximums allowed ▪ Zero-dollar preventive	▪ Metal level AV ranges ▪ No annual maximums allowed ▪ Zero-dollar preventive
Out of pocket limits[1]	▪ Separate for medical and Rx ▪ $6,700 for medical ▪ ~$5,100 (+5% thereafter) for Rx	▪ Combined for all services ▪ $7,900 individual / $15,800 families ▪ CSR plans have lower OOP limits

1. 2019 limits.

Case study assumptions

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Rating factors	Buy-in premiums are community rated within a service area (e.g., state)

Case study assumptions

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Retention	ACA admin and margin levels similar to levels filed in 2019 Buy-in admin to levels reported in 2018 MA-PD bids

Case study assumptions

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Risk adjustment	A risk adjustment program is in place that results in premiums that reflect the health status of the average buy-in member

Case study assumptions

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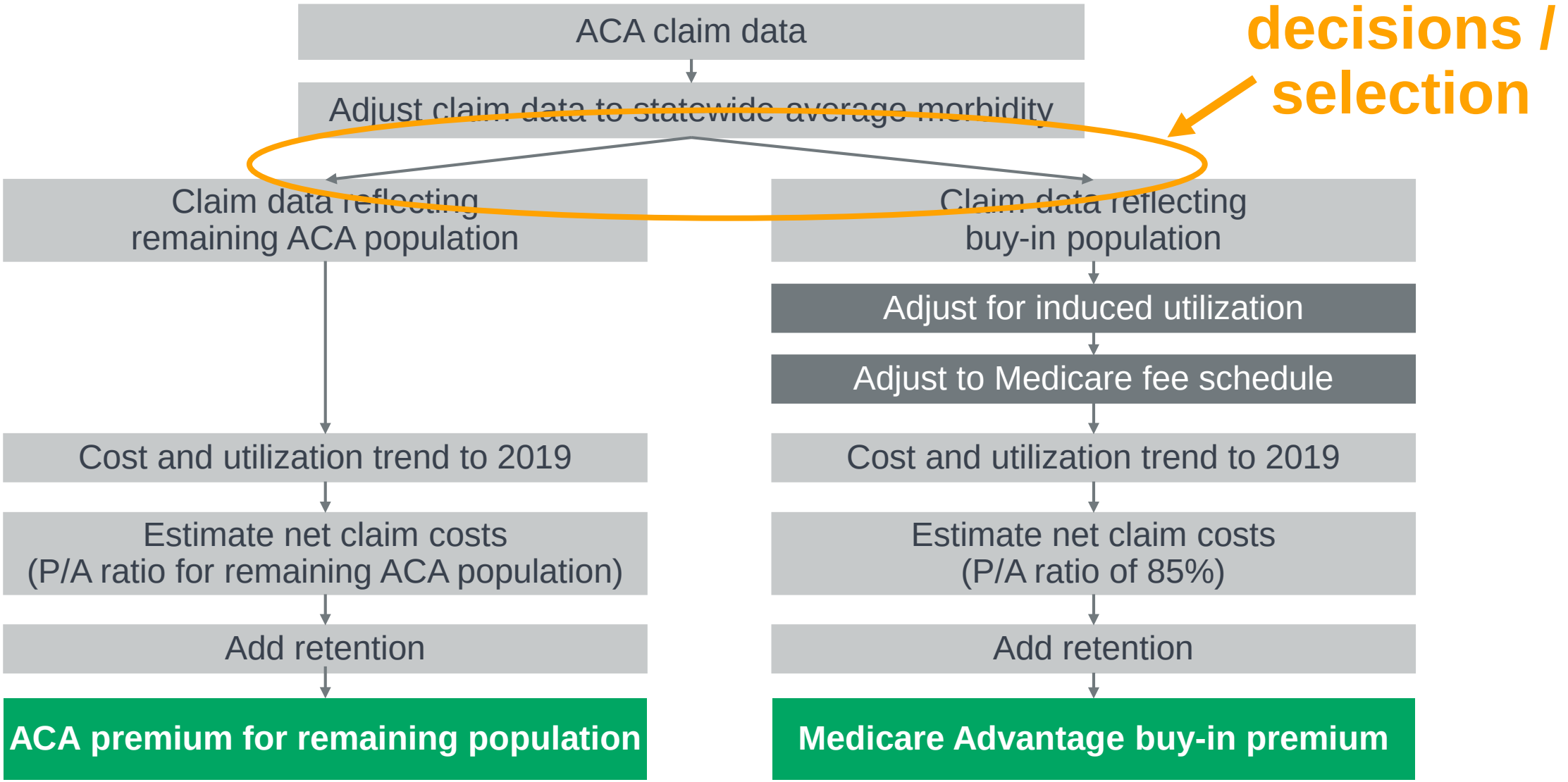
Rating factors	Buy-in premiums are community rated within a service area (e.g., state)
Retention	ACA admin and margin levels similar to levels filed in 2019 Buy-in admin similar to actual 2017 levels reported in 2019 MA-PD bids
Risk adjustment	A risk adjustment program is in place that results in premiums that reflect the health status of the average buy-in member
Subsidies	Individuals can use advanced premium tax credits (APTCs) from the ACA market for buy-in Cost sharing subsidies (CSRs) not applicable at Medicare Advantage benefit levels

Premium development



Selection considerations

Individuals try to select healthcare coverage options that are in their best interest

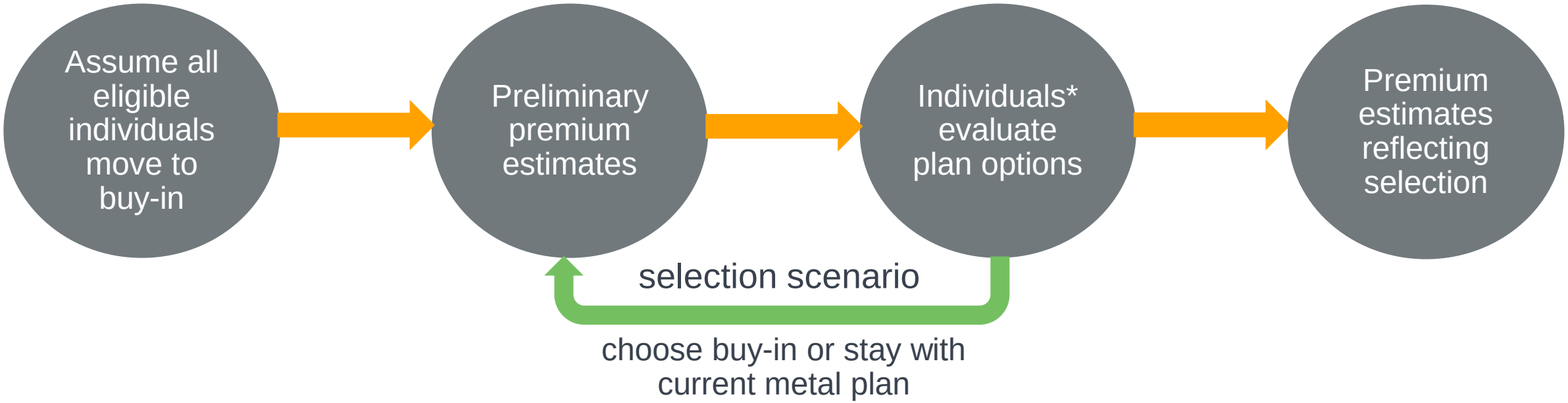
Price
Individuals generally seek the highest value for the lowest price

Benefit design
Individuals with perceived healthcare needs tend to seek a plan design with broad coverage (or coverage of particular services or drugs) and lower cost sharing

Choice in healthcare providers
Individuals value choice in healthcare providers, so a broader network is generally more valuable than a more restricted network, particularly for individuals with perceived healthcare needs

Familiarity or preference in insurance carrier / customer service
Individuals may be reluctant to switch plans if they are familiar with their existing plan unless the perceived value of switching is more significant

Premium development process with selection



*Individuals modeled in cohorts based on age, rating area, and metal level (including silver CSR variants)
Decisions based on a comparison of cost sharing (calc'd from risk adjusted claims) and premium under the ACA and buy-in options

Premium development scenarios

All eligible members choose buy-in

- Assumes all eligible individuals enrolled in ACA-compliant plans move to the buy-in plan

High selection

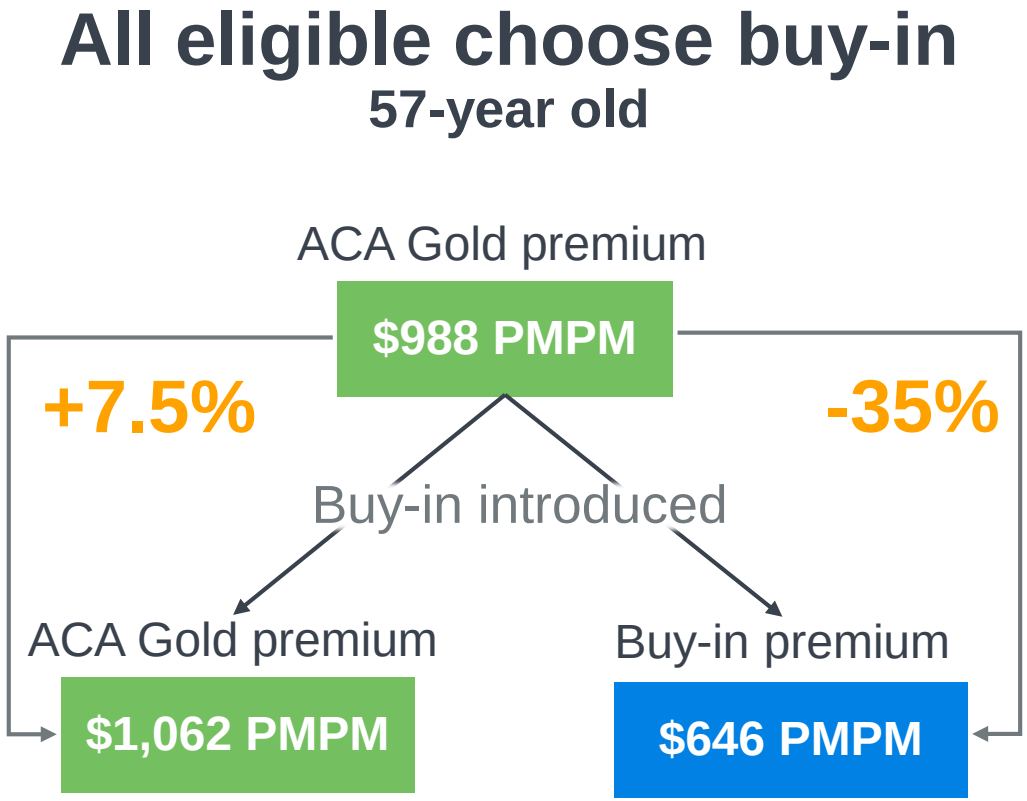
- Individuals choose plan (current ACA plan or buy-in) expected to have the lowest out-of-pocket cost (cost sharing + premium)

Practical selection

- Individuals consider plans based on expected cost, but don't always choose the lowest option
- The likelihood of choosing the lowest option increases as the differential increases

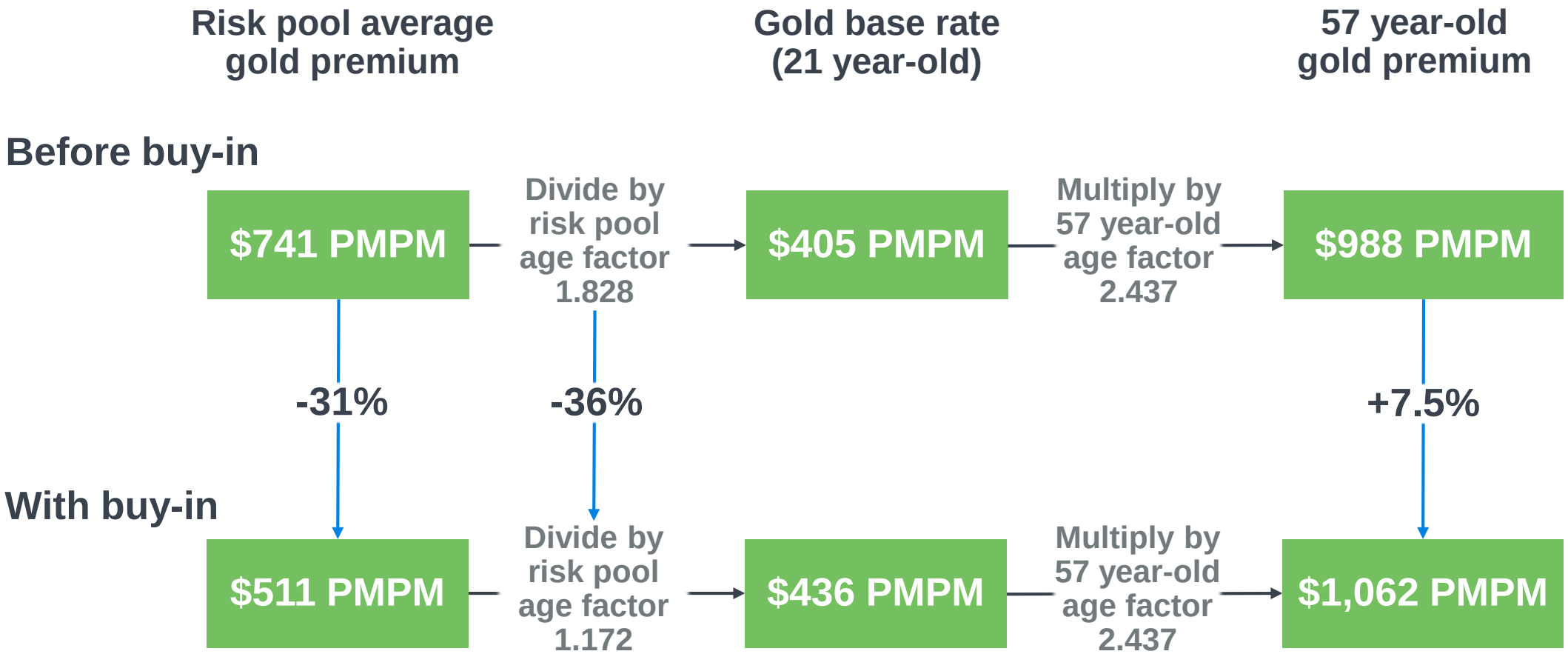
Population – all eligible members choose buy-in

Premium options before and after buy-in introduced (before subsidies)



Wait, what?

Why ACA rates could increase with buy-in option



Scenario comparison

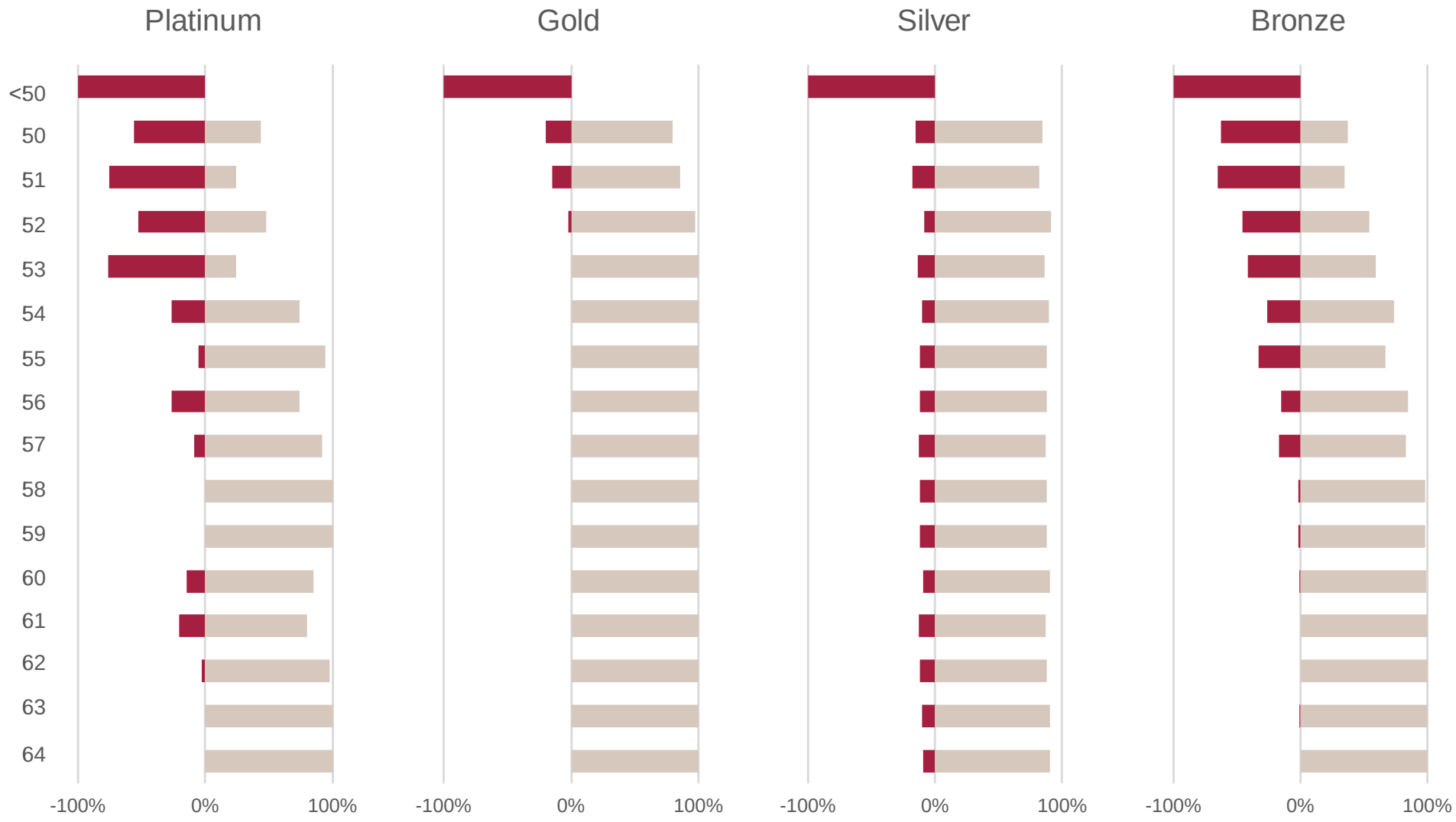
57 year-old | Average rating area

Scenario	ACA Gold premium PMPM	MA buy-in premium PMPM	Difference PMPM	Average ACA age
ACA option before buy-in	$988	N/A	N/A	51
All eligible choose buy-in	$1,062	$646	$416	32

Premium development scenarios

All eligible members choose buy-in	High selection	Practical selection
▪ Assumes all eligible individuals move to the buy-in plan	▪ Individuals choose plan (current ACA plan or buy-in) expected to have the lowest out-of-pocket cost (cost sharing + premium)	▪ Individuals consider plans based on expected cost, but don't always choose the lowest option ▪ The likelihood of choosing the lowest option increases as the differential increases

Population – high selection



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High selection	$1,084	$638	$446	40

Premium development scenarios

All eligible members choose buy-in	High selection	Practical selection
▪ Assumes all eligible individuals move to the buy-in plan	▪ Individuals choose plan (current ACA plan or buy-in) expected to have the lowest out-of-pocket cost (cost sharing + premium)	▪ Individuals consider plans based on expected cost, but don't always choose the lowest option ▪ The likelihood of choosing the lowest option increases as the differential increases

Population – practical selection

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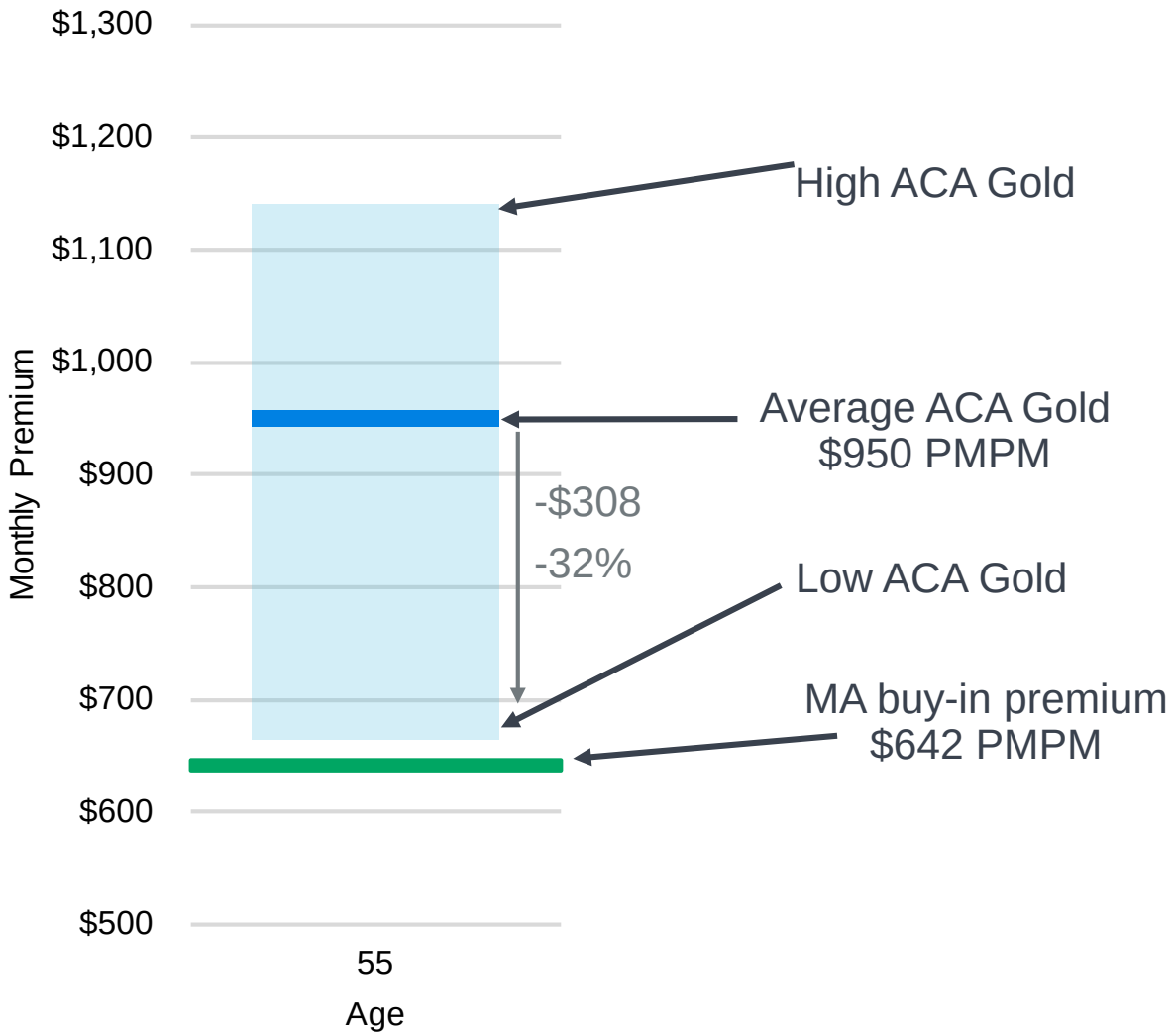
All eligible choose buy-in	$1,062	$646	$416	32
High selection	$1,084	$638	$446	40
Practical selection	$1,039	$642	$397	45

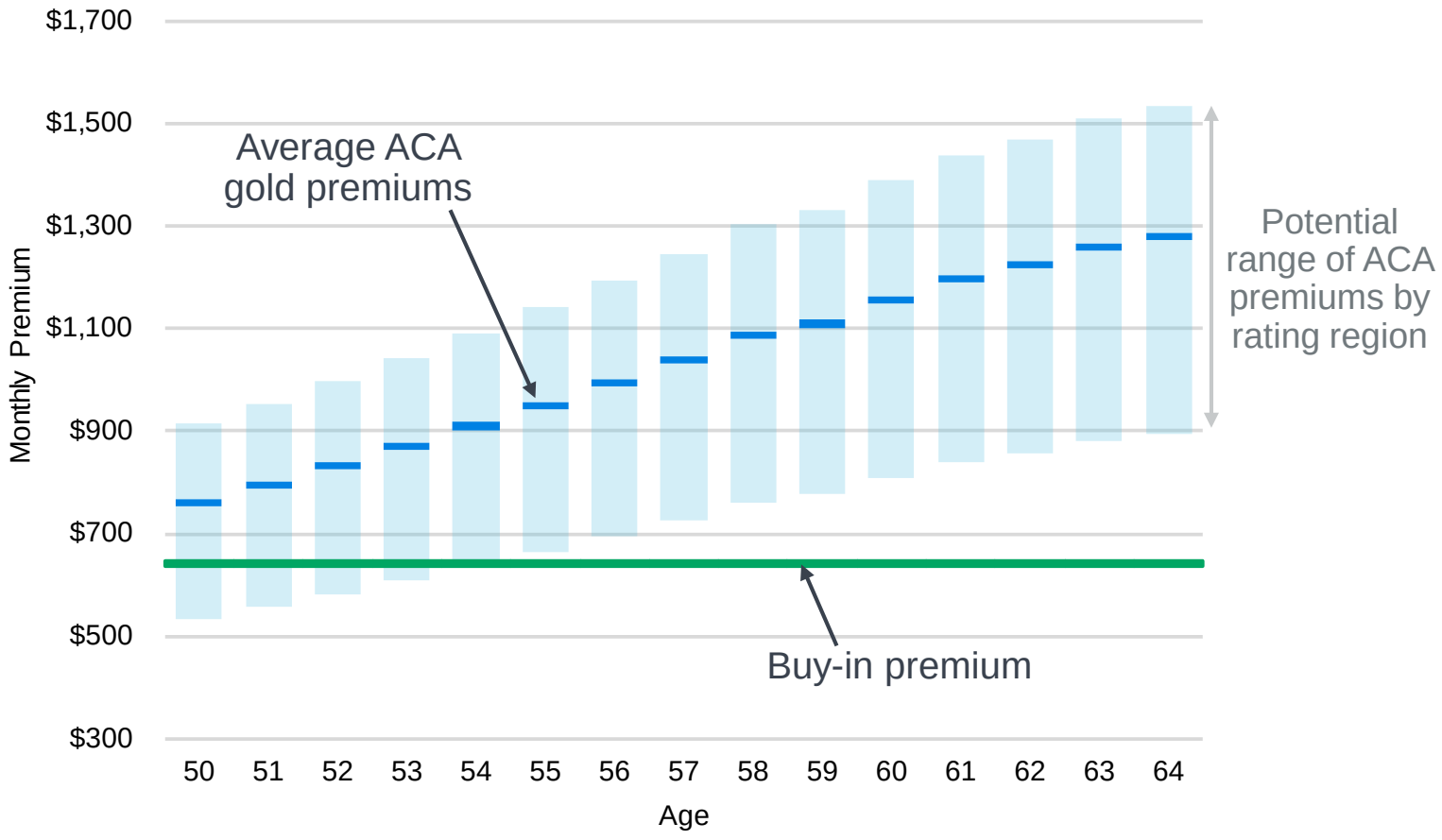
Premium results – practical selection

Gold premium comparison



Premium results – practical selection

Buy-in compared to ACA Gold



Key drivers of premium differentials

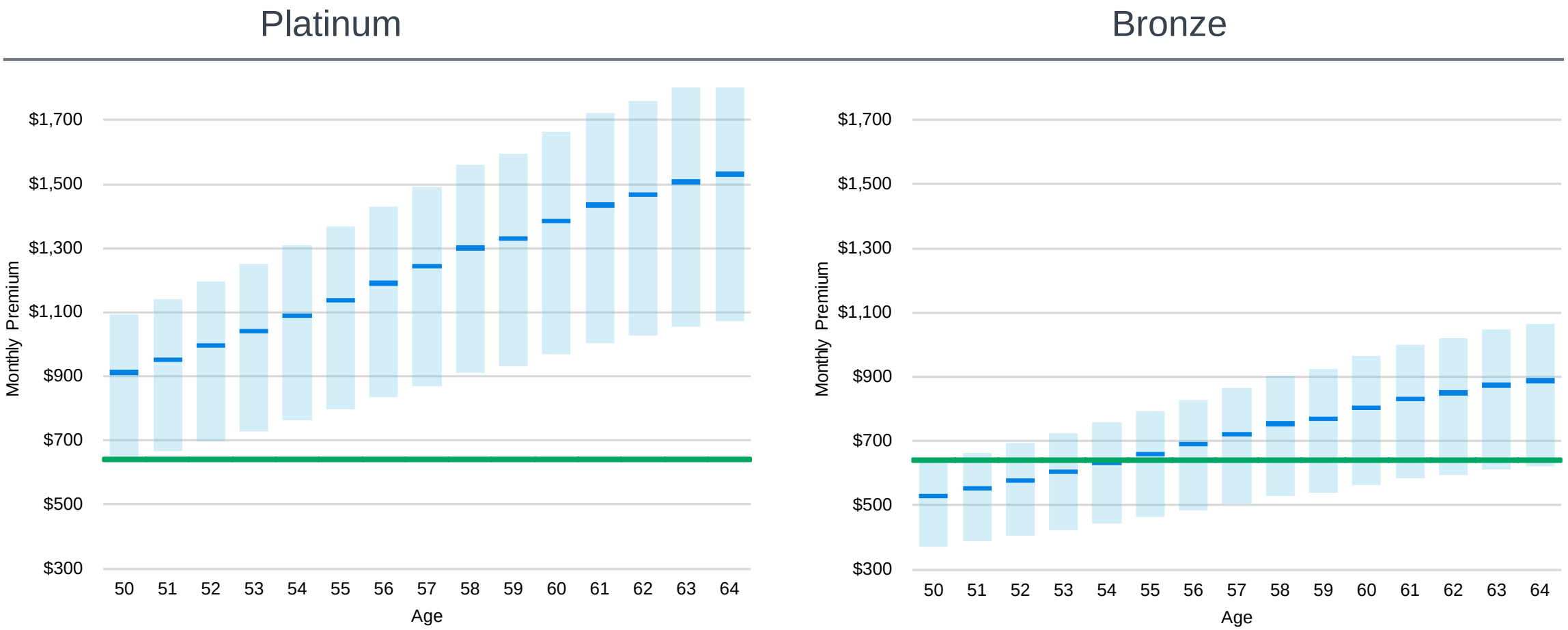
1. Provider reimbursement rates
   - ACA at 180% of Medicare
   - Buy-in at 100% of Medicare

   - 44%
2. Age rating factors
   - ACA at allowable rating factors
   - Buy-in community rated
3. Area rating factors
   - ACA at allowable area rating factors
   - Buy-in community rated
4. CSR loading on ACA plans
   - Some states load silver only
   - Some states load all plans

Note: ACA premiums reflect hypothetical gold plan premiums developed using the same data source used to develop the MA buy-in premiums to ensure a consistent comparison. Hypothetical ACA premium estimates were within 10% of actual statewide ACA gold premiums available in the marketplace for the region studied.

Premium results – practical selection

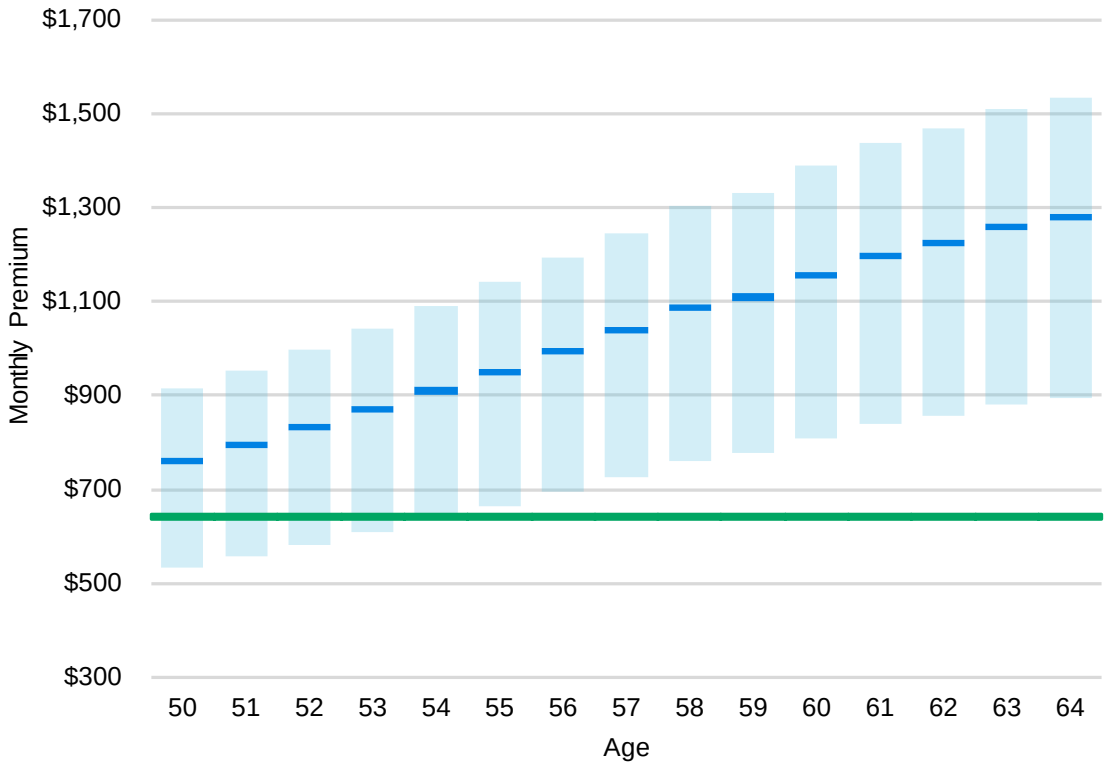
Buy-in compared to other metal levels



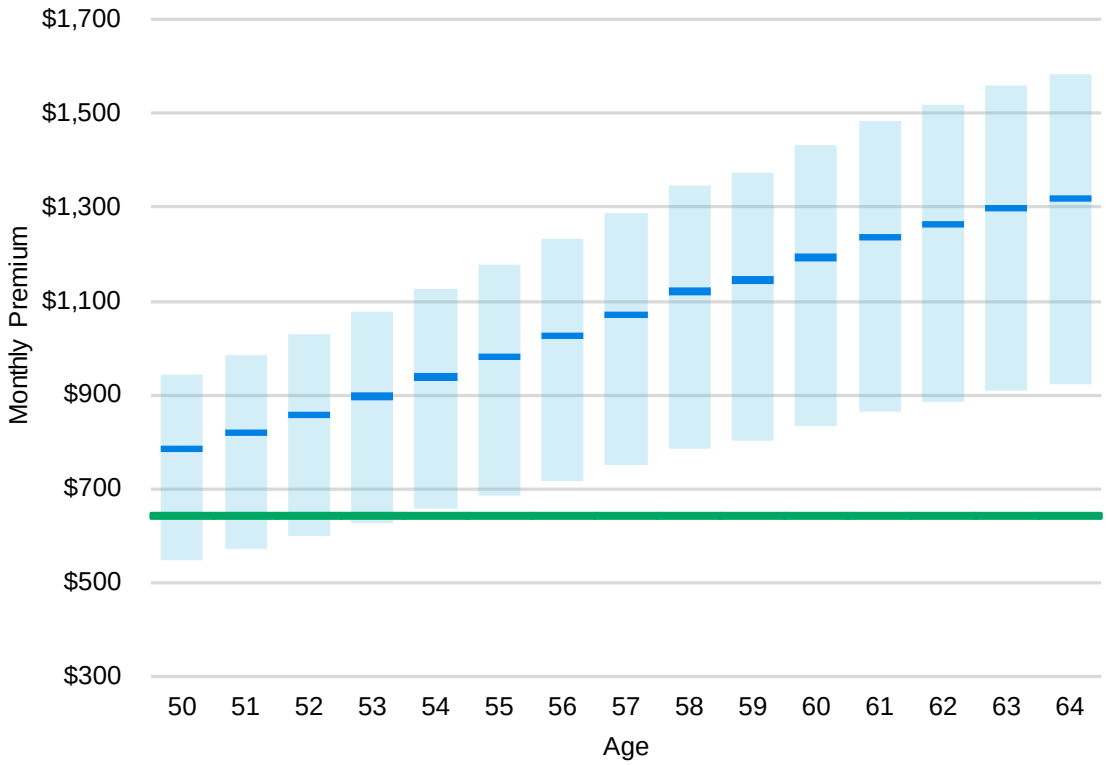
Premium results – practical selection

Buy-in compared to other metal levels

Gold



Silver*



*includes the estimated silver load for CSR shortfalls

What about subsidies?

- Advanced premium tax credits (APTCs) are based on:
  1. Second lowest ACA silver plan premiums available in the marketplace, which vary by region and age
  2. Income level
- ACA premium subsidies could cover some or all of the buy-in premium, with large variation by region, demographic, and income level.

Subsidy interactions with the buy-in

- For two individuals living in the same region with the same income, the subsidy for the older individual will be higher (because they have a higher age rating factor)
- The older individual will have the same buy-in premium as the younger individual (community rating)
- Therefore, the older individual will have a lower buy-in premium than the younger individual after subsidies.
  - Subsidized by younger buy-in members through community rated buy-in premiums
  - Higher premium subsidies because of ACA age rating

Subsidy interactions with the buy-in

- For two individuals who are the same age and have the same income, but live in different regions, the subsidy will be higher for the person living in the region that has a higher second lowest silver premium. Regional variations in premium are often significant in the ACA market.
- The buy-in premium before subsidies will be the same for these individuals.
- The person living in the higher cost area will have a lower buy-in premium after subsidies than the person living in the lower cost area.
  - Subsidized by lower cost regions through community rated buy-in premiums
  - Higher premium subsidies because of area rating factors
- It is likely that private Medicare Advantage plans will establish multiple service areas within a larger region to address some of these opportunities for selection.

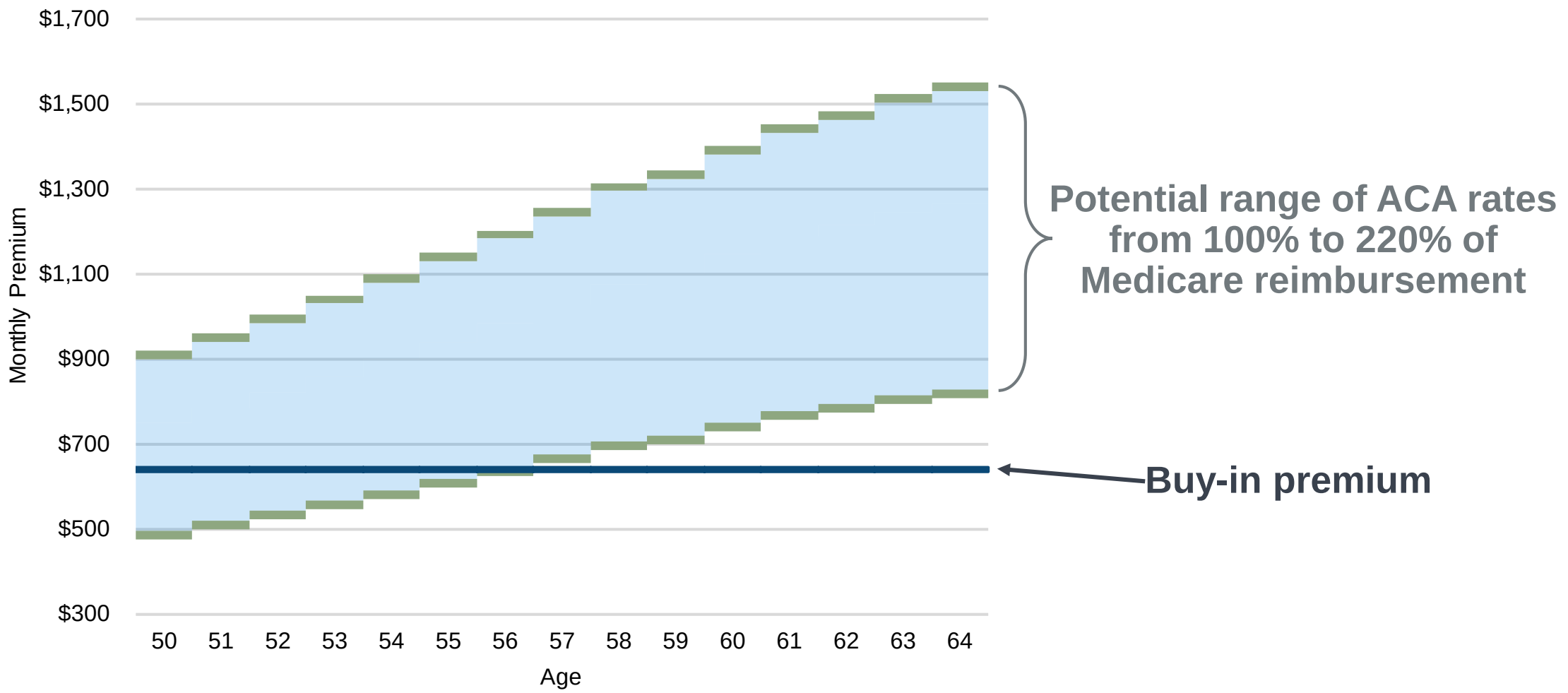
Key takeaways

Key takeaways

- Provider reimbursement rates are the primary driver of differentials between ACA and buy-in premium rates.

The differential between ACA and buy-in premiums would diminish significantly to the extent that existing ACA provider reimbursement levels are already close to Medicare allowed fees.

Potential variation in provider reimbursement rates



Key takeaways

- Provider reimbursement rates are the primary driver of differentials between ACA and buy-in premium rates.
- Buy-in premiums could be much lower than ACA marketplace options for many individuals, and for others they could be higher. Other than ACA provider reimbursement levels, age and rating region are among the key drivers of differentials between ACA and buy-in premiums.

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- Premiums in the ACA market would change if a buy-in is introduced. The change will depend on the number of buy-in members and their cost in relation to the younger population and the ACA age rating curve. Premiums in the ACA market could increase.

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- If subsidies are transferable to the buy-in program, they could cover a significant portion of premium, potentially all premium in some cases.

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- If subsidies are transferable to the buy-in program, they could cover a significant portion of premium, potentially all premium in some cases.
- Subsidies could result in older individuals or individuals in higher cost regions paying less than younger individuals or individuals in lower cost regions under the buy-in plan.

Key potential challenges

- **Reductions in provider reimbursement rates** under a buy-in would translate to reductions in revenue for providers absent other changes (such as changes in commercial fee schedules, practice patterns, shared savings arrangements, etc.).
- **A buy-in option has the potential to further fragment the ACA markets** and introduce selection opportunities that may be challenging or impossible to predict or control. Adding to this issue is the fact that the individual market is small and relatively unstable already.
- **A buy-in program creates a new layer of complexity** in an already complex healthcare system.

Final thoughts

- It is critical for stakeholders and policymakers to understand the actuarial implications of policy changes.
- The healthcare system is complex, with many interactions between markets and stakeholders. Preconceptions may not match reality.
- Actuaries are positioned to play a key role in evaluating and managing the risks associated with future healthcare system changes.

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Thank you

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