*Advising the Congress on Medicare issues*

# Reforming Medicare's Benefit Design

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MEDPAC

# Medicare Payment Advisory Commission

- Independent, nonpartisan
- 17 national experts selected for expertise, not representation
- Appointed by Comptroller General for 3-year terms (can be reappointed)
- Make recommendations to the Congress and the Secretary of HHS
- Vote on recommendations in public

# Need to improve value in Medicare

- Growth in per capita and total Medicare spending has been a persistent concern
- Beyond spending, the Commission has expressed concern about the value beneficiaries and tax payers obtain in the Medicare program
- FFS Medicare has traditionally rewarded volume and intensity, lacking tools to promote efficiency, quality, and care coordination; other limitations of FFS also hinder value

# MedPAC Approach to improving value

| | |
|---|---|
| **Payment accuracy and efficiency** | • Fiscal pressure on providers to constrain costs (e.g. rebase home health, rebase MA rates)<br>• Price accuracy for health care services (e.g. primary care bonus, site neutral payments)<br>• Measuring resource use |
| **Quality and care coordination** | • Care coordination models (ACOs, medical homes)<br>• Bundled payment for an episode of care<br>• Pay for performance<br>• Penalties for avoidable hospital readmissions |
| **Information for patients and providers** | • Public reporting of quality<br>• Comparative effectiveness<br>• Disclosure of physician financial relationships |
| **Aligned health care workforce** | • Incentives for residency programs that focus on quality, efficiency, and accountability<br>• Strategies for fueling the workforce pipeline |
| **Beneficiary Incentives** | • Benefit design<br>• Shared decision-making |

# Objectives for reforming Medicare's benefit design

- Reduce beneficiaries' exposure to risk of unexpectedly high out-of-pocket spending
- Require some cost sharing to discourage use of lower-value services
- Be mindful of effects on low-income beneficiaries and those in poor health

# Distribution of Medicare beneficiaries' cost-sharing liability, 2009

| Range of cost-sharing liability per beneficiary | Percent of FFS beneficiaries | Average amount of cost sharing liability per beneficiary |
|---|---|---|
| $0 | 6% | $0 |
| $1 to $135 (2009 Part B deductible) | 3% | $85 |
| $136 to $499 | 34% | $289 |
| $500 to $999 | 19% | $713 |
| $1000 to $1,999 | 16% | $1,456 |
| $2,000 to $4,999 | 16% | $3,048 |
| $5,000 to $9,999 | 4% | $6,869 |
| $10,000 or more | 2% | $15,536 |

Note: FFS (fee-for-service). Amounts reflect cost sharing under FFS Medicare—not what beneficiaries paid out of pocket. Most beneficiaries have secondary insurance that covers some or all of their Medicare cost sharing. Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year and not enrolled in private Medicare plans.
Source: MedPAC analysis based on data from CMS.

# Design issues

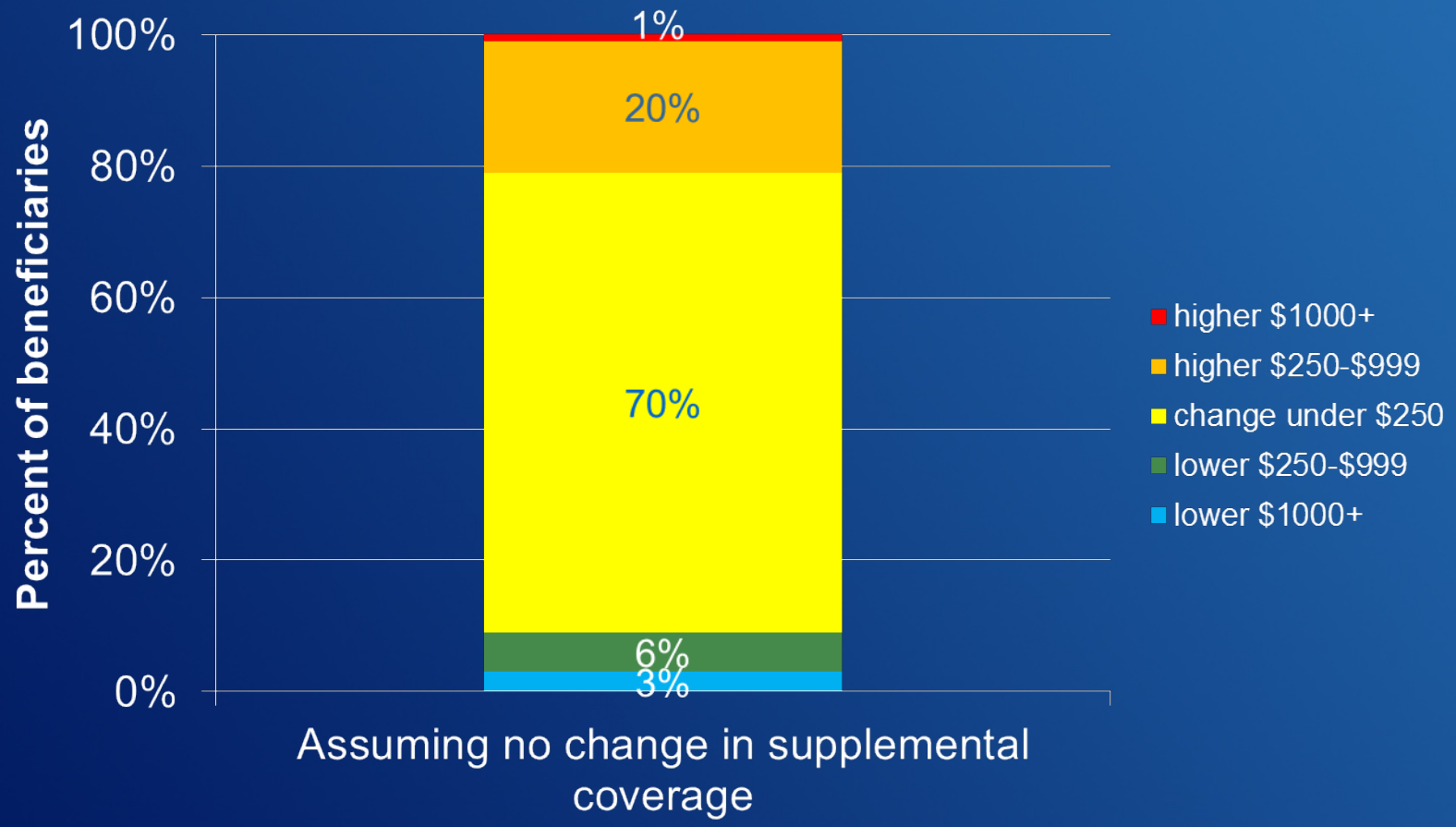
- Cost sharing
  - Out-of-pocket maximum
  - Deductible(s) for Part A and Part B services
  - Copayments for services
- Secretarial authority to alter or eliminate cost sharing based on the value of services
- Overall cost of the benefit design
  - Hold beneficiaries aggregate cost-sharing liability equal to current law
- Supplemental insurance
  - An additional charge on supplemental insurance

# Illustrative FFS benefit package

| Design elements | "Beneficiary-neutral" package |
|---|---|
| OOP maximum | $5000 |
| A & B deductible | $500 |
| Hospital (per stay) | $750 |
| Physician – PCP/specialist (per visit) | $20/$40 |
| Part B drugs | 20% |
| Advanced imaging (per study) | $100 |
| Outpatient (per visit) | $100 |
| SNF (per day) | $80 |
| DME | 20% |
| Hospice | 0% |
| Home health (per episode) | $150* |

Note: We modeled the $150 copayment considered by the Commission as 5% coinsurance on home health services for simplicity. The levels of cost sharing specified in the package are for illustrative purposes only.

# Changes in OOP spending under the illustrative package, 2009




Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year and not enrolled in private Medicare plans or Medicaid. OOP spending excludes Part B premiums.
Source: MedPAC based on data from CMS.

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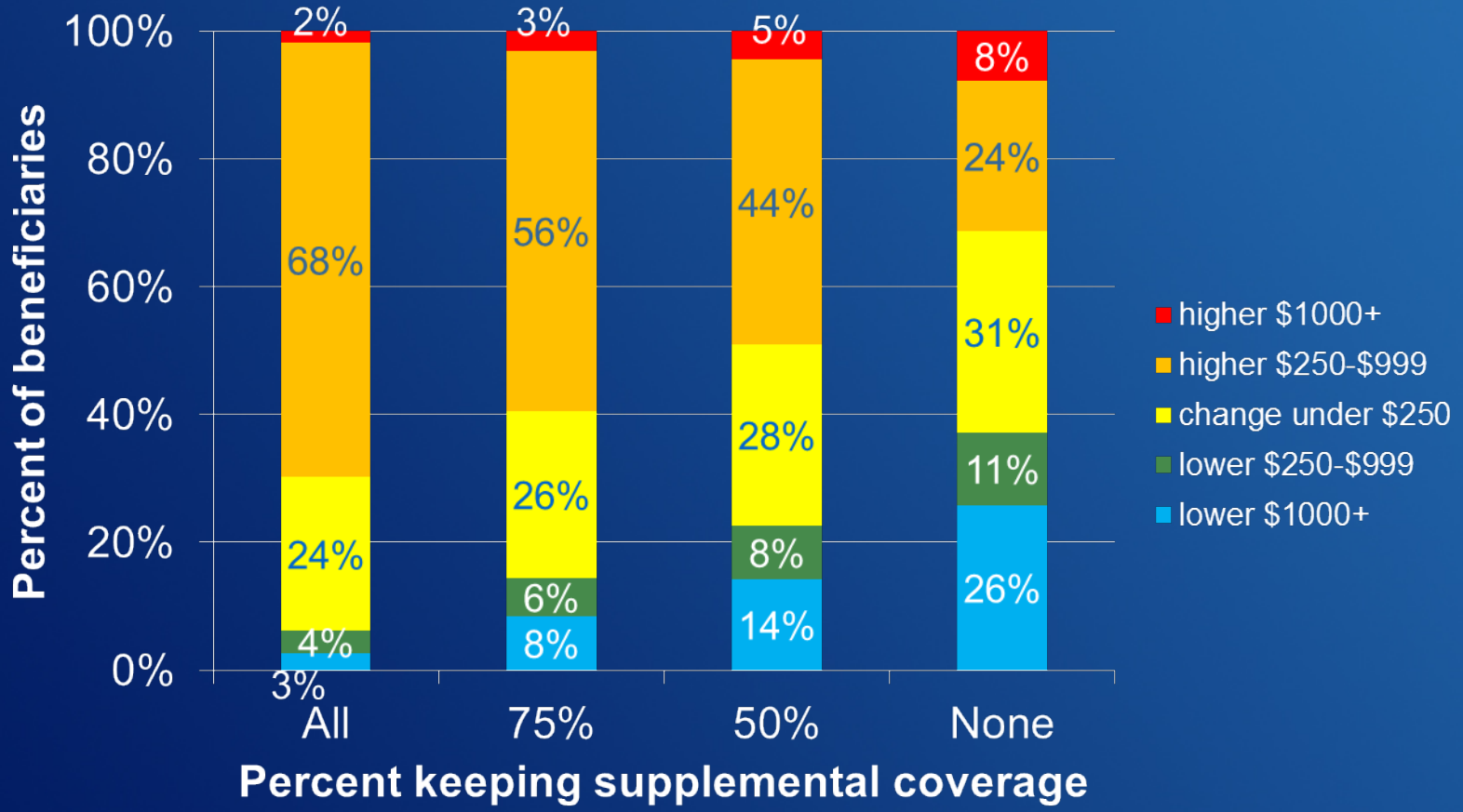
# Changes in OOP spending, supplemental premiums, and additional charge under the illustrative package, 2009




Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year and not enrolled in private Medicare plans or Medicaid. OOP spending excludes Part B premiums.
Source: MedPAC based on data from CMS.

# More beneficiaries would benefit from OOP maximum over time

| Percent of full-year FFS beneficiaries | 2009 | 2006-2009 |
|---|---|---|
| 1+ hospitalizations | 19% | 46% |
| 2+ hospitalizations | 7% | 19% |
| $5,000+ in annual cost-sharing liability | 6% | 13% |
| $10,000+ in annual cost-sharing liability | 2% | 4% |

Note: Includes beneficiaries who were enrolled in FFS Medicare for 4 full years, from 2006 to 2009. Excludes those who had any months of Medicare Advantage enrollment.

# Out-of-pocket maximum reduces the risk of high medical expenses, 2009

| | Average cost-sharing liability, 2009 | Standard deviation of cost-sharing liability, 2009 |
|---|---|---|
| Current law | $1,380 | $2,370 |
| Illustrative benefit package | $1,380 | $1,250 |

Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We estimated the cost-sharing liability in 2009 if the illustrative benefit package had been in place, compared with the actual cost-sharing liability in 2009.
Source: MedPAC analysis based on data from CMS.

# Illustrative benefit: budgetary effects

| Percent keeping supplemental coverage | Change in Medicare program spending in 2009 | 20% additional charge on supplemental insurance | Net change |
|---|---|---|---|
| All | +1.0% | -1.5% | -0.5% |
| 75% | 0.0% | -1.0% | -1.0% |
| 50% | -1.5% | -0.5% | -2.0% |
| None | -4.0% | 0.0% | -4.0% |

Note: Numbers are rounded to the nearest 0.5%.

Modeling assumptions:

- 1-year snapshot of relative changes using 2009 data
- No change in the status of dual-eligible beneficiaries (Medicaid is assumed to fill in any changes under the Medicare benefit package and keep their cost sharing the same as under current law)
- Specific set of behavior assumptions on use of services
- No change in medigap premiums in response to benefit changes in the illustrative package
- On supplemental coverage, simple assumptions of average premiums and additional charges equal to 20% of average premiums

# Recommendation (June 2012)

The Congress should direct the Secretary to develop and implement a FFS benefit design that would replace the current design and would include:

- an OOP maximum
- deductible(s) for Part A and Part B services
- replacing coinsurance with copayments that may vary by type of service and provider
- Secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the OOP maximum
- no change in beneficiaries' aggregate cost-sharing liability
- an additional charge on supplemental insurance

# Implications of the recommendation

| | Potential effects |
|---|---|
| Medicare program spending | • Savings depend on the ultimate benefit design |
| Beneficiaries | • Protect beneficiaries with very high spending<br>• Reduce the uncertainty of potentially very high spending<br>• Reduce both effective and ineffective care if the beneficiary's cost sharing were to increase<br>• Pay higher premiums on supplemental insurance due to the additional charge if beneficiaries keep supplemental coverage or move to less expensive Medigap plans<br>• OOP spending depends on whether beneficiaries keep supplemental coverage |
| Medigap plans | • Some beneficiaries might drop medigap coverage in response to the benefit change and additional charge |
| Employers offering retiree benefits | • Depends on what benefits are offered to active workers, how retiree benefits are coordinated with Medicare, and whether the additional charge might be subsidized |