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Medicare Policy

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Transforming Medicare into a Premium Support System: Implications for Beneficiary Premiums

EXECUTIVE SUMMARY

Over the past several decades, the idea of transforming Medicare from its current structure to one known as "premium support" has been raised intermittently as an approach for reforming the Medicare program, often in the context of efforts to reduce the federal debt and deficit.[i] The primary goals of a premium support system are to reduce the growth in Medicare spending, and rely more on a competitive marketplace. While the parameters of various premium support proposals differ, the general idea is for the federal government to make a predetermined contribution on behalf of each person on Medicare that would be applied toward the premium for a health insurance plan. This approach contrasts with the current Medicare program under which Medicare beneficiaries are entitled to a defined set of benefits, with the federal government contributing to the cost of these services, provided by either the traditional fee-for-service (FFS) program or Medicare Advantage plans.

Under one of the leading approaches to premium support, beneficiaries would have the option to select from a variety of health plans offered in their area for their health coverage, with the government making a payment to that plan on their behalf. If they enroll in one of the low-cost plans offered in their area, they could pay the same premium as they would under the current system, or even less. If, instead, they enroll in a higher-cost plan offered in their area – either a private plan or traditional Medicare – they would pay a higher premium.

This paper aims to help inform policy discussions by examining the potential implications of a leading premium support approach on Medicare premiums, the extent to which Medicare premiums would vary by state and by county, and the key factors that could drive variations in premiums under this approach. The analysis looks at an approach to premium support that ties federal payments to the second lowest cost plan offered in an area or traditional Medicare, whichever is lower. This approach is similar to the premium support proposal included in Chairman Paul Ryan's (R-WI) budget proposal for FY2013 that was embraced by Presidential nominee Mitt Romney, and previously included in the Wyden-Ryan and Domenici-Rivlin proposals.[ii] The study focuses on beneficiaries' Medicare premiums, but does not take into consideration out-of-pocket spending due to the effects of changes in benefits, cost-sharing requirements and premiums for supplemental insurance. Nor does it assess potential savings to the federal government, which would be achieved to the extent that the government pays less for beneficiaries in traditional Medicare in counties in which private plan costs are lower, and less for beneficiaries in private plans in areas where traditional Medicare costs are lower.

Today, Medicare beneficiaries can choose coverage under traditional Medicare or a private Medicare Advantage plan, such as a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO). Under the current system, Medicare provides capitated payments to plans on behalf of each enrollee. For beneficiaries in the traditional Medicare program, Medicare payments are not capped, but are instead tied to the medical services used by beneficiaries. Nationwide, beneficiaries generally pay the same premium for Medicare-covered

[i] In this report, we use the term 'premium support' to describe this general policy approach. Other terms used to describe this approach include defined contributions and vouchers.

[ii] See "Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future" proposed by Senator Ron Wyden (D-OR) and Representative Paul Ryan (R-WI), December 15, 2011 and "The Domenici-Rivlin Protect Medicare Act" proposed by Former Senator Pete Domenici and Dr. Alice Rivlin, initially released November 1, 2011 and updated June 15, 2012.

benefits, without regard to their choice of a private plan or traditional Medicare, or where they live. Virtually all beneficiaries enrolled in private Medicare plans pay the same premium as those in traditional Medicare for basic Medicare services. By capping federal payments per beneficiary in both private plans and traditional Medicare, and by allowing Medicare premiums to vary across plans in a given area, a premium support system would create a more competitive marketplace for plans and beneficiaries, giving beneficiaries stronger financial incentives to choose low-cost plans to reduce their out-of-pocket costs.

This study layers a premium support proposal onto the current system to understand the potential effects for beneficiaries if premium support had been fully implemented in 2010. The analysis, therefore, builds on beneficiaries' 2010 plan choices (private Medicare Advantage plans or traditional Medicare), traditional Medicare expenditures by county, and the costs of providing Medicare benefits under private plans (known as 'bids'), using actual data from 2010, the most recent year available. The analysis considers the implications of a premium support system on beneficiary premiums, based on beneficiaries' plan choices in 2010, either a private plan or traditional Medicare. It then goes on to illustrate the extent to which the expected effects for beneficiaries would vary based on alternative assumptions about individual plan choices, plan bidding behavior, and costs under traditional Medicare.

This study should not, however, be interpreted as an analysis of any particular proposal, including the Romney-Ryan proposal, because such an analysis would require additional, more detailed policy specifications than are currently available, and would also require assumptions about future shifts in demographics, spending, and enrollment, nationally and by local markets, which would occur regardless of policy changes. Additionally, this analysis assumes full implementation of a premium support system in 2010, whereas other proposals would gradually phase-in a premium support system over time, and apply the premium support system to new enrollees rather than all beneficiaries (e.g., current seniors). For example, the Romney-Ryan proposal would introduce a premium support system for new Medicare beneficiaries beginning in 2023, exempting people who are ages 55 and older today. This analysis, therefore, should be viewed as a device for illustrating the potential effects of a fully-implemented premium support system for Medicare beneficiaries, based on an approach to premium support put forward by several policymakers.

Overview of Analytic Approach and Assumptions

Since the 1970s, Medicare beneficiaries have had the option to receive their Medicare benefits through private health plans, as an alternative to traditional Medicare. Through the Medicare Advantage program, Medicare pays private plans a capitated amount per enrollee to provide all Medicare Part A and B benefits. Medicare requires plans to submit a bid that reflects the costs of providing services covered by Medicare Parts A and B per enrollee per month, although actual payments to Medicare Advantage plans are not directly tied to these bids. In contrast to the capitated payment system for beneficiaries enrolled in private plans, Medicare payments for beneficiaries in traditional Medicare are not capitated; instead, payments are generally tied to services used by beneficiaries. In 2010, approximately 25 percent of beneficiaries (11 million) were enrolled in private plans, ranging from less than 10 percent of beneficiaries in some counties to more than half of beneficiaries in others. Generally, beneficiaries in Medicare Advantage plans paid the Part B premium and no additional premium for Part A and Part B services in 2010; however, some beneficiaries in Medicare Advantage plans paid an additional premium for Part D benefits and extra benefits, with premiums varying across counties.

The analysis assesses the implications for beneficiaries of a premium support system that would cap federal payments per beneficiary using an entirely different methodology, and by extending the capitated approach to

beneficiaries in traditional Medicare. Under this approach, the federal government would provide a payment for each beneficiary in an area that is equal to the second least cost plan or the traditional Medicare plan, whichever is lower (the "benchmark"). Beneficiaries would have the option to choose among plans offered in their area, and would pay higher Medicare premiums if they enroll in a plan that bid above the benchmark.

To the extent possible, the analysis relies on policy parameters described in leading premium support proposals. When policy parameters were not available, but were important for understanding the likely effects of the proposed reform, policy assumptions were made and documented, including, for example: the service area for private plans and traditional Medicare (county level), the benefit package (Part A and Part B benefits) and the treatment of Medicare payments for indirect medical education, graduate medical education, and disproportionate share hospitals (excluded from costs of traditional Medicare).

In addition to the aforementioned policy assumptions, we examine potential changes in the behavior of insurance firms (plan bidding practices) and beneficiaries (plan switching) to assess the sensitivity of results to a range of assumptions. We test the sensitivity of the results to this assumption, and illustrate the effects of alternative scenarios with insurers bidding more or less aggressively. Our base case reflects current plan choices made by beneficiaries, primarily because there is insufficient evidence and consensus in the literature to generate confidence in any specific assumption about switching behavior.[iii] We do, however, illustrate the extent to which results would vary if we assume different shares of beneficiaries switch from a higher premium plan to a benchmark plan, based on elasticities in the literature and evidence from current programs.

Data sources. This analysis uses Medicare Advantage plan bids, for Medicare Part A and Part B services, that were submitted to the Centers for Medicare and Medicaid Services (CMS) for the 2010 plan year, as proxies for private plans' bids under a premium support system, and uses average per capita traditional Medicare spending for each county as a proxy for traditional Medicare costs under a premium support system. Traditional Medicare and Medicare Advantage enrollment data were drawn from CMS's state-county-contract file for March 2010. Since we rely on actual data from 2010 for the analysis, the results are driven by key characteristics of the Medicare program in 2010, including per capita spending for beneficiaries in traditional Medicare, bids submitted by Medicare Advantage plans, and enrollment in traditional Medicare or Medicare Advantage plans.

[iii] A second and more technical reason for not modeling individual switching is that our model does not permit analysis of plan choices by individual characteristics, and the evidence suggests that age, health status, location and income, among other factors, are associated with switching behavior.

Key Findings

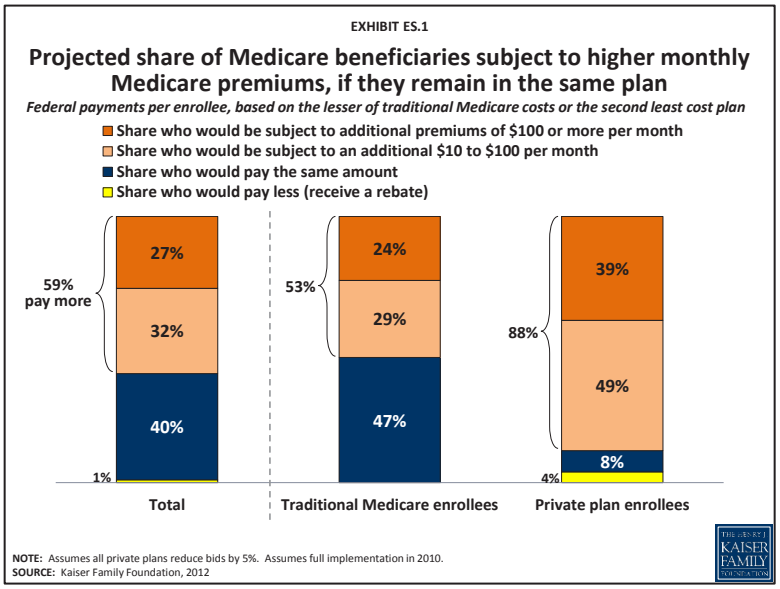
If a premium support system had been fully implemented in 2010 for all beneficiaries, with federal payments equal to the lesser of the second least expensive plan or traditional Medicare costs in a county, and plans responded to new incentives by lowering their bids by 5 percent across-the-board, then the majority of beneficiaries would face higher Medicare premiums, unless they switched to a "benchmark" plan.[iv] This analysis assumes that Medicare payments per beneficiary would be capped and beneficiaries would be making more cost-sensitive plan choices, selecting among plans with different premiums.

- The majority (59%) of Medicare beneficiaries – 25 million if fully implemented in 2010 – would be expected to pay higher Medicare premiums than they do under the current program, if they remained in the same plan (**Exhibit ES.1**). This is because a majority of beneficiaries would be in plans (or traditional Medicare) that cost more than the benchmark plan in their area. Four in ten (41%) beneficiaries would pay the same amount or less under a premium support system. Again, this analysis layers a premium support system onto the current system, which assumes current plan preferences among Medicare beneficiaries. If as many as 25 percent of beneficiaries enroll in the benchmark plan, then the share of beneficiaries subject to higher premiums would drop from 59 percent to 35 percent.

EXHIBIT ES.1

Projected share of Medicare beneficiaries subject to higher monthly Medicare premiums, if they remain in the same plan

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan



NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

- Among beneficiaries in the traditional Medicare program, about half (53%) – 18.5 million beneficiaries – would be expected to pay higher Medicare premiums for coverage under the traditional Medicare program, because about half of beneficiaries in the traditional Medicare program live in counties where traditional Medicare costs were higher than the benchmark. On average, beneficiaries in traditional Medicare would pay $60 per month ($720 per year) in additional Medicare premiums. Slightly less than half (47%) of beneficiaries in traditional Medicare would pay the same amount under a premium support system.

- Among beneficiaries enrolled in private plans, 88 percent would pay higher premiums, unless they switched to a benchmark plan. This is because the vast majority of private plan enrollees (92%) are enrolled in a plan in which the plan's bid is higher than the benchmark plan in their area. On average, private plan enrollees would pay $87 per month ($1,044 per year) in additional Medicare premiums.

[iv] Beneficiaries subject to a nominal premium increase (less than $10) were designated as having no change in Medicare premiums. If included with all other beneficiaries subject to a premium increase, the average increase would be $104 instead of $109, among beneficiaries subject to an increase in Medicare premiums.

- More than one in four beneficiaries (27%) – about 11 million beneficiaries – would be expected to pay an additional $100 or more per month ($1,200 per year) in Medicare premiums if they did not switch to a lower cost plan.[v]
    - About one in four (24%) beneficiaries in the traditional Medicare program – roughly 8 million beneficiaries – would pay an additional $100 or more in monthly Medicare premiums, unless they switched to a lower cost private plan.
    - Nearly four in ten (39%) beneficiaries enrolled in private plans – nearly 3 million private plan enrollees – would see Medicare premiums increase by at least $100 per month unless they switched to a lower cost plan.

Geographic Variations in Premiums

This approach to premium support would result in wide variations in Medicare premiums across the country, due to wide variations in Medicare spending across the country, variations in private plan bids relative to traditional Medicare costs, and variations in the share of beneficiaries enrolled in traditional Medicare versus Medicare Advantage plans.

In some parts of the country, private plan bids are lower than the costs of traditional Medicare, and in other parts of the country, private plan bids are higher than the costs of traditional Medicare – a key factor in determining premiums for beneficiaries in a given area, depending on the plan they choose for their Medicare coverage.

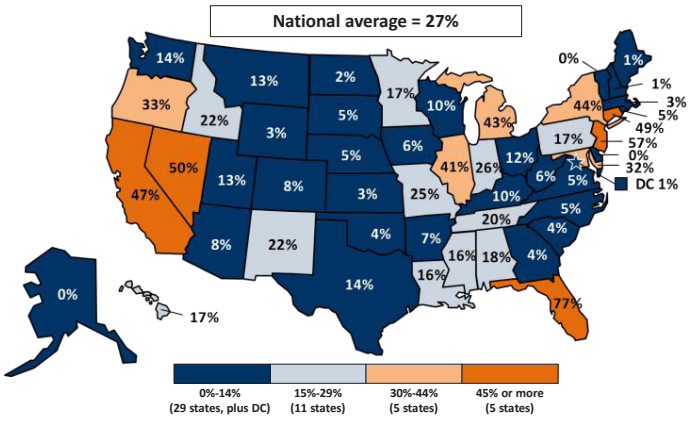
- The share of beneficiaries subject to higher premiums if they remained in their same plan would vary greatly by state, ranging from less than two percent of beneficiaries in Alaska and the District of Columbia to more than 90 percent of beneficiaries in Connecticut, Florida, Massachusetts, and New Jersey.

- In 29 states and the District of Columbia, less than 15 percent of beneficiaries would pay $100 or more in monthly Medicare premiums, but in five states (CA, CT, FL, NJ and NV) more than 45 percent of beneficiaries would pay at least $100 more in Medicare monthly premiums, unless they switched to a benchmark plan. Half or more of beneficiaries in Florida (77%), Nevada (50%), and New Jersey (57%) would be subject to additional monthly premiums of $100 or more, if they remained in the same plan (**Exhibit ES.2**).

EXHIBIT ES.2

Share of Medicare beneficiaries subject to additional premiums of $100 or more per month if they remain in the same plan, by state

Federal payments per enrollee, based on the lesser of Traditional Medicare costs or the second least cost plan



NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

[v] A 2011 analysis by the Congressional Budget Office (CBO) estimated that out-of-pocket spending for a typical 65-year old would be $6,240 higher in 2022; the CBO analysis was of a different type of premium support system, and included effects of changes in benefits, cost-sharing requirements and premiums for supplemental insurance.

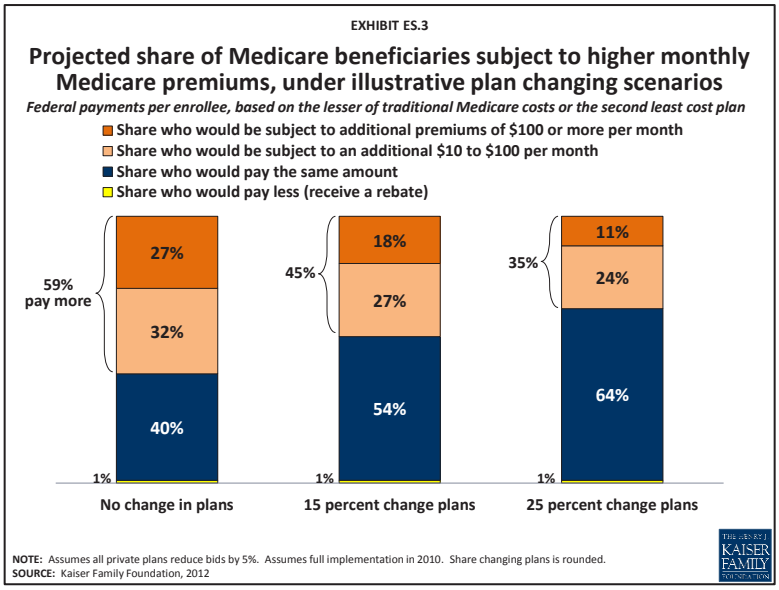
- Premiums for traditional Medicare would vary widely across states and counties, a significant departure from the current program. On average, premiums for beneficiaries enrolled in traditional Medicare would increase by $60 per month ($720 per year), if a premium support system were fully implemented. In four states (AK, DE, HI and WY) plus the District of Columbia, premiums for traditional Medicare would not increase, but, for beneficiaries in six states (CA, FL, MI, NJ, NV and NY), average additional premiums for traditional Medicare would exceed $100 per month, and in the case of Florida, would exceed $200 per month.

- Medicare premiums would be expected to vary widely by county, again due to variations in private plan bids relative to traditional Medicare costs.
    - Under a premium support system, premiums paid by beneficiaries for traditional Medicare would be expected to vary widely across counties, even within a given state. In California, for example, premiums for traditional Medicare would be expected to remain unchanged in San Francisco and Sacramento counties, but at the other extreme, traditional Medicare premiums would increase by more than $200 per month in Los Angeles and Orange counties.
    - In high-cost counties (defined as counties in the top quartile of traditional Medicare per capita costs), 80 percent of beneficiaries would pay higher premiums for Medicare coverage, unless they switched plans, because only a small share of enrollees in these counties are in a benchmark plan.
        - For example, beneficiaries in several high-cost counties would pay significantly more to remain in traditional Medicare, including Miami-Dade County, FL ($492 per month), Los Angeles County, CA ($260 per month), Kings County (which includes Brooklyn), NY ($232 per month), Wayne County (which includes Detroit), MI ($211 per month), Orange County, CA ($214 per month) and Riverside County, CA ($161 per month).
    - In contrast, in low-cost counties (defined as counties in the bottom quartile of traditional Medicare per capita costs), a smaller share, 28 percent, of beneficiaries would pay higher premiums for Medicare coverage. This occurs because the traditional Medicare plan would be the benchmark in those counties, and in most of the low-cost counties, the vast majority of beneficiaries are enrolled in traditional Medicare. In other words, most beneficiaries in low-cost counties would not pay a higher premium, if they remained in traditional Medicare.
        - However, some beneficiaries enrolled in private plans in several low-cost counties would pay significantly more to remain in their plans, including Honolulu County, HI ($254 per month, on average), Washington County (which includes Hillsboro), OR ($216 per month, on average), Multnomah County (which includes Portland), OR ($211 per month, on average) and Bernalillo County (which includes Albuquerque), NM ($164 per month, on average).

Sensitivity Testing.

The results are sensitive to changes in plan switching, plan bidding behavior, and traditional Medicare costs. The analysis shows that beneficiary plan "switching" has a greater effect on results than changes in private plans bids or traditional Medicare costs.

Individual Behavior. This paper considers the effects of plan switching on premiums, and uses market share elasticities derived from the literature to switch individuals from a given plan to a benchmark plan, with elasticities ranging from no change in market share (no plan switching) to a 3.5 percentage point decrease in a plan's market share per $10 increase in premiums from the benchmark. If as many as 25 percent of all beneficiaries enrolled in plans above the benchmark switched to a benchmark plan, then the share of beneficiaries subject to higher Medicare premiums would drop from 59 percent to 35 percent, and the share paying $100 or more in premiums would decrease from 27 percent to 11 percent (**Exhibit ES.3**).



Plan Behavior. This paper assumes a five percent reduction across all private plan bids, consistent with an assumption used by the Congressional Budget Office (CBO, 2006).[vi] However, if private plans' bids decreased further, then the share of beneficiaries facing higher premiums would increase. For example, if private plans' bids decreased by 25 percent, instead of 5 percent, the share of beneficiaries subject to higher premiums would increase from 59 percent to 93 percent.

Conversely, if private plans' bids increased, the overall share of beneficiaries who would be in plans that bid above the benchmark (and subject to higher premiums) would decrease. For example, if private plans' bids increase by 25 percent, then the share of beneficiaries subject to higher premiums would decrease from 59 percent to 24 percent. This would occur because as private plans' bids increase, traditional Medicare would be the benchmark plan in more counties, since traditional Medicare costs would be lower than private plan bids in more counties; the converse follows when private plans' bids decrease.

Traditional Medicare. The analysis also considers the effect of traditional Medicare costs on the distribution of beneficiaries expected to pay higher premiums, under alternative scenarios. If, for example, Medicare per capita spending was 10 percent lower, then the share of beneficiaries subject to higher premiums would decrease from 59 percent to 39 percent, and the share of beneficiaries subject to additional premiums of $100 more per month would decrease from 27 percent to 19 percent.

[vi] Congressional Budget Office, *Designing a Premium Support System* for *Medicare*. December 2006.

Limitations

Few premium support proposals include detailed specifications needed to model the effects of a premium support proposal with a high degree of certainty. Thus, a number of policy assumptions were made to illustrate the likely effects for beneficiaries, and discussed in as transparent a manner as possible to allow readers to understand the impact of the assumptions. This analysis *does not*:

- estimate out-of-pocket costs associated with changes in benefits, cost-sharing requirements and premiums for supplemental insurance;[vii]
- analyze the effects of either adverse selection or the imposition of Medicare spending caps over time;
- assess the implications for beneficiaries with low-incomes, including dual-eligible beneficiaries who could also be affected by changes made to the Medicaid program, such as a Medicaid block grant;
- model the potential for insurers' responses to vary, based on local market conditions; or
- estimate other changes that could potentially result from a more competitive marketplace.

A more in-depth discussion of study limitations and their implications is included in the main body of the report.

Discussion

These findings underscore the potential for highly disparate effects of a premium support system for beneficiaries across the country. The results show how individual decision making (plan choices), coupled with geographical variations in the cost of traditional Medicare and the private health plans, would play a major role in determining how well beneficiaries fare with respect to premiums under this approach.

The study estimates that the majority (59%) of Medicare beneficiaries would be expected to face additional premiums, based on current plan preferences, under the modeled premium support system. Clearly, a smaller share of beneficiaries would pay higher premiums if they instead enrolled in a low-cost plan offered in their area. In high-cost areas, such as Miami and Los Angeles, most beneficiaries in the traditional Medicare program would see a significant increase in Medicare premiums, unless they opted to enroll in a lower-cost private plan. Conversely, in low-cost areas, such as Honolulu County in Hawaii and Multnomah County in Oregon (which includes Portland), the majority of beneficiaries would *not* pay additional premiums if they remained in their plan (based on current enrollment in that county), but a sizeable minority (17% and 43%, respectively) would pay at least $100 more in monthly premiums for their Medicare coverage in a private plan.

Further, this analysis shows that premiums for traditional Medicare would likely vary across states, and within states, by county. If this system had been fully implemented in 2010, some would have paid the same Medicare premium, while others would have paid an additional $200 more per month in Medicare premiums, not considering other additional costs beneficiaries could potentially face, such as cost-sharing requirements for benefits covered by the plan, the cost of benefits not covered by the plan, and premiums for supplemental insurance.

Under the modeled premium support system, beneficiaries would choose among a variety of health plans offered in their area, and could opt to enroll in a low-cost plan for their Medicare benefits without incurring higher Medicare premiums than under the current system, or in some cases, paying even less. If beneficiaries preferred another plan, however, for whatever reason, they would have the option to enroll in that plan and pay

[vii] This is one of the ways in which this analysis is different from CBO's April 2011 analysis of Paul Ryan's "Path to Prosperity" proposal.

higher premiums. Some may see this as an appropriate way to structure a marketplace and constrain government spending, while maintaining federal payments to cover Medicare benefits (or their actuarial equivalent) for at least one plan offered in a given area. Others may have concerns about the implications for beneficiaries, particularly for those who are unable to afford the higher Medicare premiums for higher cost plans (either traditional Medicare or private plans).

Beneficiaries' preferences and plan choices are not purely driven by premiums, and some beneficiaries may not view the low-cost plan, whether a private plan or traditional Medicare, as optimal for meeting their individual needs and circumstances. Some beneficiaries may have a strong preference for a private plan, based on their past experience and comfort with known care arrangements, but, particularly in some parts of the country, may not be able to afford the higher premium to enroll in a private health plan. Others may have a strong preference for traditional Medicare because they highly value the ability to choose their own doctors or hospital, but depending on where they live, may not be able to afford higher premiums for coverage under the traditional Medicare program.

Beyond premiums, other factors could be considered in choosing a plan, which may or may not be consistent with the choice of a low-cost plan. First, enrolling in a low-cost plan, if it requires changing from another plan, may require beneficiaries to change their doctors and other health care providers, posing potential problems for beneficiaries with long-standing relationships with their doctors, especially those with chronic conditions. Second, some beneficiaries may value the option to enroll in a highly-rated plan, but quality is not a factor in determining which plan is the benchmark plan. Third, low-cost plans in a given area may or may not have the capacity to accommodate all beneficiaries who wish to enroll in the plan. As an extreme example, in Los Angeles County, California, less than one percent of Medicare beneficiaries (less than 10,000) are currently enrolled in one of the two lowest cost plans, leaving more than 900,000 beneficiaries in other plans or traditional Medicare. Fourth, the low-cost plans offered in an area could change each year or so, as has occurred in the Medicare Part D program, potentially creating instability for beneficiaries with modest incomes who would have a strong financial incentive to remain in a low-cost plan each year.

Proposals to transform Medicare from its current structure to one based on premium supports can be expected to directly affect costs incurred by beneficiaries, with the effects dependent on numerous factors, including policy specifications, geography, local market conditions, firm strategy and beneficiary choices in this new environment. Increases in Medicare premiums under a premium support system *could* be tempered by modifications in policy parameters, but the tradeoff would likely mean increases in federal costs, which could undermine the primary goal of a premium support approach. If coupled with caps on the growth in Medicare spending, a premium support approach could make federal outlays for the Medicare program more predictable, but also increase costs and financial risks for beneficiaries over time. Given a lack of specificity about some of the key policy elements and questions about the likely response of the insurance industry and beneficiaries, there remains great uncertainty about the expected effects of this approach for elderly and disabled Americans in the future.

Medicare Premium Support Proposals: Implications for Beneficiary Premiums

INTRODUCTION

Over the past several decades, the idea of transforming Medicare into a "premium support" or "defined contribution" system has emerged as an approach for Medicare reform, often in the context of discussions about strategies to reduce federal spending.[1] While the parameters of various premium support proposals differ, the general idea is for the federal government to contribute for each person on Medicare a monthly predetermined amount of money that would be applied toward the premium for a health insurance plan. This contrasts sharply with the current Medicare program under which Medicare beneficiaries are entitled to a defined set of benefits, with the federal government contributing to the cost of these services provided by either the traditional fee-for-service (FFS) program or private Medicare Advantage plans.

An argument in favor of a premium support system for Medicare is that Medicare spending would be more predictable by setting a fixed, limited payment per beneficiary. Proponents anticipate a reduction in Medicare spending over time, due to a more competitive marketplace, with multiple insurers competing on a level playing field with each other and with traditional Medicare, putting downward pressure on costs and making beneficiaries more cost-conscious in their choice of plans. Some also view a premium support approach as desirable because it could reduce the program management needed by the federal government, by delegating decisions about coverage, benefit design and provider payments to private insurers. An argument against a premium support system for Medicare is that it would shift greater financial risk and costs onto beneficiaries, increasing premiums and out-of-pocket costs for many elderly and disabled beneficiaries.[2] Opponents are also concerned about the potential for adverse selection under the traditional Medicare program, which could result in substantial increases in premiums, without adequate risk adjustment.

Recently, a number of proposals for a Medicare premium support system have been advanced in the context of broader efforts to reduce the federal deficit and debt, including proposals by Representative Paul Ryan (R-WI), Chairman of the House Committee on the Budget, Senator Ron Wyden (D-OR), Senator Richard Burr (R-NC), Senator Tom Coburn (R-OK), Dr. Alice Rivlin, former Director of the Congressional Budget Office, and former Senator Pete Domenici, former Chairman of the Senate Committee on the Budget, and other policymakers and leaders.[3] Premium support proposals differ in a number of ways, including how federal payments on behalf of beneficiaries would be determined initially and how they would grow over time; how the new program would be phased-in; whether traditional Medicare would remain an option; how service areas would be defined; what protections would be provided for low-income beneficiaries; the extent to which the new system would be regulated; and whether a federal cap on Medicare spending would be required to constrain the growth in program spending. These differences have important implications for beneficiaries, Medicare spending, health care providers, and health plans. This analysis focuses on the potential effects of a premium support system for beneficiaries' premiums, but does not take into consideration out-of-pocket spending due to the effects of changes in benefits, cost-sharing requirements and premiums for supplemental insurance. Nor does it assess potential savings to the federal government – an important consideration in the context of current deficit and debt reduction discussions – which would be achieved to the extent that the government pays less for beneficiaries in traditional Medicare in counties in which private plan costs are lower, and less for beneficiaries in private plans in areas where traditional Medicare costs are lower.

METHODS

This analysis models the effects of setting federal contributions per enrollee (i.e., the "benchmark") equal to either the second lowest plan bid or traditional Medicare costs in an area, whichever is lower. Beneficiaries who choose plans that cost more than the benchmark would pay a premium, in addition to the Medicare Part B premium, and beneficiaries who choose plans that cost less than the benchmark would receive a rebate equal to a share of the difference between the benchmark and the plan bid.

This approach is reflected in numerous proposals, such as the Domenici-Rivlin proposal, the Wyden-Ryan proposal, and Chairman Paul Ryan's budget proposal for FY2013; however, this study should not be interpreted as an analysis of any specific proposal for two reasons. First, we were required to make a number of assumptions that are not yet specified in several of these premium support proposals, such as the definition of service area and the benefits that would be required to be provided by a plan. Second, our analysis assumes full implementation of a premium support system in 2010, whereas the proposals would gradually phase-in a premium support system in five to ten years and apply the premium support proposal to only new enrollees, rather than all beneficiaries.

The analysis focuses on premiums beneficiaries would be expected to pay for Medicare benefits under Parts A and B (or benefits that are actuarially equivalent) but not benefits covered under Part D plans, consistent with policies described in several proposals. However, unlike the Congressional Budget Office (CBO) analysis of Chairman Paul Ryan's budget proposal for FY2012, this study does not take into consideration other costs that may be incurred by beneficiaries, including out-of-pocket costs for covered benefits under Parts A, B or D, or premiums for Part D or supplemental insurance.[4]

More specifically, this study examines the share of Medicare beneficiaries who would be expected to pay additional premiums for their Medicare coverage, assuming their current plan choices, nationally, by state, and at the county level, if a premium support system was already implemented. Beneficiaries subject to a nominal premium increase of less than $10 per month were included with beneficiaries who would pay the same amount. The study includes sensitivity analyses to assess the effects of alternative plan bidding behavior. We also draw on the literature and the experiences of current programs to consider the extent to which beneficiaries can be expected to switch to lower premium plans, and the effects of different switching assumptions on the study's findings. Other studies by Feldman et al. and Song et al. analyzed a similar approach to a premium support system, but did not test the sensitivity of the results to alternative assumptions.[5] For a more detailed comparison of this analysis and more recent studies, see **Appendix Table 1**.

Data sources.

The analysis uses Medicare Advantage plan bids for Medicare Part A and Part B services that were submitted to Centers for Medicare and Medicaid Services (CMS) for the 2010 plan year as proxies for private plans' bids under a premium support system, and uses average per capita traditional Medicare spending for each county, as a proxy for traditional Medicare costs under a premium support system. Traditional Medicare and Medicare Advantage enrollment data were drawn from CMS's state-county-contract file for March 2010. As with any analysis of this type, the results are dependent upon the quality of the data. Since we rely on actual data from 2010 for the analysis, the results are driven by key characteristics of the Medicare program in 2010, including per capita spending for beneficiaries in traditional Medicare, bids submitted by private Medicare Advantage plans, and enrollment in traditional Medicare or Medicare Advantage plans. More information about current federal payments to private plans and enrollment in private plans is available in the following boxes.

Current Law: Context for Understanding the Shift to Premium Support

Under current law, Medicare beneficiaries can receive Medicare coverage under the traditional Medicare program or by enrolling in a private plan, such as an HMO or PPO, known as a Medicare Advantage plan. Today, approximately 25 percent of all Medicare beneficiaries are in private plan, and the majority of beneficiaries (75%) are enrolled in the traditional Medicare program. Generally, beneficiaries (with the same income) pay the same Part B premium, and premiums do not vary based on where beneficiaries live. Beneficiaries may pay an additional premium for Part D benefits and extra benefits, with premiums varying across counties.

Medicare Payments on Behalf of Beneficiaries Enrolled in Private Plans and Traditional Medicare. Today, private Medicare plans, through the Medicare Advantage program, are paid a capitated amount per enrollee to provide all Medicare Part A and B benefits. Each plan is required to submit a bid to the federal government, reflecting the cost of providing services covered under Parts A and B to enrollees, although federal payments are not tied directly to these bids. Under current law, each plan's bid is compared to federal maximum amounts that are set by a formula established in statute and vary by county for local plans (or by region for regional plans). If a plan's bid is higher than the maximum amount, the federal government pays the maximum amount per enrollee, and plan enrollees pay the difference between the federal maximum and the plan bid in the form of a premium, which is in addition to the Part B premium. If the bid is lower than the maximum amount, the beneficiary pays no premium for the plan, other than the Medicare Part B premium, and the federal payment is equal to the plan's bid plus a share of the difference between the federal maximum and the plan bid, the latter of which must be used to provide extra benefits (benefits not covered by traditional Medicare) to the plan's enrollees. The vast majority of plan bids were lower than the federal maximum in 2010; as a result, the vast majority of beneficiaries in Medicare Advantage plans pay no more than the Part B premium ($110.50 per month in 2010). Medicare payments to plans are then risk-adjusted based on enrollees' risk profiles.[6] In addition, Medicare makes a separate payment to plans for providing prescription drug benefits under Part D. The ACA reduced the maximum payments to private plans. In contrast, Medicare payments for beneficiaries in traditional Medicare are not capitated; instead, they are tied to the services beneficiaries received.

The modeled premium support system would change the way in which payments are made on behalf of beneficiaries under private plans and traditional Medicare. Rather than rely upon the current law formula for setting payments to plans, the proposal would cap payments to plans at no more than the bid for the second least cost plan in an area, or traditional Medicare costs, whichever is lower (the "benchmark"). Payments on behalf of beneficiaries in traditional Medicare would be capped, a major departure from the current system. In areas where traditional Medicare per capita costs are higher than the second lowest plan bid, beneficiaries in traditional Medicare would pay the difference between the second least cost plan and traditional Medicare costs. Conversely, in areas where private plan bids are higher than traditional Medicare costs, private plan enrollees would pay the difference between traditional Medicare costs and the bid submitted by their plan.

Part B premiums. All beneficiaries with the same annual income are subject to the same Part B premium, generally equal to 25 percent of projected Part B program costs ($104.20 per month in 2010). Premiums do not vary based on where beneficiaries live, regardless of whether they live in an area with high traditional Medicare costs or an area with low traditional Medicare costs. It is assumed that beneficiaries would continue to pay current law premiums under the modeled premium support system if they enrolled a benchmark plan (or receive a rebate if they selected the lowest-cost private plan). However, beneficiaries could face additional premiums for their Medicare benefits, if they enrolled in a higher cost plan, either a private plan or traditional Medicare. This approach allows for variations in Medicare premiums across the country.

Factors That Help Explain Why Beneficiary Premiums Would Vary Under Premium Support

The effects of a premium support system on beneficiary premiums, where federal payments are based on the lowest cost plans in a given area, seem to be largely determined by three factors: variations in per capita traditional Medicare spending, variations in bids submitted by plans to cover Medicare benefits, and variations in beneficiaries' enrollment choices.

Variations in Per Capita Traditional Medicare Costs. Traditional Medicare costs vary widely across the country, ranging from less than $500 per beneficiary per month in some counties to more than $900 per beneficiary per month in other counties, in 2010. Medicare spending in local areas is an important factor for understanding the effects of a premium support system because of the proposed formula for determining the payment per beneficiary. In areas where traditional Medicare per capita spending is relatively high, traditional Medicare is unlikely to be a benchmark plan, which means that beneficiaries would pay more for coverage under traditional Medicare than they would for a low-cost private plan. Conversely, in areas where traditional Medicare costs are relatively low, and traditional Medicare would be the benchmark in that area, then beneficiaries would pay more for coverage under a private plan. Geographic variation in traditional Medicare spending may be due to a number of factors, including variations in medical practice across areas (volume and intensity of services used) and variations in the price of services.

Variations in Private Plan Bids Relative to Traditional Medicare Costs. Variation in private plan bids relative to the per capita costs of traditional Medicare is a key driver of the results presented in this report. Medicare Advantage plan bids were equal, on average, to the costs of traditional Medicare in 2010, but bids relative to the costs of traditional Medicare varied widely by county.[7] In counties in which per capita traditional Medicare costs were relatively high, plan bids tended to be lower than the costs of traditional Medicare, and in counties in which per capita traditional Medicare costs were relatively low, plan bids tended to be higher than the costs of traditional Medicare. Geographic variation in plan bids relative to traditional Medicare costs may be due to a number of factors, including the ability of private plans to leverage lower prices from providers in some markets and/or the ability to reduce beneficiaries' use of medical services.

Variations in Beneficiaries' Enrollment Choices. Under the current program, beneficiaries can choose to receive their Medicare benefits under traditional Medicare or a private Medicare plan. Regardless of where they live, or which option they choose, beneficiaries are generally subject to the same Medicare Part B premium. Under the modeled premium support system, enrollment preferences play an important role in determining beneficiaries' premiums. In some parts of the country (generally areas with relatively high per capita Medicare spending), beneficiaries choosing traditional Medicare would pay higher premiums and in areas with relatively low per capita costs, beneficiaries choosing private plans would pay higher premiums. Because enrollment preferences vary widely across the country, Medicare premiums will be determined in large part by decisions made by beneficiaries to enroll in a private plan or traditional Medicare.

Policy Assumptions.

Since many critical components to a premium support system have not been fully specified, we made assumptions, as needed, to model the effects, and then tested the sensitivity of the results to these assumptions.

- **Implementation date:** Many premium support proposals would be implemented between five and 11 years in the future, varying by the proposal. This analysis assumes the policy would be fully implemented in 2010. This approach has several advantages. By assuming the transformation to a premium support system is complete in 2010, we are able to illustrate the potential effects of the proposal for the total Medicare population, thus smoothing over transition issues and effects. A second advantage is that we use actual plan bid data and traditional Medicare costs to minimize the risk of producing results that could be attributable to forecasting error. The downside to this approach is that it does not take into account changes built into the baseline that are projected to result in changes in traditional Medicare spending, changes in spending for Medicare Advantage plans, changes in Medicare Advantage enrollment, and changes in local market conditions that could change the market dynamics between now and when a premium support system would be implemented (e.g., hospital consolidations or other major changes in local delivery systems). The analysis also does not take into account the effects of a cap on spending, a policy feature of some premium support proposals. For this analysis, we use sensitivity testing to illustrate the effects of reductions in traditional Medicare costs by 5 to 25 percent across all counties to account for potential future reductions in Medicare spending resulting from changes made in the ACA.

- **Service area:** Many proposals do not specify how large of an area private plans would be required to cover. Service areas could potentially be larger than a state (as with regional PPOs) or as small as counties (as with local Medicare Advantage plans). Given that most Medicare Advantage plans are county-based local plans (HMOs, POS or local PPOs), and that many of these plans would have difficulty establishing networks at a state or regional level, we assumed a county-based bidding area although we recognize that a combination of metropolitan statistical areas (MSAs) and hospital referral regions (HRRs) could be more optimal service areas than counties.[8] In 16 percent of counties nationwide, only plans without local provider networks (regional PPOs and PFFS plans) were offered in 2010. Using other service areas would have required making assumptions about the areas in which plans would be offered, and whether bids in those areas would be similar to county-based bids.[viii]

- **Benefit package:** Generally, proposals have stated that plan bids would be for a benefit package that is at least actuarially equivalent to the Medicare Part A and Part B benefits, but do not specify whether plans must cover specific services. On the one hand, allowing plans the flexibility to cover or not cover specific services could increase competition among plans. On the other hand, not requiring specific services to be covered, or allowing high cost-sharing for specific services, such as hospital stays, oncology services, or skilled nursing facility (SNF) stays, would likely lead to adverse selection among plans, with the beneficiaries in poorer health disproportionately enrolling in plans (including traditional Medicare) with better coverage for the services they need. This study assumes that plan bids are for Medicare Part A and Part B benefits, with cost-sharing that is actuarially equivalent to the cost-sharing for traditional Medicare, which is the same structure as current bids for Medicare Advantage plans.

[viii] The plan bids (which often cover more than one county) were converted to county-based bids by the multiplying the plan bids by the intra-service area rate (ISAR) scale for the county, which is the ratio between Medicare Advantage benchmark for the county and the average benchmark (weighted by plan enrollment) for the counties covered by the plan bid; this is the same method used by CMS to calculate the county-based plan bids and determine the plans' rebates. Similarly, all regional plan bids were converted to county-based bids.

- **Part B premiums:** Generally, premium support proposals have not been explicit in describing how the Medicare Part B premium would be affected. Currently, all beneficiaries with the same annual income generally pay the same Part B premium; for most beneficiaries the premium is equal to 25 percent of projected Part B program costs ($110.50 per month in 2010). Under a premium support system, Part B premiums could vary by factors other than income, such as the Medicare costs in the county in which the beneficiary resides or the year in which the beneficiary became eligible for Medicare. This analysis assumes no change in the calculation of Part B premiums and assumes no increase in the Part B premium if beneficiaries choose the benchmark plan. Some proposals would modify premium contributions by income beyond current law; this study does not consider the effect of such a policy because it does not assess variations for beneficiaries by income. A policy that continues the current method for calculating the Part B premium implicitly assumes beneficiaries in areas with relatively high per capita Medicare spending would be subsidized by beneficiaries in areas with relatively low per capita Medicare spending for their Part B premium.

- **Risk adjustment:** All proposals have specified that federal contributions would be risk adjusted and plan bids would reflect costs for a risk-neutral beneficiary, so both the payments to plans and the bids submitted by plans would be subject to risk adjustment. However, risk adjustment systems are not perfect; researchers estimate that the current risk adjustment system for the Medicare Advantage program accounts for only 11 percent of the variation in beneficiary spending.[9] If the risk-adjustment system greatly underestimates the spending for high-cost beneficiaries, and high-cost beneficiaries disproportionately enroll in traditional Medicare (or another plan) then beneficiaries in traditional Medicare (or other plans that attract relatively sicker enrollees) could face rapidly-escalating, unaffordable premiums as a result of adverse selection.[10] While issues with risk adjustment are not a large concern in the short-term, they could have significant implications for beneficiaries and traditional Medicare in the long-term horizon. This model assumes that the risk adjustment system is perfect (a highly optimistic assumption), in the absence of other alternatives.

- **Treatment of IME, GME, and DSH in traditional Medicare costs:** Proposals have not specified whether the traditional Medicare bid for an area would include payments for Indirect Medical Education (IME), Graduate Medical Education (GME), or the Disproportionate Share Hospital (DSH) program. Private plan bids do not include IME, GME, or DSH payments because the traditional Medicare program makes these payments on behalf of Medicare Advantage enrollees.[ix] On the one hand, the best apples-to-apples comparison between traditional Medicare costs and the plan bids would exclude these payments from the traditional Medicare bid. On the other hand, the Medicare program may continue to make these payments in a premium support system in order to support physician education, although DSH payments were significantly reduced by the ACA. If the payments for IME, GME, and DSH were to be included in the traditional Medicare costs, then traditional Medicare costs (and premiums) would be higher, particularly in areas with large teaching hospitals, such as Boston or New York City. This model excludes IME, GME, and DSH payments from the traditional Medicare bid in the base case analysis, and tests the sensitivity of the results to this assumption.

[ix] A smaller difference between plan bids and FFS Medicare costs is that plan bids currently do not include the costs of hospice care, whereas FFS Medicare costs do include hospice. Plan bids would increase slightly if these costs were included.

- **Exclusion of certain plans:** Employer-group plans, Special Needs Plans and plans with low enrollment.
    - ***Employer Group Plans*.** Proposals have not specified as to whether a premium support system would include employer-group health plans (EGHPs) that are an option for some beneficiaries with retiree coverage from a former employer or a union (approximately 1.9 million beneficiaries in 2010). Since the price and benefit negotiation process between the plans and employers occurs outside of the CMS plan bidding process, EGHPs do not have the competitive pressure to submit a bid to CMS that is lower than the county benchmark and are not an apples-to-apples comparison to the bids for individual plans.[11] This model excludes EGHPs and EGHP enrollees.
    - ***Special Needs Plans*.** Premium support proposals have not yet specified whether Special Needs Plans (SNPs) may continue to be offered in a premium support system. SNPs can only enroll beneficiaries who are dual eligibles, have certain chronic conditions, or require an institutional level of care; approximately 1.3 million beneficiaries were enrolled in SNPs in 2010. Including bids for SNPs would pose both practical and technical problems in a premium support system. First, if the bid for a SNP is one of the lowest in the area, but enrollment in SNPs is restricted to certain types of beneficiaries, then either non-qualifying beneficiaries would only have one fully-subsidized plan in which to enroll, or SNP bids would need to be disregarded in the benchmark calculations. Second, if the bids for SNPs are not one of the lowest in an area, then the beneficiaries who are eligible to enroll in the SNP (particularly dual eligibles and institutionalized beneficiaries) may not be able to afford the additional premium, if it is not subsidized. If a subsidy is provided for SNPs with bids above the benchmark, then SNPs may not have an incentive to bid lower than the subsidy and Medicare spending would increase. For these reasons, the model excludes SNPs and SNP enrollees.[x]
    - ***Plans with no or low enrollment*.** Proposals have not specified whether plans with few enrollees would be permitted to operate in a county due to concerns about the operational viability and quality of care provided by the plan.[xi] This model excludes bids for plans with 10 or fewer enrollees in a county, resulting in the exclusion of about 3 percent of beneficiaries (about 300,000 beneficiaries).

In addition, we assumed all territories would be excluded from a premium support system; all beneficiaries would be required to enroll in Medicare Part A and Part B (and could not enroll in Medicare Part A only); and no change in policy for Medigap supplemental coverage. We also assumed no changes in plan offerings from 2010, including private fee-for-service (PFFS) plans. Since 2010, many PFFS plans have exited the market, some of which have been replaced by preferred provider organizations (PPOs). It is not clear how the bids for the PPOs would differ from the bids for the PFFS plans. More broadly, this analysis assumes a static marketplace with no new plan entrants or exits. To the extent that a premium support system would reduce private plans' profits and induce plans to exit the market, the dynamics could change for beneficiaries.

[x] The authority of SNPs to limit enrollment to certain types of beneficiaries expires in January 2014, and policymakers may also choose to discontinue SNPs for reasons that are unrelated to a premium support bidding environment.

[xi] CMS requires all plans (other than SNPs) to have at least 500 enrollees, across all of the counties covered by the plan. CMS does not require plans to have a minimum number of enrollees in each county served by the plan, and many plans have fewer than 50 enrollees in a county. More than half of Medicare Advantage enrollees are in plans with fewer than 50 enrollees in the county.

Behavioral Assumptions.

Firm Behavior: How Will Private Plans Bid Under a Premium Support Proposal? Under current rules, Medicare Advantage plan bids are required to reflect plans' true costs for Medicare Part A and Part B services, and are subject to federal audits. It is not clear how insurers would change their plan bids under a premium support system, knowing that federal payments would be equal to the lesser of the second lowest plan bid, or the bid for traditional Medicare in the area. There is little evidence upon which to base an assumption, and some justification for assuming a range of responses from insurers and variations by market. For example, some believe a premium support system would provide stronger incentives for private plans to compete based on price, resulting in lower plan bids; yet, there is no consensus on how much plan bids would decrease or whether insurers' bidding strategies would be uniform across the country.[xii] In 2006, CBO assumed, in one set of analyses, that a premium support system would induce all private plans to reduce their bids by five percent, based upon premium reductions among employer plans after implementation of managed competition; in other analyses, CBO assumed no change in plan bids.[12] Others believe plan bids could feasibly decrease even more; private plan bids from the competitive bidding demonstration in Denver (developed by the Health Care Financing Administration in 1996, but never implemented) were reportedly between 25 percent and 38 percent lower than that costs of traditional Medicare.[13] Another theory is that private plan bids may actually increase in some areas relative to traditional Medicare costs as a result of mergers and consolidations among hospitals and other providers, which would increase providers' negotiating leverage and decrease plans' leverage. Still others posit that changes in plan bids will be more market specific, depending on the relative negotiating power of providers in each market.

It is also conceivable that a private plan could choose to bid highly aggressively and below operating costs in the first couple of years, as occurred in the Part D market, in order to capture a large share of the market.[14] Private plans could also engage in bidding strategies designed to attract or avoid low-income or sicker beneficiaries. Ultimately, plan bids will depend on numerous factors and business strategies that are difficult to predict with a high degree of certainty.

Our base case analysis assumes that all private plans uniformly reduce their bids by 5 percent relative to traditional Medicare, consistent with one of the assumptions made by the CBO in its 2006 study.[15] To assess the implications of alternative scenarios, we examine how the results of the analysis would change under alternative bidding assumptions, ranging from decreasing all bids up to 25 percent to increasing all bids up to 25 percent.

Individual Behavior: Will Beneficiaries Switch To a Lower Premium Plan? This analysis layers a premium support approach onto the current landscape, which assumes current plan preferences and enrollment choices with respect to private Medicare Advantage plans versus traditional Medicare. The willingness of beneficiaries to enroll in a low premium plan (potentially on an annual basis) is a critical factor in assessing the share of beneficiaries who would face higher premiums in a premium support environment. Unfortunately, the extent to which beneficiaries can be expected to switch plans is not entirely clear, nor is it clear whether beneficiaries would switch to a plan at or below the benchmark, or a plan above the benchmark. There are no published estimates of plan switching among Medicare Advantage enrollees, but the data from the Part D marketplace suggests a fairly high rate of plan "stickiness" among the Medicare population. In 2008, just six percent of all enrollees in stand-alone prescription drug plans (PDPs) who did not qualify for low-income subsidies voluntarily switched plans, despite substantial variations in premiums, cost-sharing requirements and other factors.[16] Similar rates of switching have occurred in the younger population in the Massachusetts' Commonwealth Care

[xii] Some note that the current Medicare Advantage program, which gives plans a share of the difference between the plan bid and the county benchmark (known as a "rebate") to be used to provide extra benefits to plan enrollees, may not provide a strong financial incentive for plans to bid as low as possible since plans only receive a fraction of the amount by which they lower their bid.

plans, where just seven percent of enrollees voluntarily switched plans in 2011.[17] Among federal employees, a higher percentage (about 12%) switched plans annually between 1996 and 2001.[18]

An examination of beneficiaries' current plan choices suggests that many beneficiaries are willing to pay relatively high premiums, even when lower premium or no-premium plans are offered in the area. Slightly less than half (47%) of all Medicare Advantage enrollees (about 12% of all Medicare beneficiaries) elected a zero-premium Medicare Advantage Prescription Drug (MA-PD) plan in 2010, even though in nearly every county, such a plan is available as an alternative to other Medicare Advantage plans or to traditional Medicare (coupled with supplemental insurance and/or stand-alone PDPs). About 35 percent of Medicare Advantage enrollees paid more than $50 per month for their plan, when a zero-premium plan was available. About 27 percent of beneficiaries in traditional Medicare purchased a Medigap policy for supplemental coverage of traditional Medicare benefits (with premiums averaging $178 per month in 2010).

Several studies indicate that premiums can be an important consideration in beneficiaries' plan choices,[19] but other factors may also be important. Beneficiaries may be willing to incur higher premiums for broader provider networks,[20] lower cost-sharing, extra benefits, and familiarity or satisfaction with the company or firm offering the plan.[21] Additionally, beneficiaries' willingness to make trade-offs varies by demographic characteristics. Beneficiaries who are older,[22] cognitively impaired,[23] or in HMOs[24] are less likely to switch plans than beneficiaries who are younger, not cognitively impaired, or in PPOs. Beneficiaries with lower incomes may be more price sensitive than others, although the experience of Part D and the low income subsidy suggests that even low-income beneficiaries are somewhat "sticky" and do not always switch to low or zero-premium plans. In 2010, 15 percent of beneficiaries receiving low-income subsidies paid a premium for a PDP, rather than enrolling in a zero-premium plan.[25]

Researchers have examined Medicare beneficiaries' plan switching behavior in response to premium changes, but the most applicable studies are either relatively dated[26] or more narrowly focused on supplemental retiree health coverage[27] or Part D drug plan choices.[28] These studies found that for every $10 increase in plan premiums, market share for a given plan declines by a range of estimates, from 0.62 percentage points to 3 percentage points. The market elasticity is the change in a plan's market share (percent of enrollment) that results from a difference between the plan's premium and the benchmark. The elasticity would decrease a plan's share of the enrollment in a county by a fixed percentage for every $10 difference between the plan's premium and the benchmark plan. A larger difference between a plan's bid and the benchmark would result in a larger share of the plan's enrollees switching plans. For example, if Plan A's premium was $10 higher than the benchmark and 20 percent of beneficiaries in the county were enrolled in Plan A, applying an elasticity equal to "a 3.5 percentage point decrease in a plan's market share per $10 increase in premiums from the benchmark" would result in Plan A's market share declining to 16.5 percent (20 percent minus 3.5 percent) with 3.5 percent of beneficiaries in the county moving from Plan A to the benchmark plan.

Unfortunately, the elasticities derived from these studies cannot be readily applied to an analysis of beneficiary switching behavior in a premium support environment for three reasons. First, as noted above, the studies are either not recent or not directly applicable to a Medicare premium support system. Second, these elasticities provide guidance for switching beneficiaries from a higher premium plan when lower premium plans are available, but it is not clear how to assign beneficiaries to one of the various lower-premium plans offered in the area.[xiii] Third, the elasticities do not reflect geographic variations in the share of beneficiaries willing to pay

[xiii] Beneficiary choice models typically switch individuals from one plan to another, based on relative premiums, but this model has multiple plans in a given market. One possible solution would be to create a microsimulation model with individual-level characteristics (such as health status, income, and source of supplemental coverage) that would be important determinants of plan choice in this population, and have the model select the optimal plan choice for each

additional premiums for their health coverage.[xiv] This geographic variation in the share of beneficiaries paying additional premiums, and the amount they are willing to pay, suggests that the "sticker shock" of higher premium plans may be more attenuated in some parts of the country than in others.

- ***Sensitivity Testing*.** Given the lack of strong evidence upon which to base beneficiary switching decisions, the base case analysis builds on beneficiaries' current plan choices, rather than assume some share shift plans, consistent with the approach taken by Feldman et al. and Song et al. We then illustrate through sensitivity analyses how these results could vary, under alternative assumptions about beneficiaries' willingness to change from a higher premium plan to a plan at the benchmark. In reality, beneficiaries could switch from a higher-premium plan to lower-premium plan above the benchmark (perhaps one offered by the same insurer) and still incur an additional premium for their Medicare benefits. By switching beneficiaries into plans at the benchmark, this assumption provides a conservative estimate for the share of beneficiaries who would pay additional premiums, and the share who would receive a rebate.

    - ***Low-Income Beneficiaries*.** The treatment of low-income beneficiaries in a premium support environment, including those dually-eligible for Medicare and Medicaid, will have important implications for premiums, plan choices, and ultimately patient care. If low-income beneficiaries could only receive subsidies if they enrolled in a low-cost benchmark plan in their county, and were automatically assigned to such a plan, then a smaller share of beneficiaries would pay higher premiums because some would be shifted from their current plan to a benchmark plan to receive low-income assistance.[xv] If low-income beneficiaries were not assigned to a benchmark plan, then some would likely face higher premiums, based on the current experiences of the low-income population in the Part D program.[29] Moreover, if full subsidies were limited to benchmark plans, low-income beneficiaries would often not be able to enroll in SNPs (assuming SNPs were still offered), unless they paid a higher premium. However, if low-income beneficiaries could receive premium subsidies for plans above the benchmark, federal costs would rise.[xvi]

      The base case for this analysis makes a policy assumption that low-income Medicare beneficiaries could only receive subsidies for plans at or below the benchmark, but also assumes that low-income beneficiaries would switch plans at the same rate as other beneficiaries. Given the likelihood that low-income beneficiaries would be more price-sensitive and could be switched into a benchmark plan in their area, we conducted a sensitivity test to examine the expected effects if all or more low-income beneficiaries shift from their current plan (traditional Medicare) to a low-cost benchmark plan to receive full subsidies. For this analysis, we use beneficiaries receiving low-income subsidies (LIS) under Part D in the traditional Medicare program, as a proxy for the share of beneficiaries who would be eligible for low-income subsidies under premium support proposals.

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beneficiary; however, county-level characteristics of beneficiaries are not available for this study. Another possible solution would be to repeatedly apply the elasticities, such that some beneficiaries move from a high-cost plan to a lower-cost plan, a share of whom would move to an even lower cost plan; however, the order in which beneficiaries are moved from one plan to another could arbitrarily change the findings of the analysis.

[xiv] For example, 81% of Medicare Advantage enrollees in Massachusetts are paying more than $100 per month for a MA-PD plan, even though all have access to an MA-PD plan with no premium. For these beneficiaries, a somewhat modest increase in premiums may be insufficient to induce them to switch plans. In contrast, 87% of Medicare Advantage enrollees in Florida are enrolled in plans with no premium and a modest increase in premiums may induce them to switch plans.

[xv] In this case, the benchmark refers to the second least cost plan or traditional Medicare, and not the Part D benchmark.

[xvi] The June 2012 update of the Domenici-Rivlin Protect Medicare Act specifies that dual eligibles and other low-income beneficiaries would retain a choice between traditional Medicare or a private plan for no additional premium.

RESULTS

If a premium support system had been fully implemented in 2010 for all beneficiaries, with federal payments equal to the lesser of the second least expensive plan or traditional Medicare costs, in a county, and plans responded to new incentives by lowering their bids by 5 percent across-the-board, then the majority of beneficiaries would have faced higher Medicare premiums, unless they switched to a "benchmark" plan.[xvii]

The 'Base Case'.

The base case analysis shows that more than half (59%) of beneficiaries (25 million beneficiaries) would be subject to higher Medicare premiums, in addition to the Part B premium, assuming current plan preferences (**Exhibit 1**). Four in ten (40%) beneficiaries would pay the same amount or less, and 1 percent would receive a rebate as a result of enrolling in the lowest bidding plan, if they remained in the same plan.

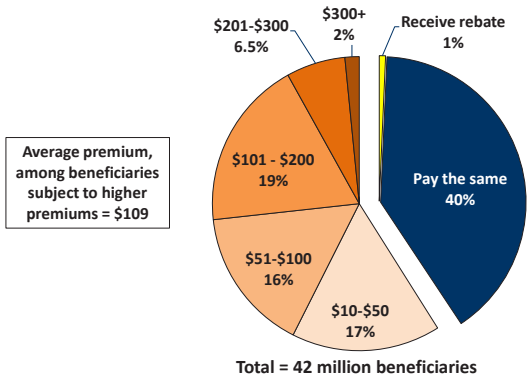
On average, beneficiaries subject to higher premiums would pay $109 per month ($1,308 per year) in additional premiums, assuming their current plan preferences. About 27 percent of beneficiaries would pay an additional $100 or more per month ($1,200 or more per year), 16 percent would pay an additional $50 to $100 per month, and 17 percent would pay an additional $10 to $50 per month, if they remained in the same plan.

Among beneficiaries enrolled in traditional Medicare, slightly more than half (53%) would be subject to higher Medicare premiums under the premium support system, $113 more on average per month, while about half (47%) would not (**Exhibit 2**).

EXHIBIT 1

Projected share of all Medicare beneficiaries subject to higher monthly premiums, if they remain in the same plan

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan



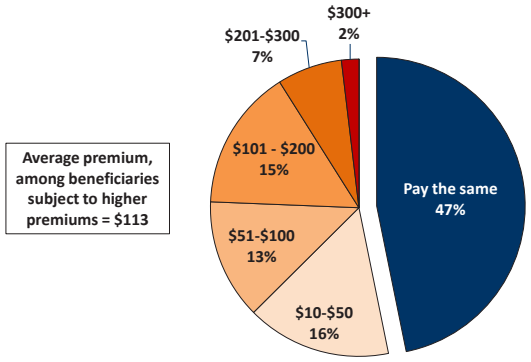
Total = 42 million beneficiaries

NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

EXHIBIT 2

Projected share of beneficiaries in traditional Medicare subject to higher premiums, if they remain in the same plan

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan



Total = 35 million beneficiaries

NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

The majority of traditional Medicare enrollees would pay an additional premium because most traditional Medicare enrollees live in counties in which traditional Medicare costs are higher than the second lowest private plan bid. About 24 percent of traditional Medicare enrollees would pay an additional $100 or more per month in Medicare premiums, 13 percent would pay an additional $50 to $100 per month, and 16 percent would pay an additional $10 to $50 per month, for traditional Medicare. Beneficiaries enrolled in traditional Medicare could not qualify for rebates.

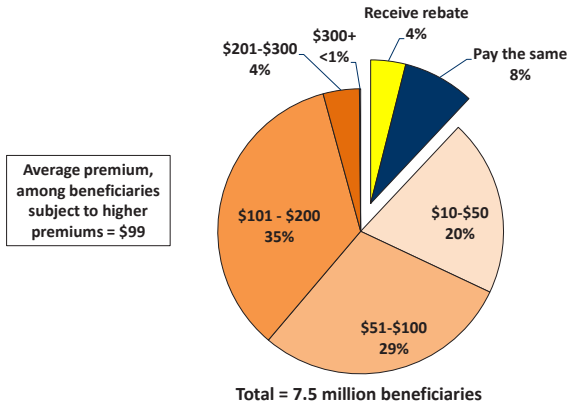
[xvii] Beneficiaries subject to a nominal premium increase (less than $10) were designated as having no change in Medicare premiums. If included with all other beneficiaries subject to a premium increase, the average increase would be $104 instead of $109.

Among beneficiaries currently enrolled in private plans, the vast majority (88%) would be subject to higher premiums, 12 percent (about 1 million beneficiaries) would pay the same or less, including 4 percent who would receive a rebate as a result of enrolling in the lowest bidding plan – assuming current plan preferences (**Exhibit 3**). On average, private plan enrollees subject to higher premiums would pay an additional $99 more per month, if they remained in the same plan. Nearly four in ten (39%) private plan enrollees would pay an additional $100 or more per month, if they remained in the same plan, two in ten (20%) would pay an additional $10 to $50 per month and nearly three in ten (29%) would pay an additional $50 to $100 per month.

EXHIBIT 3

Projected share of Medicare beneficiaries in private plans subject to higher monthly premiums, if they remain in the same plan

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan



Total = 7.5 million beneficiaries

NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

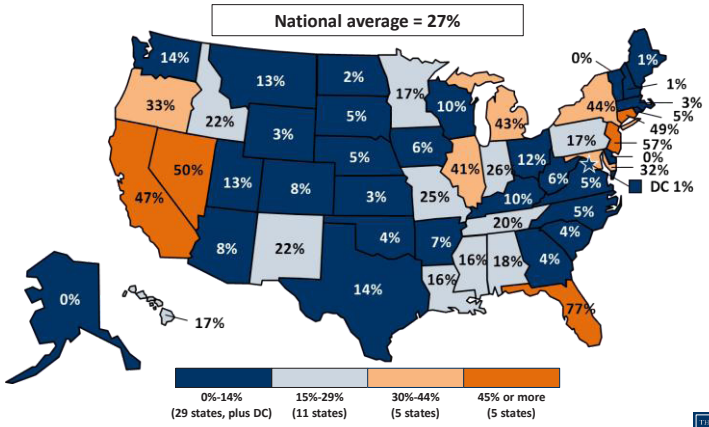
The majority of private plan enrollees would pay an additional premium if they did not switch plans because currently most beneficiaries in private plans are enrolled in plans with bids well above the lowest or second lowest bids in the county. Nationally, in 2010, only 8 percent of private plan enrollees were in a plan with either the lowest or second lowest bid in their county, ranging from an average of 10 percent of enrollees in high-cost counties to an average of 3 percent of enrollees in the low-cost counties. The vast majority of private plan enrollees (88%) is in plans with higher bids in the county and would pay an additional premium of at least $10, to remain in that same plan.

Variations by State. The share of beneficiaries who would be subject to higher premiums would vary greatly across states and counties, ranging from less than 2 percent of beneficiaries in the District of Columbia and Alaska to more than 90 percent of beneficiaries in 4 states (CT, FL, MA, and NJ). While more than one in four (27%) beneficiaries nationwide would be subject to additional premiums of $100 or more per month, this ranges from less than 14 percent of beneficiaries in 29 states and the District of Columbia, to more than 45 percent in 5 states (CA, CT, FL, NJ, and NV; **Exhibit 4**). At the extreme, half or more of beneficiaries in Florida (77%), Nevada (50%), and New Jersey (57%) would be subject to additional premiums of $100 or more per month, if they remained in the same plan.

EXHIBIT 4

Share of Medicare beneficiaries subject to additional premiums of $100 or more per month if they remain in the same plan, by state

Federal payments per enrollee, based on the lesser of Medicare FFS costs or the second least cost plan



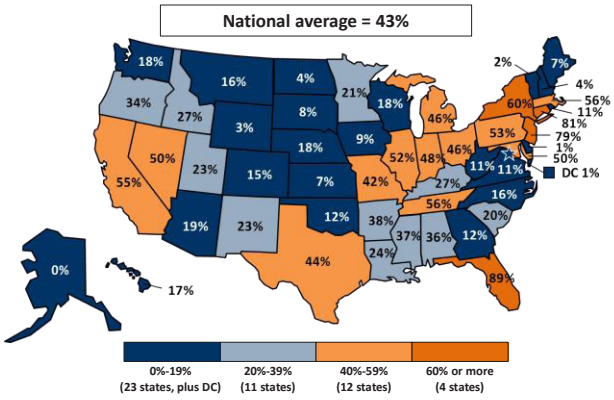
NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

While four in ten (43%) beneficiaries nationwide would be subject to additional premiums of $50 or more per month assuming they remained in the same plan, in 23 states and the District of Columbia, fewer than 20 percent of beneficiaries would be subject to additional premiums of $50 or more per month, including 6 states (AK, DE, ND, NH, VT, and WY) and the District of Columbia in which less 5 percent of beneficiaries would be subject to additional premiums of $50 or more per month (**Exhibit 5**). However, in 16 states, more than 40 percent of beneficiaries would be subject to additional premiums of $50 or more per month, including 4 states (CT, FL, NJ, and NY) in which more than 60 percent of beneficiaries would be subject to additional premiums of $50 or more per month. In Florida, the vast majority of beneficiaries (89%) would be subject to additional premiums of $50 or more per month, whereas in the District of Columbia, Delaware, and Alaska, less than 2 percent of beneficiaries would be subject to additional premiums of $50 or more per month.

EXHIBIT 5

Share of Medicare beneficiaries subject to additional premiums of $50 or more per month if they remain in the same plan, by state

Federal payments per enrollee, based on the lesser of Medicare FFS costs or the second least cost plan



NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

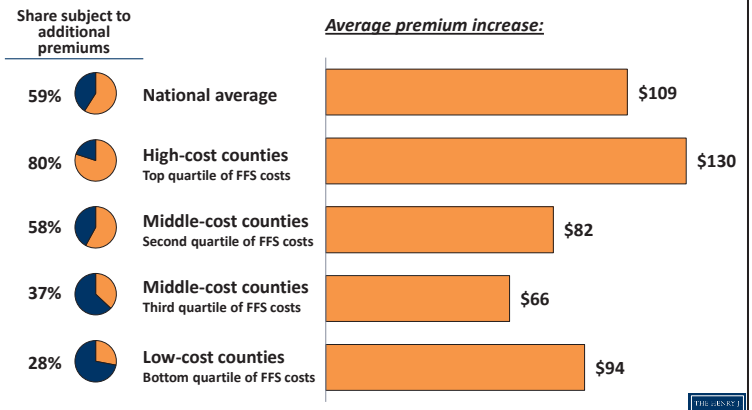
Variations by County. Ultimately, whether or not a large share of beneficiaries will be subject to higher or lower premiums depends on whether or not traditional Medicare would be a benchmark plan in the county, since most Medicare beneficiaries are enrolled in traditional Medicare. In this model, less than half (18 million) of Medicare beneficiaries are living in counties where traditional Medicare would be the benchmark plan, and 24 million beneficiaries are living in counties where private plans would be the benchmark plan. In general, the share of beneficiaries subject to higher premiums is larger in higher cost counties (that is, higher traditional Medicare costs) and smaller in the lower cost counties because in many of the high-cost counties, private plan costs are *lower* than traditional Medicare costs, and in most of the low-cost counties, private plan costs are *higher* than traditional Medicare costs.

In the highest cost counties, defined as counties in the top quartile of traditional Medicare spending per capita, 80 percent of beneficiaries would be subject to higher Medicare premiums, and these beneficiaries would pay an additional $130 per month, on average, if they remained in the same plan (**Exhibit 6**); most of the beneficiaries who would be subject to higher premiums are in traditional Medicare. In the counties in the second or third quartile of traditional Medicare spending per capita, that is the "middle-cost" counties, 58 percent and 37 percent of beneficiaries, respectively, would be subject to higher premiums, and these beneficiaries would pay an additional $82 per month and $66 per month, respectively, on average, if they remained in the same plan.

EXHIBIT 6

Average projected increase in monthly premiums for beneficiaries subject to an additional premium if they remain in the same plan, by counties' traditional Medicare costs

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan



NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

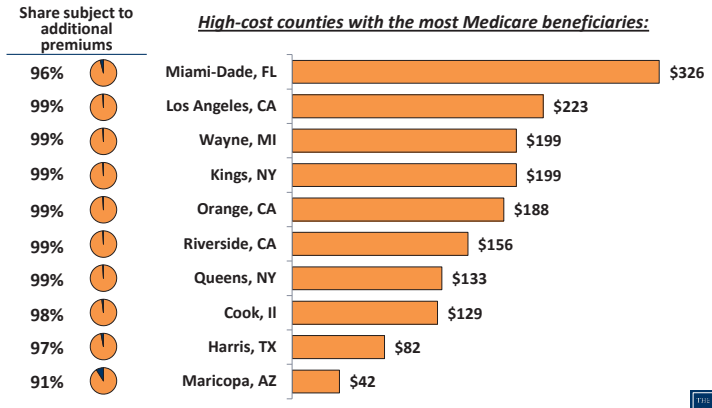
In the lowest cost counties, defined as counties in the bottom quartile of traditional Medicare spending, less than one-third (28%) of beneficiaries would be subject to higher premiums, and these beneficiaries would pay an additional $94 per month, on average, if they did not switch plans.

Counties with Large Numbers of Medicare Beneficiaries. Among the 10 high-cost counties with the most Medicare beneficiaries, each with more than 250,000 Medicare beneficiaries, the vast majority (more than 90%) of beneficiaries in each of the 10 counties would be subject to higher Medicare premiums (**Exhibit 7**). In several counties, beneficiaries would pay significantly more to stay in traditional Medicare, including Miami-Dade County, FL, Los Angeles County, CA, Kings County (including Brooklyn), NY, Wayne County (including Detroit), MI, Orange County, CA, and Riverside County, CA (for more details, see **Appendix Table 2**). In contrast, beneficiaries in Maricopa County (including Phoenix), AZ would pay significantly less to stay in traditional Medicare, and would be subject to lower additional premiums overall – $42 per month – compared to other high-cost counties.[xviii]

EXHIBIT 7

Average projected increase in monthly premiums for beneficiaries subject to an additional premium if they remained in the same plan, among high-cost counties

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan

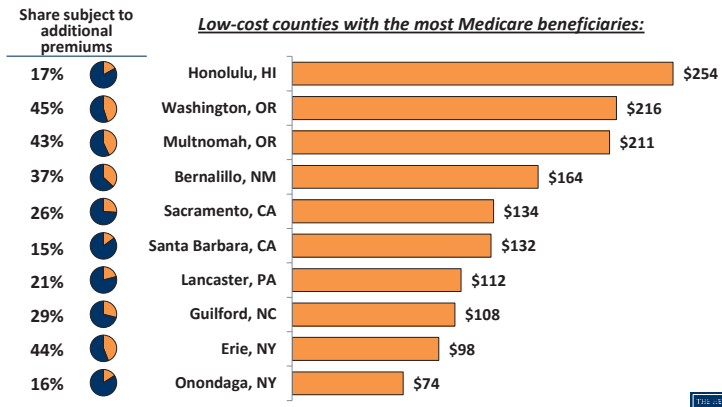


NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

EXHIBIT 8

Average projected increase in monthly premiums for beneficiaries subject to an additional premium if they remained in the same plan, among low-cost counties

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan



NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

In the 10 most populous low-cost counties, each with more than 55,000 Medicare beneficiaries, the majority of Medicare beneficiaries would not be subject to additional premiums because traditional Medicare costs are lower than all plan bids and most Medicare beneficiaries in these counties are in traditional Medicare (**Exhibit 8**). However, in some low-cost counties, the premiums for non-benchmark plans (private plans) would be very high. For example, in Honolulu County, HI, only 17 percent of Medicare beneficiaries would pay higher premiums to remain in their private plan, but these beneficiaries would pay an additional $254 in premiums per month, on average, in Medicare premiums to remain in their private plan. In Bernalillo County (including Albuquerque), NM, Multnomah County (including Portland), OR, Erie County (including Buffalo), NY and Washington County (including Hillsboro), OR, more than one-third of Medicare beneficiaries would pay higher premiums, unless they switched to traditional Medicare, because traditional Medicare costs are lower than all plan bids in the county, and a large share of Medicare beneficiaries in these counties are enrolled in private plans. In Multnomah County, OR and Washington County, OR, beneficiaries would pay an additional $211 and $216, respectively, in premiums per month, on average, if they remained in the same plan.

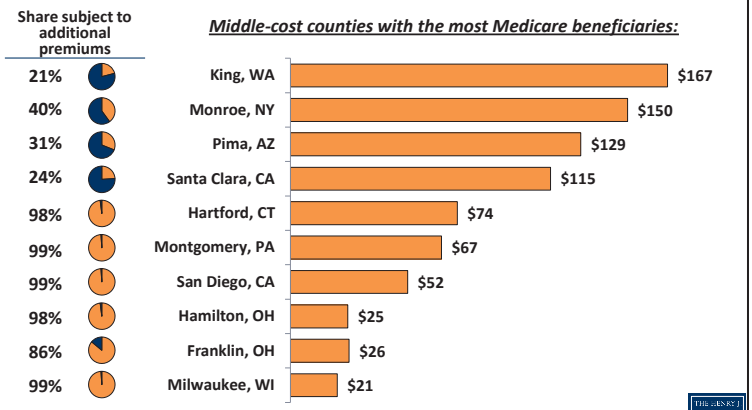
[xviii] A relatively small increase in premiums is projected in Maricopa County, AZ because the plans' bids and FFS Medicare costs are relatively close to each other.

In five of the ten most populous middle-cost counties (counties in the second and third quartile of traditional Medicare costs), at least 98 percent of Medicare beneficiaries would be subject to additional Medicare premiums; the average premium increase would be less than $75 per month in these counties (**Exhibit 9**). In other populous middle-cost counties, most Medicare beneficiaries would not be subject to additional premiums because the benchmark plan would be traditional Medicare; however, the minority of beneficiaries enrolled in private plans would pay more than $100 per month in additional premiums, on average, if they remained in the same private plan. For example, in King County (including Seattle), Washington, only 21 percent of beneficiaries would be subject to an additional premium, but on average these beneficiaries would pay $167 more per month, if they remained in the same private plan.

EXHIBIT 9

Average projected increase in monthly premiums for beneficiaries subject to an additional premium if they remained in the same plan, among middle-cost counties

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan

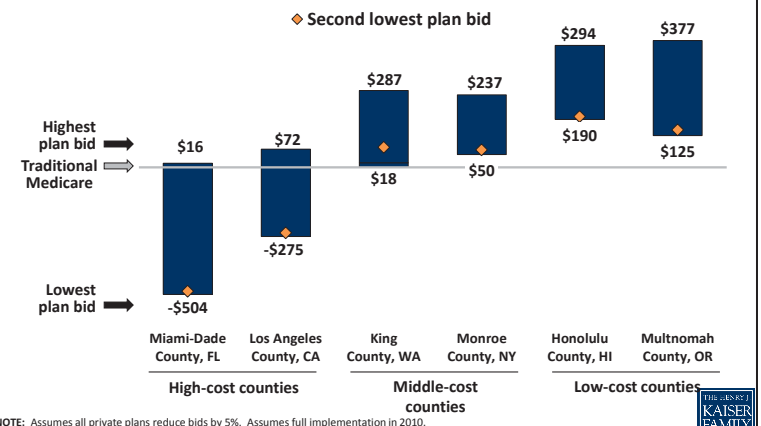


NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

Exhibit 10 helps to explain the variations across counties, based on current bidding practices relative to the costs of traditional Medicare. For example, in this model, most bids for private plans in Miami-Dade County, FL, a high-cost county, would be lower than the costs of traditional Medicare, ranging from more than $500 below traditional Medicare costs to $16 higher than traditional Medicare costs, and the second lowest plan bid (the benchmark plan) would be $492 lower than the costs of traditional Medicare. Thus, all traditional Medicare enrollees and most private plan enrollees in Miami-Dade County would be subject to additional Medicare premiums. In King County, WA, a middle-cost county, the bids for private plans would range from $18 higher to $287 higher than traditional Medicare costs in the county; traditional Medicare would be the benchmark plan in the county because the costs of traditional Medicare are lower than all plan bids, and all private plan enrollees in the county would be subject to additional Medicare premiums. Similarly, in Multnomah County in Oregon, a low-cost county, all private plan bids would be higher than traditional Medicare costs, ranging from $190 higher to $294 higher than traditional Medicare costs, and all private plan enrollees would be subject to additional Medicare premiums because traditional Medicare would be the benchmark plan.

EXHIBIT 10

Range in private plan bids relative to the costs of traditional Medicare, by county, 2010



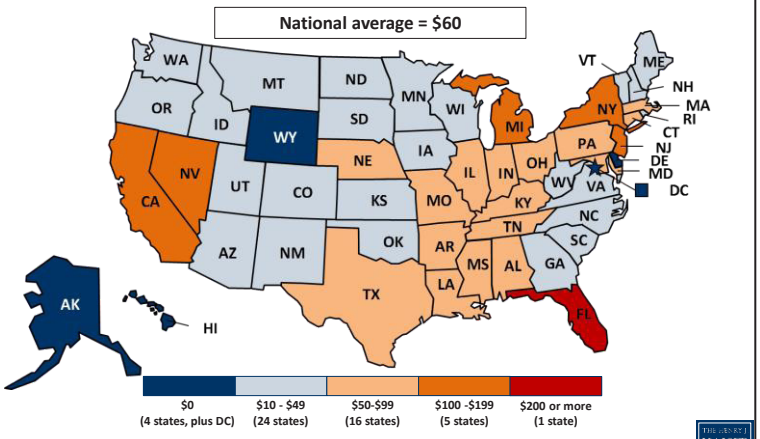
NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

Variations in Additional Medicare Premiums for Traditional Medicare. Currently, all beneficiaries with the same annual income pay the same premium for traditional Medicare. Premiums do not vary based on where beneficiaries live, regardless of whether they live in an area with relatively high traditional Medicare costs or an area with relatively low traditional Medicare costs. Under the modeled premium support approach, premiums for traditional Medicare would not be uniform and would vary across states and counties. On average, beneficiaries in traditional Medicare would be subject to additional premiums of $60 per month ($720 per year) to remain in traditional Medicare, ranging widely across states. In 4 states (AK, DE, HI, and WY) and the District of Columbia, premiums for traditional Medicare would not increase in any county because traditional Medicare would be the benchmark plan in every county in the state (**Exhibit 11**). In 24 states, average additional premiums for traditional Medicare would range from $10 to $49 per month and in 16 states, average additional premiums for traditional Medicare would range from $50 to $99 per month. At the extreme, in five states (CA, MI, NJ, NV, and NY), average additional premiums for traditional Medicare would range from $100 to $199 per month, and in one state, Florida, average additional premiums for traditional Medicare would exceed $200 per month.

EXHIBIT 11

Projected average additional monthly premium to remain in traditional Medicare, by state

Federal payments per enrollee, based on the lesser of Medicare FFS costs or the second least cost plan



NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

Examining the average additional premiums for traditional Medicare across states masks the large variations within some states. The average increase in premiums for traditional Medicare would be approximately $165 per month, but would be higher in some counties and lower in other counties. For example, beneficiaries in San Francisco and Sacramento would face no increase in premiums for traditional Medicare, while beneficiaries in Los Angeles County and Orange County would see premiums for traditional Medicare increase by more than $200 per month (see **Appendix Table 2**). In general, in counties with relatively high traditional Medicare spending, beneficiaries would need to pay more to remain in traditional Medicare, and in counties with relatively low traditional Medicare spending, beneficiaries would not be subject to an additional premium to remain in traditional Medicare.

Sensitivity Analyses.

As previously explained in the Methods section, there is great uncertainty about how firms would behave, how beneficiaries would react, and the details of how a premium support system would work. Therefore, we tested the sensitivity of our findings to several assumptions we made in the model, to understand how the findings may change under different assumptions. Specifically, we tested the sensitivity of the findings to the following model parameters:

- **Firm behavior**. The base case model assumes a 5 percent reduction in private plans' bids. We test alternative scenarios, ranging from reductions in bids of up to 25 percent to increases in bids of up to 25 percent, without changing any other parameters in the base case model.
- **Costs of traditional Medicare**. To assess the effects of lower traditional Medicare costs relative to private plan bids, we reduce traditional Medicare costs between 5 percent and 25 percent, without changing any other parameters in the base case model.
- **Individual behavior**. The base case model makes no assumptions with respect to plan switching. The sensitivity tests consider alternative assumptions by increasing the market share elasticity, from no change in market share (no plan switching) to a 3.5 percentage point decrease in a plan's market share per $10 increase in premiums from the benchmark (30% switch plans), without changing any other parameters in the base case model.
- **Treatment of low-income beneficiaries**. The base case model makes a policy assumption that low-income Medicare beneficiaries could only receive subsidies for benchmark plans, but also makes a behavioral assumption that low-income beneficiaries would switch plans at the same rate as other beneficiaries. We test the effect of switching all beneficiaries who are enrolled in traditional Medicare and receive low-income subsidies (LIS) under Part D into a benchmark plan, as a proxy for individuals who might be eligible for low-income premium assistance under a premium support system.
- **Combining changes in firm behavior and individual behavior**. The base case model assumes a 5 percent reduction in private plan bids and makes no assumptions with respect to plan switching. The sensitivity tests consider the effects of changing plan bids in conjunction with increases in the market share elasticity.
- **Treatment of IME, GME, and DSH**. The base case model excludes traditional Medicare costs associated with IME, GME, and DSH, and we test the effect of including these payments in the costs of traditional Medicare.

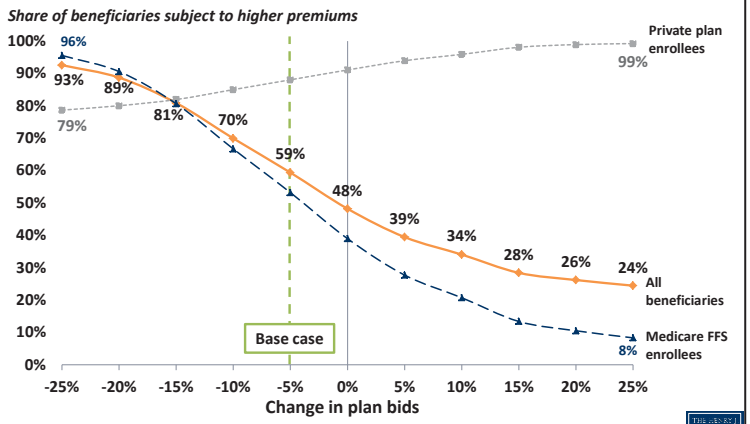
Firm Behavior. As previously discussed, some have hypothesized that the bids could decrease, as the market becomes more competitive, and price-competition among plans increases. Others have hypothesized that the private plan bids could increase because consolidations among providers could reduce private plans' leverage to negotiate lower provider payment rates. Others posit that insurers' bidding strategies will likely vary by market, based on the relative negotiating leverage of plans and providers. In this model, we examined the sensitivity of the findings to variations in private plans' bids under a range of scenarios from reductions in bids of 25 percent to increases in bids of 25 percent, without changing any other parameters in the base case model.

We examined the effects of alternate assumptions about insurers' bidding practices on premiums for Medicare benefits, relative to current practices. The sensitivity testing shows that changes in private plan bids (reductions or increases) can be expected to have a significant impact on the share of beneficiaries who would pay more or less for Medicare benefits, if they remained in their plan (**Exhibit 12; Appendix Table 3**). More specifically, as bids decrease relative to current practices, the share of beneficiaries subject to higher premiums increases, and as bids increase, the share of beneficiaries subject to higher premiums decreases. This may seem counter-intuitive because generally we would expect decreases in the prices of commodities to decrease how much people pay for that commodity. However, the results can be explained by a careful look at the distribution of beneficiaries, by plan bids and plan types, and across counties.

EXHIBIT 12

Illustrative effects of plan bidding behavior on beneficiary premiums, if beneficiaries remain in the same plans

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan



NOTE: Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

As private plans' bids decrease, traditional Medicare would be the benchmark plan in fewer counties because in more counties, private plan bids would be lower than traditional Medicare costs. As a result, as private plans' bids decrease by 25 percent, more traditional Medicare enrollees would be expected to be above the benchmark (and be subject to higher premiums), *increasing* from 53 percent (base case) to 96 percent, and a larger share of beneficiaries in traditional Medicare would be subject to $100 or more per month in additional Medicare premiums, increasing from 24 percent to 73 percent. Conversely, fewer private plan enrollees would be expected to be above the benchmark (and subject to higher premiums), *decreasing* from 88 percent (base case) to 79 percent, and a smaller share of private plan enrollees would be subject to $100 or more per month in additional Medicare premiums, decreasing from 39 percent to 13 percent, as the private plans' bids decrease by 25 percent. The effect on the total Medicare population is similar to the effect on beneficiaries enrolled in traditional Medicare because most beneficiaries are enrolled in traditional Medicare.

In this model, many private plan enrollees would continue to be subject to additional premiums even if bids decrease by 25 percent because nationally, only 8 percent of beneficiaries in private plans are enrolled in one of the two lowest-bidding plans, with some variation by county. All other private plan enrollees would continue to be subject to additional premiums, if they remained in the same plan. Consequently, a reduction in private plans' bids has little effect on the share of private plan enrollees who would be subject to higher premiums.

As private plans' bids increase, traditional Medicare would be the benchmark plan in more counties because in more counties, traditional Medicare costs would be lower than all private plan bids. Thus, as private plans' bids increase by 25 percent, fewer traditional Medicare enrollees would be expected to be above the benchmark and be subject to higher premiums, *decreasing* from 53 percent to 8 percent, and the share of traditional Medicare enrollees who would be subject to $100 or more per month in additional premiums would decrease from 24 percent to 3 percent. Conversely, as private plans' bids increase by 25 percent, private plans would be the benchmark in fewer counties, and more private plan enrollees would be expected to be in plans above the benchmark (and subject to higher premiums), *increasing* from 88 percent to 99 percent, and the share of private plan enrollees who would be subject to $100 or more per month in additional premiums would increase from 39 percent to 94 percent.

These sensitivity analyses did not account for variations across markets that could occur, depending upon local market conditions and plan strategy, nor the possibility that a plan might enter the market with a relatively low bid to capture market share, as has been seen in the Medicare Part D program. In the modeled premium support approach, a single plan with a very low bid would not change the benchmark, because the benchmark would be equal to the second lowest cost plan or traditional Medicare, whichever is lower. However, if multiple plans in a county were to submit bids that were lower than true costs initially, attract many enrollees, and then increase their bids over time, this could cause disruptions in the market with large shifts in the benchmark plan from one year to the next. Such shifts in the market, if permitted, would make premiums and plan choices more unpredictable.

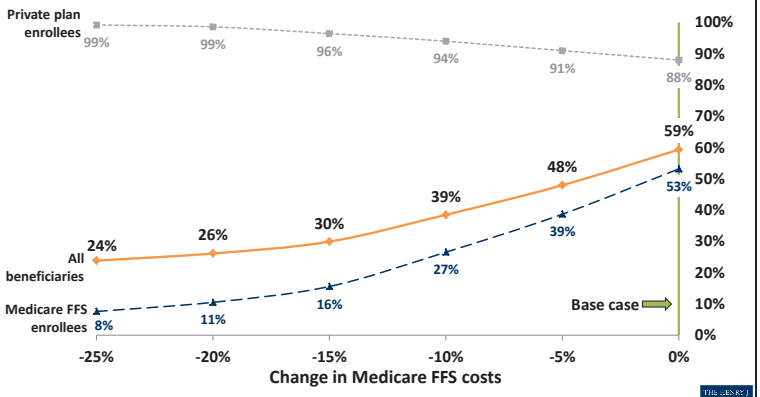
Costs of Traditional Medicare. The relative costs of traditional Medicare are projected by CBO to decrease over the next decade, due to reductions in Medicare spending resulting from the ACA. Our sensitivity analysis shows that reductions in traditional Medicare costs results in fewer Medicare beneficiaries who would be subject to higher premiums **(Exhibit 13)**. If we assume a 10 percent reduction in traditional Medicare costs across the board, the share of beneficiaries who would be subject to higher premiums would be expected to decrease from 59 percent (base case) to 39 percent, and the share of beneficiaries who would be subject to additional premiums of $100 or more per month would decrease from 27 percent to 19 percent. This would occur because traditional Medicare would become the benchmark plan in more counties. The effect of decreasing traditional Medicare costs is similar to the effect of increasing private plans' bids. Among beneficiaries enrolled in traditional Medicare, the share that would be expected to pay higher premiums, due to lower traditional Medicare costs, would decrease from 53 percent to 8 percent because traditional Medicare would become the benchmark plan in more counties. In contrast, among beneficiaries enrolled in private plans, the share that would be expected to pay higher premiums increases from 88 percent to 99 percent, similar to the effect of increasing private plans' bids, because private plans would be the benchmark plan in fewer counties.

EXHIBIT 13

Illustrative effects of reductions in traditional Medicare costs, if beneficiaries remain in the same plans

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan

Share of beneficiaries subject to higher premiums



NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

Individual Behavior. Under a premium support system, beneficiaries would face financial incentives to select lower premium plans, and beneficiaries in some parts of the country could see a large range in premiums for plans available in their county. At the same time, many beneficiaries may choose to remain in their current plan and pay an additional premium for many reasons. For example, beneficiaries may be reluctant to change plans if it means they would need to switch doctors, beneficiaries may feel satisfied with and loyal to their current plan, or beneficiaries may not be aware that they can switch plans to decrease their premiums. One way of quantifying people's sensitivity to changes in premiums is to use a market share elasticity: the change in a plan's market share (percent of enrollment) that results from a difference between the plan's premium and the benchmark. A larger difference between a plan's bid and the benchmark would result in a larger share of the plan's enrollees switching plans.

In this model, we examined the sensitivity of the findings to variations in beneficiaries' price sensitivity under a range of scenarios, increasing the elasticity from no change in market share (zero plan switching) to a 3.5

percentage point decrease in market share per $10 increase in premiums from the benchmark;[xix] we did not change any other parameters in the base case model. Beneficiaries were only switched from a higher premium plan to a plan at the benchmark because we had no basis for allocating switchers to alternative plans offered in the area; this approach is highly conservative and likely to understate the share of beneficiaries who would pay additional Medicare premiums, and the average premiums they would pay. In reality, beneficiaries could switch from a higher-premium plan to a lower-premium, non-benchmark plan and still incur an additional premium for their Medicare benefits.

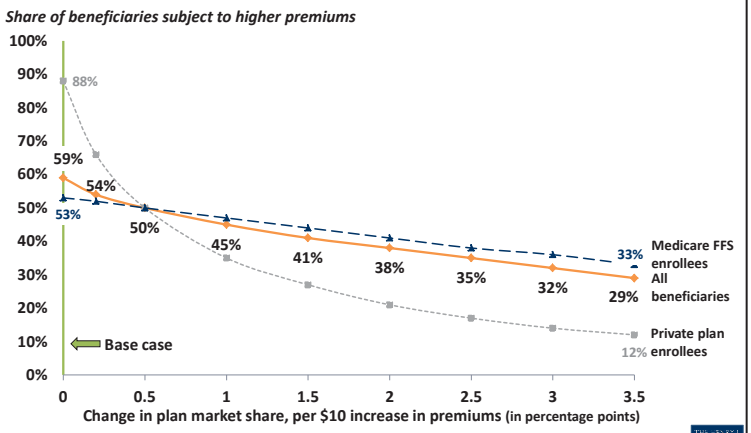
To simulate this shift in enrollees, the premiums for all private plan bids and traditional Medicare costs in a county were compared to the county benchmark, and, for each $10 difference in premiums between the benchmark and plans with bids above the benchmark, the market share for each plan above the benchmark was decreased, and the market share of the benchmark plan was increased accordingly.

Our sensitivity analysis shows that the share of total beneficiaries subject to higher premiums declines somewhat linearly as the elasticity increases (**Exhibit 14; Appendix Table 4**). As the elasticity increased to a 3.5 percentage point decline in market share per $10 difference in premiums (from no plan switching), the share of beneficiaries paying higher premiums decreased from 59 percent to 29 percent, and the share of beneficiaries subject to $100 or more in additional premiums decreased from 27 percent to 8 percent. We did not apply different elasticities to beneficiaries enrolled in traditional Medicare than to private plans enrollees, although some have suggested that beneficiaries in traditional Medicare may be less willing to switch plans than beneficiaries in private plans. However, the share of private plan enrollees who would pay higher premiums declined at a faster rate compared to the share of traditional Medicare enrollees who would pay higher premiums. This difference occurs because in the majority of counties, most private plan enrollees would be initially enrolled in plans with bids above traditional Medicare costs, and thus a larger share of private plan enrollees than traditional Medicare enrollees would move into benchmark plans, even if the benchmark is lower than traditional Medicare costs in the county.

EXHIBIT 14

Illustrative effects of beneficiary switching behavior on premiums

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan



NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

These sensitivity analyses do not account for individual-specific factors that could affect the propensity of individuals to switch plans. A microsimulation model with individual-level characteristics (such as health status, income, and source of supplemental coverage) would be able to more accurately vary plan switching decisions by individual-specific factors, and may be an important area for future research on premium support, given the large variation in beneficiary characteristics across counties. Unfortunately, this analysis could not build a microsimulation model because county-level characteristics of beneficiaries were not available for this analysis.

[xix] The upper range of these elasticities is larger than the elasticities found in the relevant literature. Buchmueller et al. found that for every $10 increase in premiums for retiree health plans, the plan's market share would decrease between 2 and 3 percentage points. See Buchmueller, Thomas C., Kyle Grazier, Richard A. Hirth and Edward N. Okeke. "The Price Sensitivity of Medicare Beneficiaries: A Regression Discontinuity Approach." *Health Economics*, 2012.

Treatment of Low-Income Beneficiaries. Our base case assumes that low-income beneficiaries would switch plans at the same rate as other beneficiaries. We tested the effect of switching all low-income beneficiaries into a benchmark plan. To do this, we used, as a proxy, all low-income beneficiaries who are enrolled in traditional Medicare and receive low-income subsidies (LIS) under Part D. Our analysis is limited to LIS enrollees in the traditional program, and excludes those in private plans, because we are not able to identify LIS private plan enrollees in the datasets used for this model.

The sensitivity analysis shows that, if all Part D LIS enrollees in the traditional Medicare program (our proxy for low income beneficiaries who would be eligible for premium subsidies under a premium support system) switched to a benchmark plan in their area, the share of Medicare beneficiaries who would pay an additional premium would decrease from 59 percent to 54 percent, all other things being equal. Among traditional Medicare enrollees, the share that would pay an additional premium would decrease from 53 percent to 46 percent. However, it should be noted that switching all low-income beneficiaries into a benchmark plan raises a number of issues that are beyond the scope of this analysis, including plan capacity and continuity of care arrangements. For example, the benchmark plans may not have the capacity to manage the care of all low-income beneficiaries, in addition to other beneficiaries. Further, since 45 percent of beneficiaries live in counties in which the only plans at or below the benchmark are HMOs, the benchmark plans may not include low-income beneficiaries' providers.

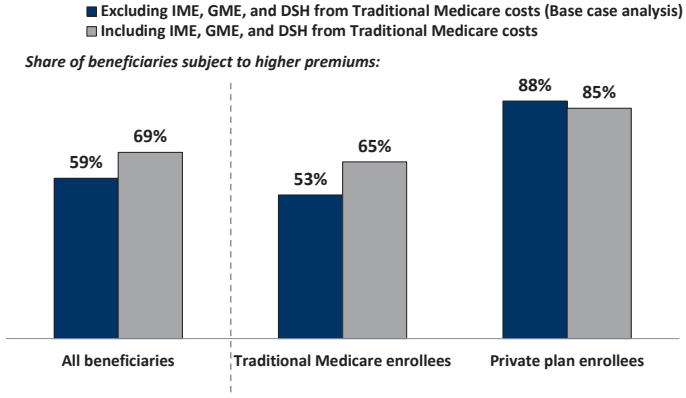
Combining Changes in Firm Behavior and Individual Behavior. When the changes in firm behavior are tested in conjunction with changes in individual behavior, the model results change greatly (**Appendix Table 5**). When private plan bids decrease, the share of beneficiaries who would be subject to higher premiums increases. Regardless of how the private plan bids change, if at all, increases in the market share elasticity would result in fewer beneficiaries subject to higher premiums. Plan switching appears to attenuate the effect of private plan bids increasing or decreasing. For instance, when the elasticity is increased from zero plan switching to a 2.0 percentage point decline in market share per $10 difference in premiums, a market share elasticity th4at has been observed in studies of retirees,[30] and the private plan bids decrease by 25 percent, the share of beneficiaries who would be subject to an additional premium decreases from 93 percent to 55 percent. This analysis shows that irrespective of how much private plan bids change, the extent to which beneficiaries would be attuned to the annual changes in the plan premiums, and would be willing to change plans (perhaps also change their doctors) would play a large role in the share of beneficiaries who would be subject to additional premiums and how much they would pay.

Treatment of IME, GME, and DSH. Proposals have not specified as to whether IME, GME, and DSH payments would be included in the costs of traditional Medicare. The decision to include or exclude these payments is important because it greatly affects traditional Medicare costs in certain areas, particularly areas with large teaching hospitals. Including these payments in the costs of traditional Medicare would increase traditional Medicare costs relative to private plans' bids. Our sensitivity analysis shows that if these payments were to be included in traditional Medicare costs, a larger share of beneficiaries would be expected to pay additional premiums, increasing from 59 percent to 69 percent of beneficiaries, if they remain in the same plans. Among traditional Medicare enrollees, the share that would be expected to pay additional premiums increases, from 53 percent to 65 percent, if they remain in the same plans. However, among private plan enrollees, the share that would be expected to pay additional premiums slightly decreases, from 88 percent to 85 percent (**Exhibit 15**), if they remain in the same plans. These findings result from the fact that as traditional Medicare costs increase with the inclusion of these payments, traditional Medicare would be the benchmark plan in fewer counties because in more counties, private plan bids would be lower than traditional Medicare costs, particularly in counties with large teaching hospitals.

EXHIBIT 15

Illustrative effects of the treatment of IME, GME, and DSH payments in traditional Medicare costs

Federal payments per enrollee, based on the lesser of traditional Medicare costs or the second least cost plan



NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012

Including IME, GME, and DSH payments in traditional Medicare costs increases the costs of traditional Medicare and would result in more beneficiaries being required to pay an additional Medicare premium to remain in traditional Medicare, raising questions of whether traditional Medicare would be able to compete on a level playing field with private plans. However, excluding these payments from the costs of traditional Medicare (our "base case") raises questions about how medical education and treatment of indigent patients would be funded under a premium support system.

LIMITATIONS

Few premium support proposals include detailed specifications needed to model the effects of a premium support proposal with a high degree of certainty. Thus, a number of policy assumptions were made to illustrate the likely effects for beneficiaries, and discussed in as transparent a manner as possible to allow readers to understand the impact of the assumptions. Still, a number of limitations are worth noting:

- **As previously noted, this study should not be construed as an analysis of a particular proposal.** To conduct the study, we made a number of policy assumptions that may or may not be consistent with the intent of premium support proposals. Due to the lack of specificity around key policy parameters, we made several policy assumptions needed for the analysis (e.g., definition of service area; treatment of IME and DSH; specific provisions for low-income beneficiaries). Our analysis departs from several leading proposals in that we assume all beneficiaries are covered under the new system as a device for illustrating how a premium support system would look when fully implemented. In contrast, leading premium support proposals tend to "grandfather" adults who are currently ages 55 and older and phase-in the program over several years.

- **This study focuses narrowly on the expected effects of a premium support system on beneficiaries' Medicare premiums – an approach that excludes the effects of changes in benefits, cost-sharing requirements and premiums for supplemental insurance.** Our approach is similar to the one used by Feldman et al. (2012) and Song et al. (2012) but is less comprehensive than the approach taken by CBO in its analysis of Paul Ryan's budget proposal entitled "The Pathway to Prosperity" in March 2011, which included premiums for supplemental coverage and Part D, and out-of-pocket costs for services covered under Parts A, B and D. Our analysis does not account for increases in out-of-pocket costs that would occur if private plans scale back extra benefits in response to stronger incentives to reduce their bids. Further, this study does not take into account the possibility that some additional beneficiaries may incur premiums for supplemental insurance. Throughout the report, we focus on Medicare premiums that beneficiaries would pay to remain in their same plan, without accounting for additional costs they may incur if their plan reduces extra benefits. In 2010, the value of these extra benefits for Medicare Advantage enrollees was about $76 per person per month (over $900 per person per year).

- **This study models the effects of a premium support system in a given year, but not the expected costs for beneficiaries over the longer term, including the effects of adverse selection for beneficiaries in traditional Medicare or the potential for Medicare spending caps to increase premiums for beneficiaries over time.** One concern that has been expressed about premium support is that over time, if sicker and more costly beneficiaries choose coverage under traditional Medicare, rather than private plans, then in the absence of adequate risk adjustment for payments to plans, premiums for beneficiaries who choose traditional Medicare will rise, leading to a potential "death spiral" for the traditional Medicare program. Further, our analysis does not consider the implications of caps on federal payments. For instance, if per capita costs for Medicare beneficiaries rise faster than the allowable growth rate (e.g., GDP+1), and if federal payments per enrollee are reduced to keep spending below the cap, then premiums for beneficiaries could rise over time.

- **This study does not examine the effects of a premium support system for beneficiaries with low-incomes, including dual-eligible beneficiaries who could also be affected by changes made to Medicaid, such as a Medicaid block grant.** This analysis does not dig deeply into the effects of premium support for low-income beneficiaries, primarily due to the lack of specificity in many proposals with respect to eligibility, benefits, and requirements pertaining to plan choice (e.g., whether low income beneficiaries could receive full premium and/or cost-sharing subsidies if they enrolled in a plan other than the least cost plan in their area, including traditional Medicare). Many proposals do not specify whether low-income beneficiaries would be required to enroll in a benchmark plan to receive full subsidies, or if they would be auto-assigned to the second least cost plan in the area. Given the large number of low-income beneficiaries on Medicare, such policy parameters have important implications for beneficiaries, both in terms of their costs, and also for the continuity of care they are able to receive one year to the next. Further, the analysis does not take into

account the interactive effects of a premium support system in conjunction with proposed changes to Medicaid, including a block grant and medical savings account (MSA), which could have significant implications for beneficiaries dually eligible for Medicare and Medicaid who today, account for about 20 percent of the Medicare population.

- **This study considers potential changes in plan behavior (changes in bids), but does not analyze the potential for insurers' responses to vary, based on local market conditions.** Consistent with CBO, our analysis assumes a five percent reduction in plan bids across the board, and considers the implications of lower or higher bids relative to traditional Medicare. We recognize, however, that this approach most likely oversimplifies plan behavior and fails to take into account the likelihood that bidding practices would likely vary depending on local market conditions. In some areas, plans may be able to lower their costs, while in other areas, their ability to lower costs may be more limited. Future research may wish to consider this in greater depth.

- **This study does not capture the nuances of beneficiaries' plan switching behavior and only allows for beneficiaries to switch into a benchmark plan, rather than a plan that is less expensive than their current plan, but is not a benchmark plan.** The analysis considers alternative scenarios with respect to plan choices made by beneficiaries. As explained more thoroughly in the methodology, we use elasticities derived from the literature to illustrate the effects of beneficiaries switching from a plan with a relatively high additional premium to a plan in which they would not be required to pay an additional premium. For this purpose, individuals are switched to a benchmark plan, because we have no theoretical basis for switching beneficiaries to any other plan, either higher or lower than the benchmark plan.

- **This study assumes all individuals who would be entitled to Medicare would be enrolled in a premium support system, with 100 percent participation, without considering the implications if a share of beneficiaries do not enroll in a premium support plan.** Sponsors of leading premium support proposals suggest that the marketplace would function similarly to health insurance exchanges established under the Affordable Care Act of 2010. Proposals do not indicate whether individuals would be required to be enrolled in a plan (essentially a mandate), whether they would be assigned to a plan, or whether traditional Medicare would be the "default" if they did not enroll in a plan on their own. We assumed 100 percent participation and use beneficiaries' current enrollment choices as a framework for the analysis. Without requirements for enrollment, and full participation, there is some risk that younger and healthier beneficiaries would delay enrollment, changing the dynamics and potentially increasing premiums and other costs for other beneficiaries.

- **This study does not consider whether benchmark plans (if not traditional Medicare) would have sufficient capacity to serve all potential enrollees.** This study found that only 8 percent of private plan enrollees are in the plans with either the lowest or second lowest bids in the county, ranging from an average of 10 percent of enrollees in high-cost counties to an average of 3 percent of enrollees in the low-cost counties, suggesting that enrollment in the lowest bidding plans could greatly increase in a premium support system. However, it is not known whether these plans would be able to sufficiently expand their networks of providers and care management processes to meet the needs of all potential enrollees.

- **Finally, this analysis does not consider the effect of a premium support system for other payers, including the federal government, state governments (Medicaid), or employers.** The primary goal of a premium support system would be to control and decrease federal spending for the Medicare program. The costs for secondary payers, such as state Medicaid programs (for dual eligibles) and employers (for retirees), could also increase or decrease, depending on the structure of the program, and the benefits provided by the payer. This analysis only examines the effects of a premium support system on beneficiaries' premiums.

DISCUSSION

These findings underscore the potential for highly disparate effects of a premium support system for beneficiaries across the country. The results show how individual decision making (plan choices), coupled with geographical variations in the cost of traditional Medicare and the private health plans, would play a major role in determining how well beneficiaries fare with respect to premiums under this approach.

The study estimates that the majority (59%) of Medicare beneficiaries would be expected to face additional premiums, based on current plan preferences, under the modeled premium support system. Clearly, a smaller share of beneficiaries would pay higher premiums if they instead enrolled in a low-cost plan offered in their area. In high-cost areas, such as Miami and Los Angeles, most beneficiaries in the traditional Medicare program would see a significant increase in Medicare premiums, unless they opted to enroll in a lower-cost private plan. Conversely, in low-cost areas, such as Honolulu County in Hawaii and Multnomah County in Oregon (which includes Portland), the majority of beneficiaries would *not* pay additional premiums if they remained in their plan (based on current enrollment in that county), but a sizeable minority (17% and 43%, respectively) would pay at least $100 more in monthly premiums for their Medicare coverage in a private plan.

Further, this analysis shows that premiums for traditional Medicare would likely vary across states, and within states, by county. If this system had been fully implemented in 2010, some would have paid the same Medicare premium, while others would have paid an additional $200 more per month in Medicare premiums, not considering other additional costs beneficiaries could potentially face, such as cost-sharing requirements for benefits covered by the plan, the cost of benefits not covered by the plan, and premiums for supplemental insurance.

Under the modeled premium support system, beneficiaries would choose among a variety of health plans offered in their area, and could opt to enroll in a low-cost plan for their Medicare benefits without incurring higher Medicare premiums than under the current system, or in some cases, paying even less. If beneficiaries preferred another plan, however, for whatever reason, they would have the option to enroll in that plan and pay higher premiums. Some may see this as an appropriate way to structure a marketplace and constrain government spending, while maintaining federal payments to cover Medicare benefits (or their actuarial equivalent) for at least one plan offered in a given area. Others may have concerns about the implications for beneficiaries, particularly for those who are unable to afford the higher Medicare premiums for higher cost plans (either traditional Medicare or private plans).

Beneficiaries' preferences and plan choices are not purely driven by premiums, and some beneficiaries may not view the low-cost plan, whether a private plan or traditional Medicare, as optimal for meeting their individual needs and circumstances. Some beneficiaries may have a strong preference for a private plan, based on their past experience and comfort with known care arrangements, but, particularly in some parts of the country, may not be able to afford the higher premium to enroll in a private health plan. Others may have a strong preference for traditional Medicare because they highly value the ability to choose their own doctors or hospital, but depending on where they live, may not be able to afford higher premiums for coverage under the traditional Medicare program.

Beyond premiums, other factors could be considered in choosing a plan, which may or may not be consistent with the choice of a low-cost plan. First, enrolling in a low-cost plan, if it requires changing from another plan, may require beneficiaries to change their doctors and other health care providers, posing potential problems for beneficiaries with long-standing relationships with their doctors, especially those with chronic conditions. Second, some beneficiaries may value the option to enroll in a highly-rated plan, but quality is not a factor in

determining which plan is the benchmark plan. Third, low-cost plans in a given area may or may not have the capacity to accommodate all beneficiaries who wish to enroll in the plan. As an extreme example, in Los Angeles County, California, less than one percent of Medicare beneficiaries (less than 10,000) are currently enrolled in one of the two lowest cost plans, leaving more than 900,000 beneficiaries in other plans or traditional Medicare. Fourth, the low-cost plans offered in an area could change each year or so, as has occurred in the Medicare Part D program, potentially creating instability for beneficiaries with modest incomes who would have a strong financial incentive to remain in a low-cost plan each year.

Proposals to transform Medicare from its current structure to one based on premium supports can be expected to directly affect costs incurred by beneficiaries, with the effects dependent on numerous factors, including policy specifications, geography, local market conditions, firm strategy and beneficiary choices in this new environment. Increases in Medicare premiums under a premium support system *could* be tempered by modifications in policy parameters, but the tradeoff would likely mean increases in federal costs, which could undermine the primary goal of a premium support approach. If coupled with caps on the growth in Medicare spending, a premium support approach could make federal outlays for the Medicare program more predictable, but also increase costs and financial risks for beneficiaries over time. Given a lack of specificity about some of the key policy elements and questions about the likely response of the insurance industry and beneficiaries, there remains great uncertainty about the expected effects of this approach for elderly and disabled Americans in the future.

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APPENDIX

How This Study Differs From Other Recent Analyses

A few recent studies have also examined the effect of a premium support system on beneficiaries' out-of-pocket spending, with some important differences from this analysis (**Appendix Table 1**).

In April 2011, the CBO analyzed beneficiaries' out-of-pocket spending under Chairman Paul Ryan's budget proposal for FY2012, including beneficiary spending for Part D, Part B premiums, cost-sharing, and premium for supplemental insurance. CBO concluded that out-of-pocket spending for a typical 65-year old in 2022 would be $6,240 higher under the proposal.[xx] First, this Kaiser Family Foundation (KFF) analysis differs from the CBO analysis because it focuses exclusively on additional Medicare premiums for benefits covered under Parts A and B, rather than total premiums (including Part D and supplemental coverage) or total out-of-pocket costs (Parts A, B and D). Second, the CBO study examines a different approach to premium support, with different methods for determining federal payments per enrollee. The KFF analysis examines the effects of tying federal payments to the lesser of second lowest bid in an area or traditional Medicare costs, whereas the 2011 CBO estimate examined the effects of tying federal payments to Medicare per capita costs in 2011, trended forward based on a measure of inflation (CPI-U). Third, the KFF analysis assumes full implementation for all beneficiaries in 2010, whereas CBO assumes a phase-in for new enrollees beginning in 2022, consistent with Paul Ryan's FY2012 plan; therefore, the CBO analysis takes into account changes in Medicare payments to providers and other changes that occur following the enactment of the ACA. Fourth, the CBO analysis assumes private plan costs would be 28 percent higher than traditional Medicare for the same set of benefits in 2022, due to private plans' higher and more rapidly growing provider payments and administrative costs; the KFF analysis does not make this assumption, but rather tests the sensitivity of the findings to variations in plans' bids and traditional Medicare costs. Finally, the KFF analysis presents results in 2010 dollars, whereas the CBO analysis considers out-of-pocket costs for beneficiaries in 2022.

More recently, two additional studies have looked at the effects of premium support proposals on beneficiary premiums, one by Feldman et al. (February, 2012) and another by Song et al. (August, 2012).[xxi] Feldman et al. estimated the 25th percentile of private plan bids in 2009 (as a proxy for the second least cost plans), and found that 57 percent of beneficiaries (61 percent of traditional Medicare enrollees, and 94 percent of Medicare Advantage enrollees) would face additional premiums. Song et al. used actual plan bids from 2009 and found that 68 percent of traditional Medicare enrollees would face additional premiums and traditional Medicare enrollees would pay an average of $64 in additional premiums to stay in traditional Medicare. The KFF study takes a similar approach, and has broadly consistent findings. The KFF analysis differs from these two studies in the following ways: it uses more current data (2010); it assumes plan bids decline by 5 percent, consistent with CBO; it excludes payments for IME, GME, and DSH from traditional Medicare costs, which are included in the other papers; and it treats relatively modest premium increases of less than $10 per month as if they are not an increase. In contrast to the analysis by Feldman et al. and Song et al., this analysis tests the sensitivity of results to changes in firm behavior (bidding) and beneficiary response (plan switching), and considers the effect of changes in traditional Medicare costs.

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Appendix Table 1. Comparison of KFF analysis to other analyses of beneficiaries' spending under premium support proposals

	KFF analysis	CBO,[1] April 5, 2011	Feldman et al.,[2] February 2012	Song et al.,[3] August 2012
General Approach	Premium support payments tied to the lesser of the second lowest plan bid or traditional Medicare costs.	• Provide premium support payments for Medicare Parts A, B, and D to new beneficiaries, beginning in 2022. • Beneficiaries younger than age 65 in 2022 could enroll in a private plan; traditional Medicare program would not be an option. • Support payments equal to the average government contribution in 2022, increasing by CPI-U.	Analyzed Wyden-Ryan 2011 proposal, with premium support payments tied to the lesser of the second lowest plan bid or traditional Medicare costs (similar to KFF analysis).	Analyzed Wyden-Ryan 2011 proposal, with premium support payments tied to the lesser of the second lowest plan bid or traditional Medicare costs (similar to KFF analysis).
Year of implementation	Full implementation in 2010.	Phased-in, beginning in 2022.	Full implementation in 2009.	Full implementation in 2009.
Role of traditional Medicare	Traditional Medicare would remain an option.	Traditional Medicare would not be an option for beneficiaries receiving premium support payments.	Same as KFF analysis.	Same as KFF analysis.
Federal contribution	Premium support payments would be tied to the lesser of the second lowest bidding plan or traditional Medicare.	Premium support payments would be tied to a specified dollar amount.	Premium support payments would be tied to the lesser of the second lowest bidding plan or traditional Medicare.	Premium support payments would be tied to the lesser of the second lowest bidding plan or traditional Medicare.
Data year and source	Plan bids and traditional Medicare costs from CMS for 2010.	Plan bids and traditional Medicare costs in 2022.	Estimated private plan bids in 2009 using the 25th, 50th, and 75th percentiles of Medicare Advantage plans' bids by intervals of traditional Medicare spending, as included in a presentation by MedPAC in 2009; traditional Medicare costs from CMS.	Plan bids and traditional Medicare costs from CMS for 2006-2009.

	KFF analysis	CBO,[1] April 5, 2011	Feldman et al.,[2] February 2012	Song et al.,[3] August 2012
Change in plan bids or traditional Medicare costs due to competitive bidding	Base case analysis assumes plan bids would decrease by 5%; sensitivity analyses test alternative scenarios, ranging from reductions in bids of up to 25% to increases in bids of up to 25%.	Assumed traditional Medicare costs would be 28% less than the same benefits provided by a private plan in 2022, due to provider payments and administrative costs; projected that private plan costs would grow more rapidly over time than Medicare traditional costs.	No change assumed.	No change assumed.
Share of beneficiaries who switch plans	Base case analysis assumes beneficiaries remain in the same plan; sensitivity analyses consider alternative assumptions by increasing the market share elasticity, from no change in market share (no plan switching) to a 3.5 percentage point decrease in a plan's market share per $10 increase in premiums from the benchmark.	Not specified.	Assumed all beneficiaries remain in the same plan.	Assumed all beneficiaries remain in the same plan.
Special treatment of low-income beneficiaries	No special treatment in the base case; sensitivity analyses consider the effect of automatically enrolling all beneficiaries enrolled in traditional Medicare who receive low-income subsidies (LIS).	Provide medical savings accounts for beneficiaries who are dually eligible for Medicare and Medicaid or with incomes below 150 percent of FPL.	No special treatment of low-income beneficiaries.	No special treatment of low-income beneficiaries.
Scope of beneficiary spending included	Only includes spending for additional premiums for Part A and B services.	Included beneficiary spending for Part D, Part B premiums, cost-sharing, and premiums for supplemental insurance	Same as KFF analysis.	Same as KFF analysis.

	KFF analysis	CBO,[1] April 5, 2011	Feldman et al.,[2] February 2012	Song et al.,[3] August 2012
Treatment of IME, GME, and DSH payments	Excludes IME, GME, and DSH payments in traditional Medicare spending.	Not specified.	Included IME, GME, and DSH payments in traditional Medicare spending.	Not specified.
Employer Group Health Plans (EGHPs)	Excludes EGHPs.	Not specified.	Not specified.	Excluded EGHPs.
Special Needs Plans (SNPs)	Excludes SNPs.	Not specified.	Not specified.	Not specified.
Plans with low or no enrollment	Excludes plans with low or no enrollment.	Not specified.	Not specified.	Not specified.
De minimis increase in premiums	Excludes the first $10 in additional monthly premiums.	Included all premium increases.	Included all premium increases.	Included all premium increases.
Geographic variations	Examines geographic variations in the effects.	Did not examine geographic variations in the effects.	Similar to KFF analysis.	Did not examine geographic variations in the effects.
Sensitivity testing	Tests the sensitivity of the findings to key assumptions.	Did not test the sensitivity of the findings to key assumptions.	Did not test the sensitivity of the findings to key assumptions.	Did not test the sensitivity of the findings to key assumptions.

NOTE: In the CBO report titled "The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan," released in March 2012, the CBO concluded that Medicare spending under the revised Ryan proposal would be $2,200 higher for a typical 66-year old in 2030 (in 2011 dollars) compared to Medicare spending under the alternative fiscal scenario; however, the CBO analysis did not examine beneficiary spending under the proposal.

SOURCE: Kaiser Family Foundation, 2012.

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Appendix Table 2. Projected share of beneficiaries subject to additional premiums, and average increase in premiums, if they remain in the same plan, among counties with the most Medicare beneficiaries

County	State	Benchmark	Medicare enrollment	Projected share of beneficiaries who would pay additional premiums, if they remained in the same plan	Additional premium to remain in traditional Medicare (monthly)	Average additional premium to remain in private plans (monthly)
HIGH COST						
Los Angeles	CA	Private plans	1,145,113	99%	$260	$116
Cook	IL	Private plans	692,853	98%	$134	$38
Maricopa	AZ	Private plans	473,275	91%	$30	$73
Harris	TX	Private plans	369,288	97%	$85	$70
Orange	CA	Private plans	368,854	99%	$214	$130
Miami-Dade	FL	Private plans	363,385	96%	$492	$120
Kings	NY	Private plans	303,957	99%	$232	$88
Queens	NY	Private plans	291,863	99%	$152	$83
Wayne	MI	Private plans	286,939	99%	$211	$90
Riverside	CA	Private plans	266,731	99%	$161	$146
Palm Beach	FL	Private plans	251,458	99%	$371	$121
Broward	FL	Private plans	248,023	99%	$405	$168
Dallas	TX	Private plans	239,985	99%	$78	$104
Allegheny	PA	Private plans	233,468	91%	$109	$89
Suffolk	NY	Private plans	233,023	96%	$132	$47
New York	NY	Traditional Medicare	231,088	18%	$0	$105
Clark	NV	Private plans	229,992	81%	$113	$53
Philadelphia	PA	Private plans	225,240	99%	$25	$62
Cuyahoga	OH	Private plans	224,308	99%	$80	$37
Nassau	NY	Private plans	222,724	95%	$171	$42
MIDDLE COST						
San Diego	CA	Private plans	387,336	98%	$37	$83
King	WA	Traditional Medicare	232,153	21%	$0	$167
Santa Clara	CA	Traditional Medicare	208,706	24%	$0	$115
St. Louis	MO	Private plans	166,605	93%	$101	$105
Pima	AZ	Traditional Medicare	159,286	31%	$0	$129
Hartford	CT	Private plans	146,842	98%	$75	$66
Franklin	OH	Private plans	136,367	86%	$24	$43
Milwaukee	WI	Private plans	132,422	99%	$18	$35
Montgomery	PA	Private plans	129,298	98%	$54	$113
Hamilton	OH	Private plans	126,040	98%	$19	$46
Monroe	NY	Traditional Medicare	123,838	40%	$0	$150

County	State	Benchmark	Medicare enrollment	Projected share of beneficiaries who would pay additional premiums, if they remained in the same plan	Additional premium to remain in traditional Medicare (monthly)	Average additional premium to remain in private plans (monthly)
MIDDLE COST, CONTINUED						
San Francisco	CA	Traditional Medicare	122,585	22%	$0	$85
Jefferson	KY	Private plans	119,862	94%	$47	$80
Marion	IN	Private plans	117,798	99%	$102	$113
Polk	FL	Private plans	113,222	98%	$245	$130
Volusia	FL	Private plans	111,469	99%	$175	$112
Fresno	CA	Private plans	106,295	18%	Less than $10	$77
Fairfax	VA	Traditional Medicare	105,599	2%	$0	$190
Pierce	WA	Traditional Medicare	105,215	18%	$0	$134
Bucks	PA	Private plans	103,562	98%	$18	$80
LOW COST						
Sacramento	CA	Traditional Medicare	185,006	26%	$0	$134
Erie	NY	Traditional Medicare	172,370	44%	$0	$98
Honolulu	HI	Traditional Medicare	144,174	17%	$0	$254
Bernalillo	NM	Traditional Medicare	91,727	37%	$0	$164
Multnomah	OR	Traditional Medicare	91,361	43%	$0	$211
Lancaster	PA	Traditional Medicare	85,690	21%	$0	$112
Onondaga	NY	Private plans	78,732	16%	Less than $10	$74
Guilford	NC	Traditional Medicare	71,044	29%	$0	$108
Santa Barbara	CA	Traditional Medicare	60,792	15%	$0	$132
Washington	OR	Traditional Medicare	58,245	45%	$0	$216
Placer	CA	Traditional Medicare	57,807	33%	$0	$158
Clackamas	OR	Traditional Medicare	56,440	49%	$0	$229
Clark	WA	Traditional Medicare	56,321	41%	$0	$154
Yavapai	AZ	Traditional Medicare	54,904	16%	$0	$108
Polk	IA	Traditional Medicare	54,869	13%	$0	$161
Virginia Beach City	VA	Traditional Medicare	51,343	9%	$0	$90
Allen	IN	Traditional Medicare	50,090	30%	$0	$95
Albany	NY	Traditional Medicare	48,951	23%	$0	$93
Cumberland	ME	Traditional Medicare	47,574	10%	$0	$74
Marion	OR	Traditional Medicare	47,182	46%	$0	$196

NOTE: Enrollment from the CMS Medicare Advantage penetration file, March 2010, which includes all beneficiaries eligible for Medicare Advantage plans in the county. Study results applicable to beneficiaries in the premium support model, which excludes beneficiaries in EGHPs, SNPs, and low enrollment plans. Beneficiaries subject to a nominal premium increase (less than $10) were designated as having no change in premiums.
SOURCE: Kaiser Family Foundation, 2012.

Appendix Table 3. Projected share of beneficiaries subject to additional premiums, under alternative assumptions for private plan bidding behavior

Change in plan bids	Change in plan bids										
	← Decrease						Increase →				
	- 25%	- 20%	-15%	- 10%	- 5% Base case	No change	+5%	+10%	+15%	+20%	+25%
All beneficiaries	**93%**	**89%**	**81%**	**70%**	**59%**	**48%**	**39%**	**34%**	**28%**	**26%**	**24%**
Private plan enrollees	79%	80%	82%	85%	88%	91%	94%	96%	98%	99%	99%
Traditional Medicare enrollees	96%	91%	81%	67%	53%	39%	28%	21%	13%	11%	8%
Average premium, among beneficiaries subject to higher premiums	$164	$141	$125	$115	$109	$112	$122	$133	$161	$184	$210

NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012.

Appendix Table 4. Illustrative effects of beneficiary switching behavior on premiums

Change in market share (per $10 increase in premiums)	Percent switching plans	Percent subject to higher premiums			Average premium, among beneficiaries subject to higher premiums
		All beneficiaries	Beneficiaries in private plans	Beneficiaries in traditional Medicare	
Base Case					
0 percentage points	0%	59%	88%	53%	$109
Sensitivity Analyses					
0.2 percentage points	5%	54%	66%	52%	$107
0.5 percentage points	9%	50%	50%	50%	$107
1.0 percentage points	14%	45%	35%	47%	$106
1.5 percentage points	18%	41%	27%	44%	$106
2.0 percentage points	22%	38%	21%	41%	$104
2.5 percentage points	25%	35%	17%	38%	$99
3.0 percentage points	28%	32%	14%	36%	$95
3.5 percentage points	30%	29%	12%	33%	$92

NOTE: Assumes all private plans reduce bids by 5%. Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012.

Appendix Table 5. Projected share of beneficiaries subject to additional premiums, under alternative assumptions for private plan bidding behavior and beneficiary switching behavior

Change in market share, per $10 increase in premiums		Change in plan bids										
		← Decrease						Increase →				
		- 25%	- 20%	-15%	- 10%	- 5% Base case	No change	+5%	+10%	+15%	+20%	+25%
0 percentage points	**All beneficiaries**	**93%**	**89%**	**81%**	**70%**	**59%**	**48%**	**39%**	**34%**	**28%**	**26%**	**24%**
	Private plan enrollees	79%	80%	82%	85%	88%	91%	94%	96%	98%	99%	99%
	Traditional Medicare enrollees	96%	91%	81%	67%	53%	39%	28%	21%	13%	11%	8%
0.5 percentage points	**All beneficiaries**	**81%**	**78%**	**71%**	**60%**	**50%**	**39%**	**30%**	**24%**	**17%**	**15%**	**12%**
	Private plan enrollees	51%	51%	51%	51%	50%	48%	46%	42%	40%	36%	32%
	Traditional Medicare enrollees	87%	84%	75%	63%	50%	37%	26%	20%	13%	10%	8%
1.0 percentage points	**All beneficiaries**	**71%**	**70%**	**64%**	**55%**	**45%**	**34%**	**26%**	**20%**	**14%**	**11%**	**9%**
	Private plan enrollees	39%	38%	38%	37%	35%	33%	30%	26%	23%	19%	16%
	Traditional Medicare enrollees	78%	77%	70%	58%	47%	35%	25%	19%	12%	9%	7%
1.5 percentage points	**All beneficiaries**	**63%**	**63%**	**58%**	**50%**	**41%**	**31%**	**23%**	**18%**	**12%**	**9%**	**7%**
	Private plan enrollees	32%	31%	30%	29%	27%	24%	21%	17%	15%	11%	9%
	Traditional Medicare enrollees	70%	70%	64%	54%	44%	33%	23%	18%	11%	9%	7%
2.0 percentage points	**All beneficiaries**	**55%**	**56%**	**53%**	**46%**	**38%**	**28%**	**21%**	**16%**	**10%**	**8%**	**6%**
	Private plan enrollees	26%	26%	25%	24%	21%	19%	15%	12%	10%	7%	5%
	Traditional Medicare enrollees	61%	63%	59%	50%	41%	30%	22%	16%	10%	8%	7%
2.5 percentage points	**All beneficiaries**	**47%**	**50%**	**48%**	**42%**	**35%**	**26%**	**19%**	**14%**	**9%**	**7%**	**6%**
	Private plan enrollees	22%	22%	21%	19%	17%	15%	12%	9%	7%	5%	3%
	Traditional Medicare enrollees	53%	56%	54%	46%	38%	28%	20%	15%	10%	8%	6%
3.0 percentage points	**All beneficiaries**	**41%**	**44%**	**43%**	**38%**	**32%**	**24%**	**17%**	**13%**	**8%**	**6%**	**5%**
	Private plan enrollees	19%	18%	18%	16%	14%	12%	9%	7%	5%	4%	2%
	Traditional Medicare enrollees	45%	50%	49%	43%	36%	26%	19%	14%	9%	7%	6%
3.5 percentage points	**All beneficiaries**	**35%**	**39%**	**39%**	**35%**	**29%**	**22%**	**16%**	**12%**	**7%**	**6%**	**5%**
	Private plan enrollees	17%	16%	15%	14%	12%	10%	7%	5%	4%	3%	1%
	Traditional Medicare enrollees	39%	44%	44%	39%	33%	25%	17%	13%	8%	7%	5%

NOTE: Assumes full implementation in 2010.
SOURCE: Kaiser Family Foundation, 2012.

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