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Rethinking Medicare Cost Sharing and Supplemental Coverage: What are the Implications?

National Health Policy Forum

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Exhibit 2

Traditional Medicare has a fairly complicated benefit design and no limit on out-of-pocket spending

Part A 	Part B 	Part D Standard benefit 
Deductible $1,184/spell of illness	**Deductible** $147/year	**Deductible** $325/year
Inpatient hospital No coinsurance, for days 1-60; $296/day, for days 61-90; $592/day, for days 91-150; No coverage after day 150	**Physician and other services** 20% coinsurance	**Initial coverage** 25% coinsurance (up to $2,970 in total drug costs)
Skilled nursing facility No coinsurance, for days 1-20; $148/day for days 21-100;	**Outpatient mental health** 35% coinsurance	**Coverage gap** 47.5% coinsurance for brands, 79% coinsurance for generics between $2,970 and $6,955 in total drug costs
Home health, hospice No coinsurance	**Annual “wellness” visit, clinical laboratory services, home health care** No coinsurance	
	Preventive services No coinsurance for many services, 20% for some	
No limit on cost-sharing for Part A services	**No limit on cost-sharing for Part B services**	**Catastrophic coverage** Minimum of $2.65/generic, $6.60/brand, or 5% coinsurance above $4,750 in out-of-pocket spending

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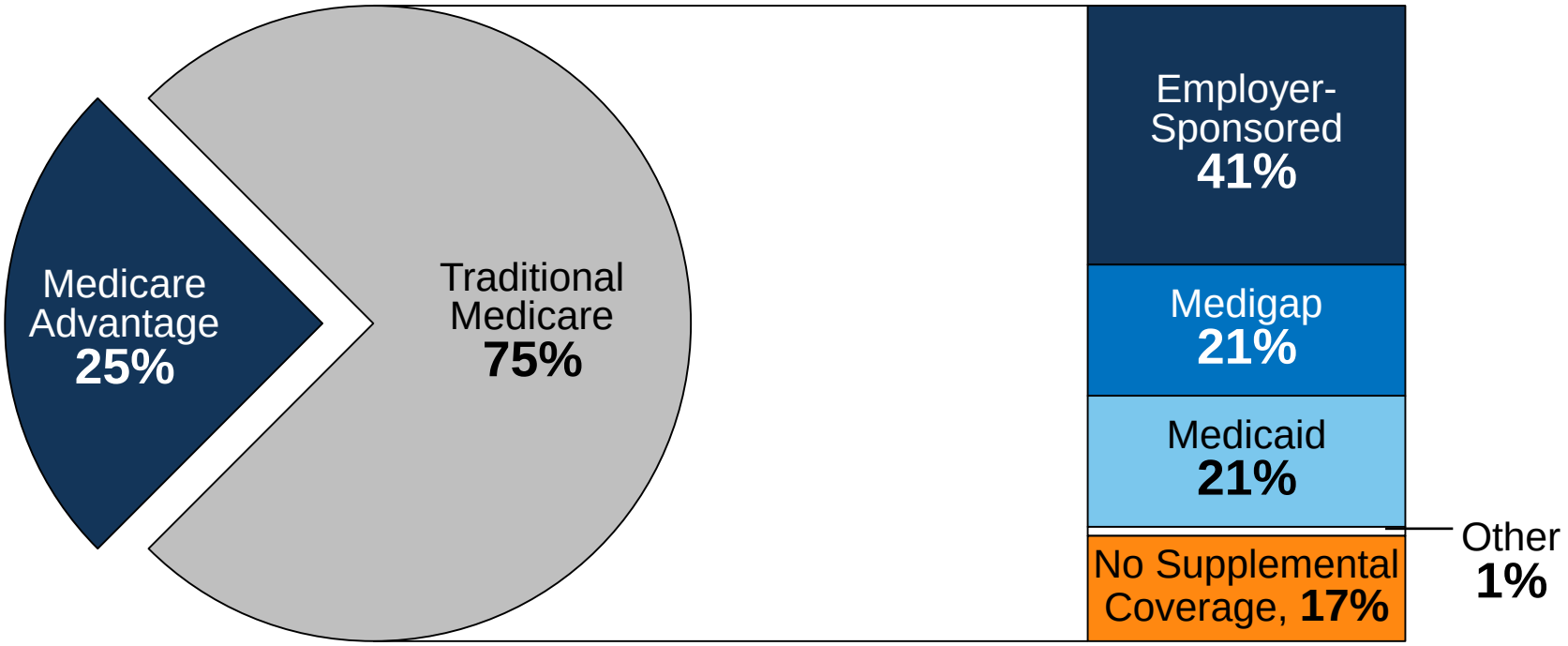
Exhibit 3

Most people in traditional Medicare have supplemental coverage to help cover Medicare's cost-sharing requirements



47 Million
total Medicare beneficiaries

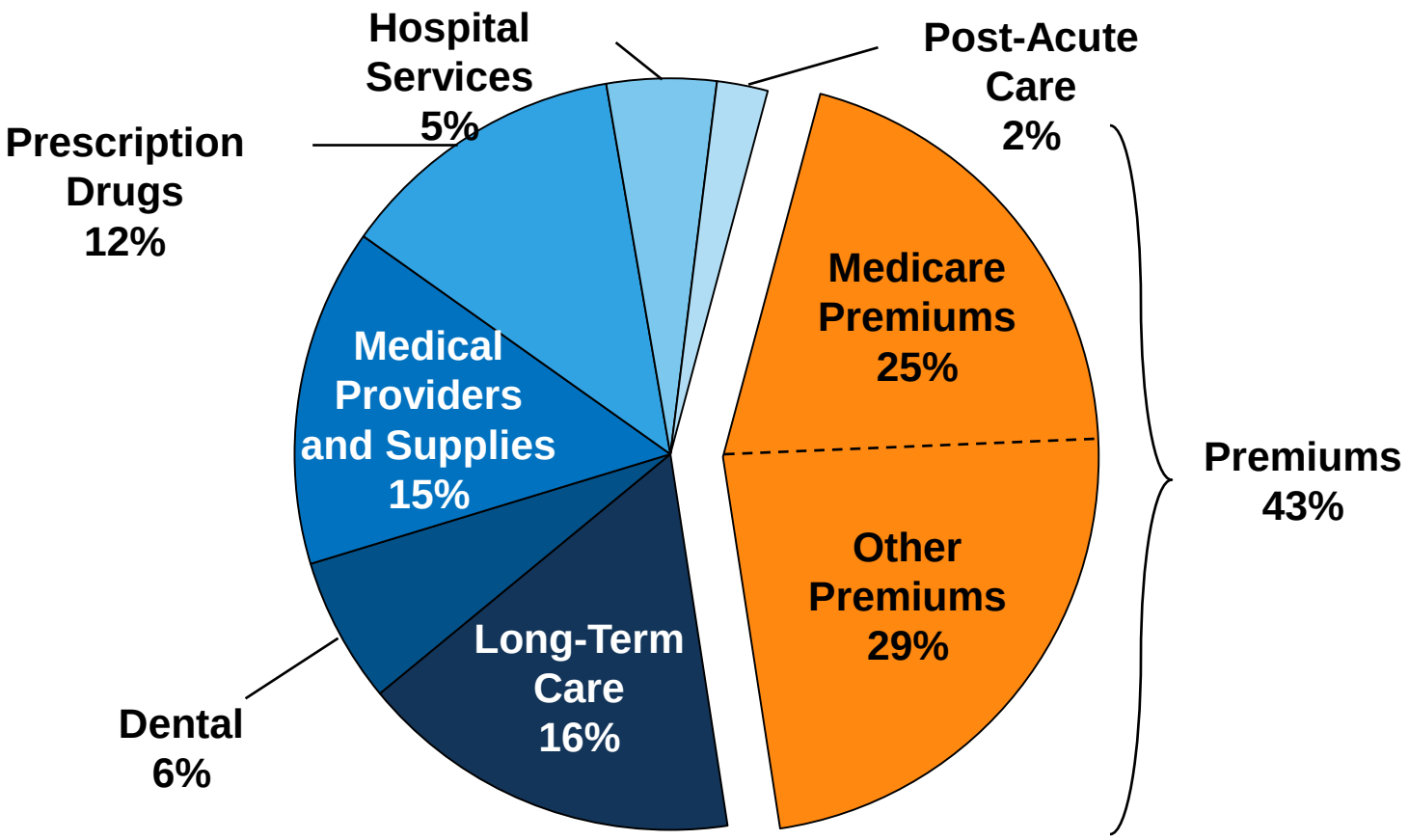
35 Million
Traditional Medicare beneficiaries

NOTE: Some Medicare beneficiaries have more than once source of coverage during the year. Supplemental coverage hierarchy: 1) Medicare Advantage, 2) Medicaid, 3) Employer, 4) Medigap, 5) Other public/private coverage, 6) No supplemental coverage; individuals with more than one source of coverage were assigned to the category that appears highest in the ordering. Numbers rounded.

SOURCE: Kaiser Family Foundation analysis of Medicare Current Beneficiary 2009 Cost and Use file.

Exhibit 4

Premiums comprise the largest share of beneficiaries' out-of-pocket health care spending, on average



Average Total Out-of-Pocket Health Care Spending per Beneficiary, 2009 = $4,335

NOTES: "Medicare premiums" include Medicare Part A and B premiums; "Other premiums" include Medigap, Medicare Advantage, Part D, Employer-Sponsored insurance, or other private health insurance premiums.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey 2009 Cost and Use file.

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Exhibit 5

Option 1: Restructure Medicare's benefit design with unified A/B deductible; modified cost-sharing; out-of-pocket limit

- **CBO option (March 2011):** Includes a unified $550 Part A and B deductible, 20% coinsurance on all Medicare services, and $5,500 limit on out-of-pocket spending
  - $32.2 billion in Medicare savings, 2012-2021 (2013 implementation)
  - Similar options: Bowles-Simpson, Domenici-Rivlin, Rivlin-Ryan, Burr-Coburn, Corker, and Hatch

- **MedPAC (June 2012):** Merges or maintains the Part A and B deductibles, replaces coinsurance with copays that may vary by service and provider, maintains aggregate cost-sharing requirements for beneficiaries, adds an out-of-pocket maximum, and gives HHS Secretary authority to make value-based changes to the benefit design

Exhibit 6

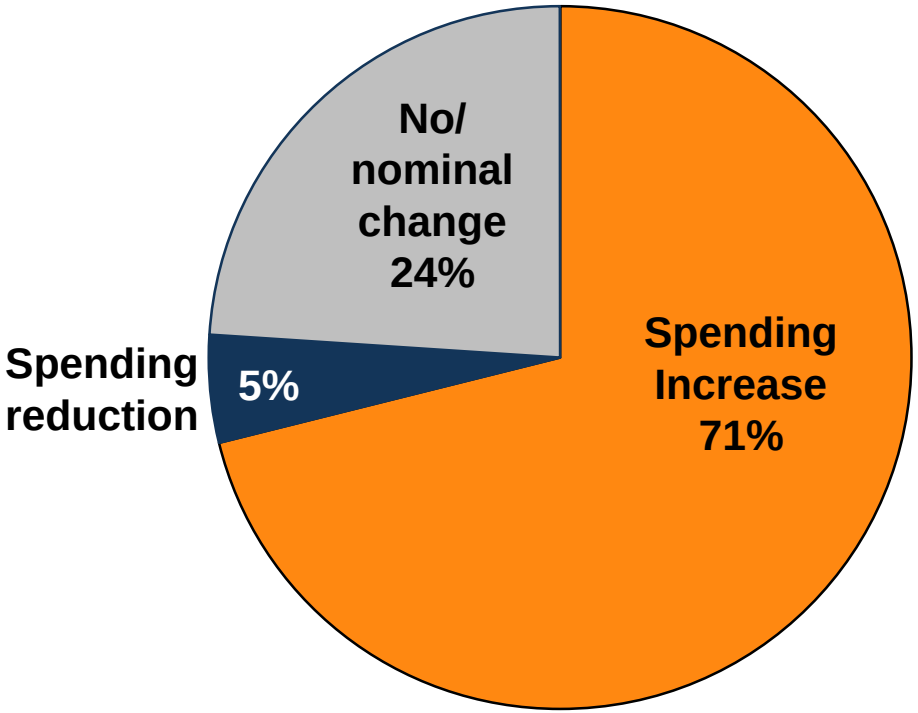
Why restructure Medicare's benefit design?

- To achieve Medicare savings
- To simplify Medicare cost sharing
- To protect against catastrophic expenses
- To reduce the need for supplemental insurance
- To encourage the use of high-value services

Exhibit 7

A small share of Medicare beneficiaries would pay less than under current law; most would face higher costs

Benefit Design: $550 deductible, 20% coinsurance for all services, $5,500 cost-sharing limit in 2013



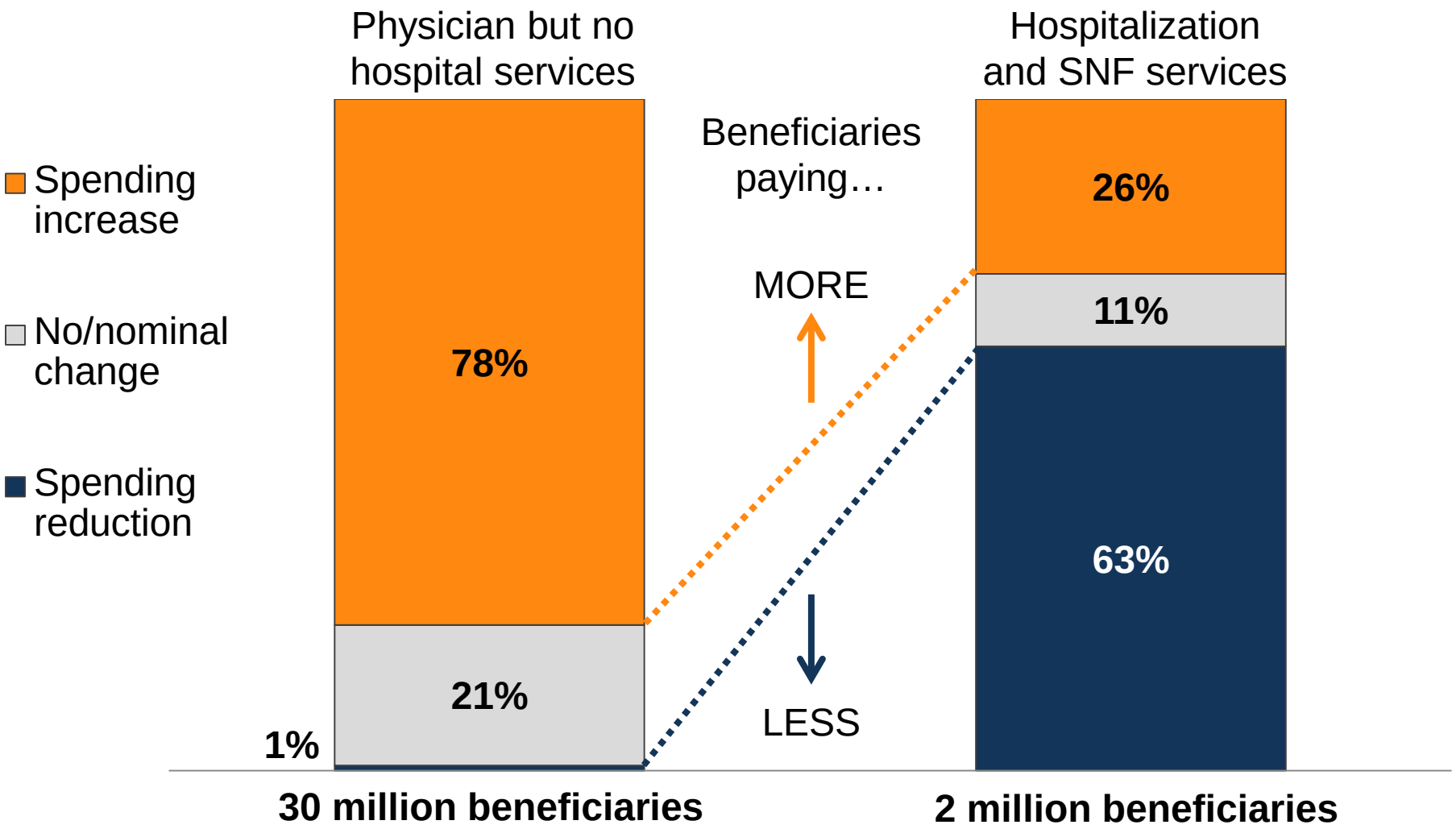
Traditional Medicare beneficiaries, 2013: 40.8 million

- **About 2 million beneficiaries (5%) would be expected to see savings, averaging $1,570**
  - — Over time, a larger share would benefit from the cost-sharing limit
- **About 29 million beneficiaries (71%) would be expected to see costs increase ($180 on average)**
  - — For those using physician but no inpatient care, the deductible would more than triple from $147 (current law) to $550 (proposal)

NOTES: Out-of-pocket costs includes premiums and cost-sharing requirements. No/nominal change group includes beneficiaries with changes in spending no more than $25.
SOURCE: Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending," November 2011.

Exhibit 8

Most beneficiaries in relatively poor health could see spending reductions, but they are a small share of the Medicare population

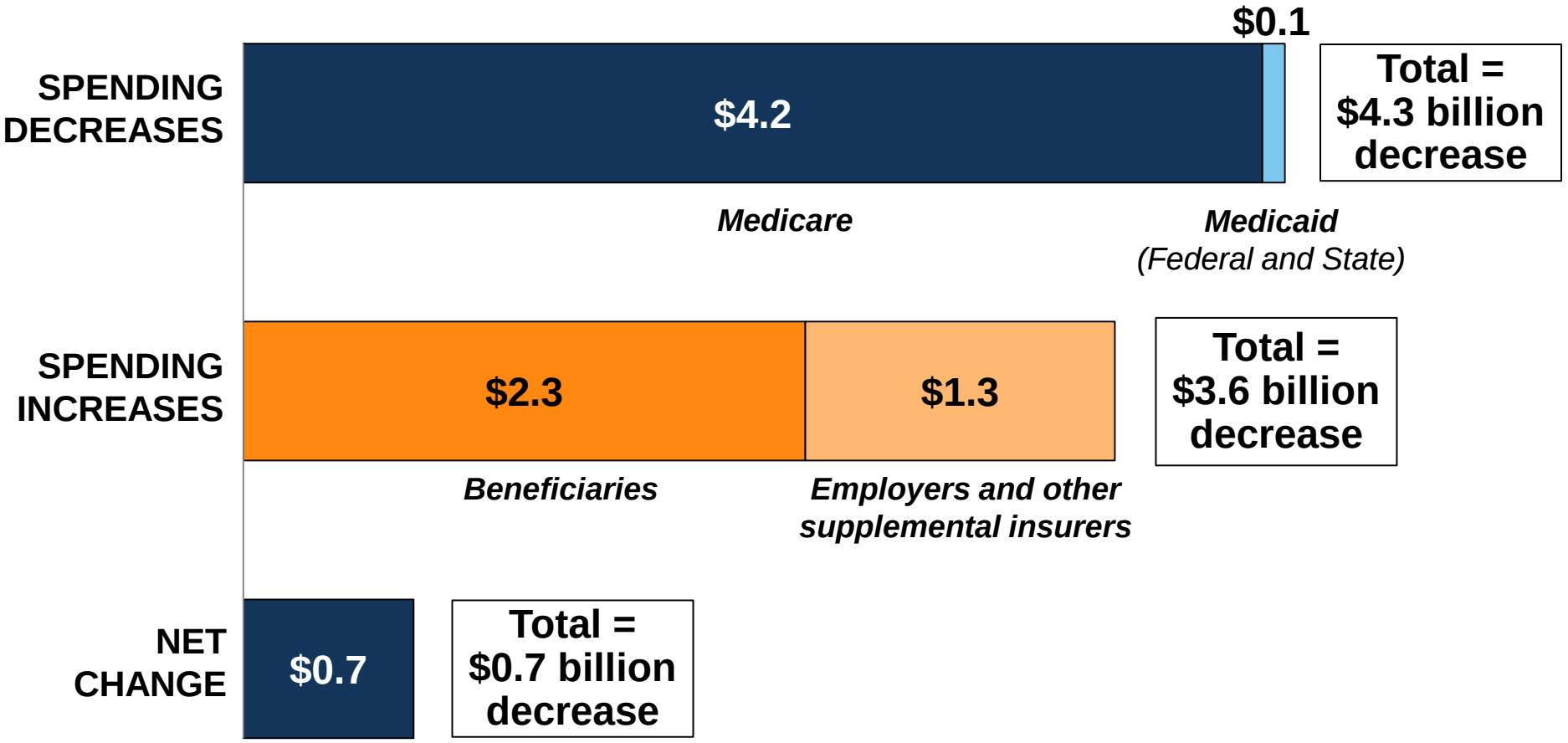


SOURCE: Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending," November 2011.

Exhibit 9

A restructured benefit design would reduce Medicare spending in 2013, but shift costs onto beneficiaries and other payers

Benefit Design: $550 deductible, 20% coinsurance for all services, $5,500 cost-sharing limit in 2013



NOTES: Other supplemental insurers includes Veterans' Administration, Indian Health Service and other federal sources; other state and local sources; worker's compensation; and other unclassified sources.
SOURCE: Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending," November 2011.

Exhibit 10

Key considerations in restructuring the Medicare benefit design

- Not all benefit redesign options are alike
- Restructuring Medicare's benefit design could simplify the program, protect beneficiaries from catastrophic expenses, and reduce Medicare spending
- A small share would benefit from the out-of-pocket spending limit in any given year; a larger share over a multi-year period
- If designed to reduce Medicare spending, most beneficiaries would pay more with a unified deductible and uniform coinsurance than they would under current law

Exhibit 11

Option 2: Prohibit and/or discourage supplemental coverage

- **CBO option (March 2011):** Prohibits first dollar Medigap coverage. Plans not allowed to cover first $550 in cost sharing for A/B services and limited to covering half of the next $4,950 (but would cover any remaining obligations)
  - $53.4 billion in Medicare savings, 2012 to 2021 (beginning 2013)
  - Similar options proposed by Bowles-Simpson, Rivlin-Ryan, Burr-Coburn, Corker, and Hatch

- **MedPAC (June 2012):** Additional charge on supplemental insurance (both Medigap and employer-sponsored retiree plans)

- **President's FY2014 Budget:** Part B premium surcharge for new beneficiaries with "first dollar" or "near-first dollar" Medigap beginning in 2017

Exhibit 12

Why prohibit or discourage supplemental coverage?

➢ To achieve Medicare savings

- With prohibition on first dollar coverage, beneficiaries are expected to use fewer Medicare services in response to higher cost sharing
- With premium surcharge on supplemental (first dollar) coverage, fewer may purchase this coverage, leading to lower use of Medicare-covered services
- A surcharge on supplemental coverage would increase program revenues

➢ To make beneficiaries more cost-sensitive

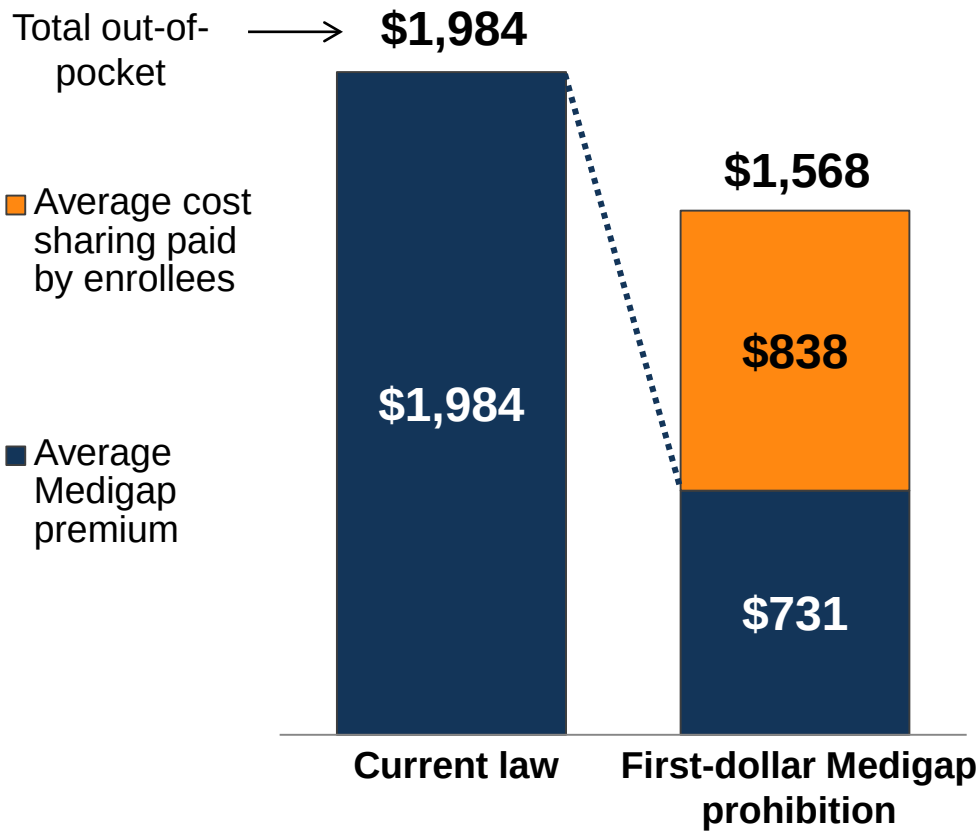
- Supplemental insurance insulates beneficiaries from the cost of care, leading to higher utilization of services and higher Medicare spending

➢ To eliminate inefficiencies and administrative costs associated with supplemental coverage

Exhibit 13

Implications of prohibiting first-dollar Medigap coverage for Medicare beneficiaries with Medigap

Plans not allowed to cover first $550 in A/B cost sharing and limited to covering half of the next $4,950, but would cover any remaining obligations
(CBO March 2011 option)



- Total out-of-pocket costs would decline among Medigap enrollees on average
- Medigap premiums would fall on average because plans would cover a smaller share of claims
- Medigap enrollees' cost sharing for Medicare services would rise on average
- Medigap enrollees would be expected to use fewer services if exposed to higher costs for Medicare-covered services

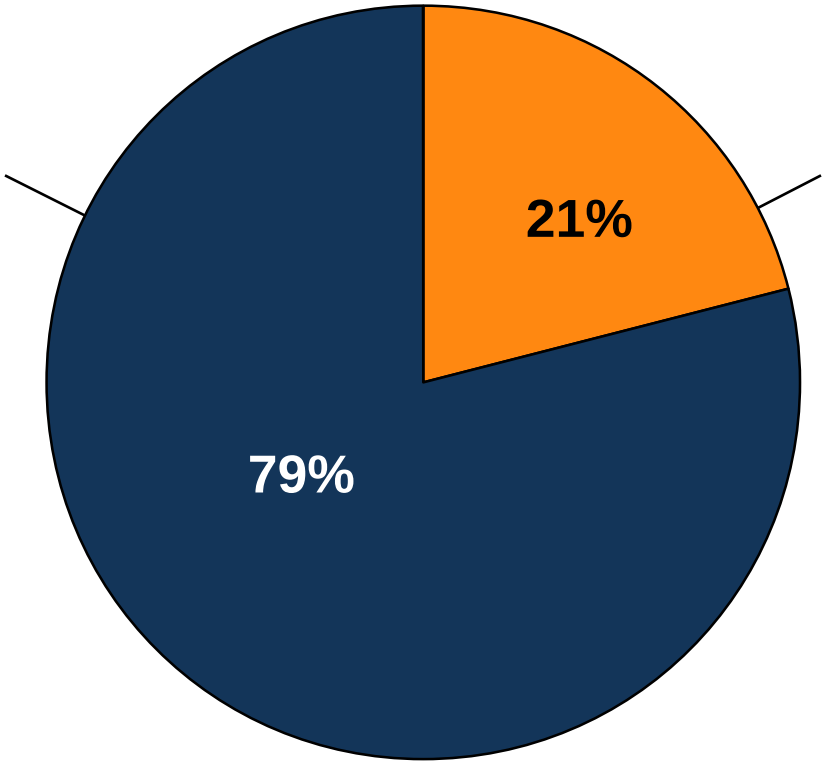
SOURCE: Kaiser Family Foundation, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," July 2011.

Exhibit 14

Prohibiting first-dollar Medigap coverage would reduce costs for many Medigap enrollees, but one in five expected to pay more

Plans not allowed to cover first $550 in cost sharing for A/B services and limited to covering half of the next $4,950, but would cover any remaining obligations

Share of Medigap policyholders expected to see costs decline (due to lower Medigap premiums)

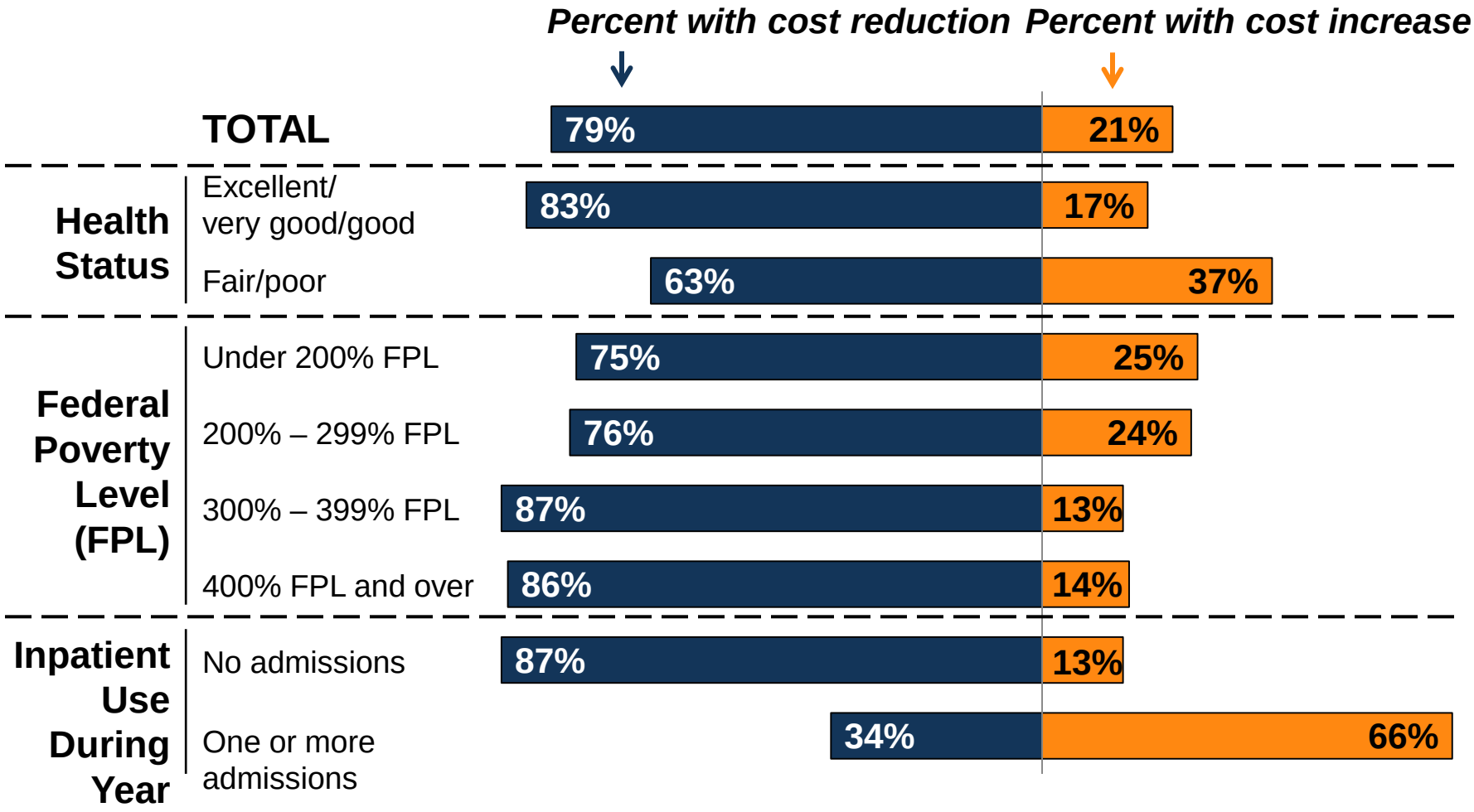


Share of Medigap policyholders expected to see costs rise
(because cost sharing increases would be greater than expected premium reductions)

SOURCE: Kaiser Family Foundation, “Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs,” July 2011.

Exhibit 15

Medigap restrictions would have a disproportionately negative effect on enrollees in relatively poor health and those with modest incomes



SOURCE: Kaiser Family Foundation, “Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs,” July 2011.

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Exhibit 16

Key considerations for supplemental coverage restrictions or surcharges

- **Achieves savings by increasing enrollees' exposure to Medicare cost-sharing obligations and/or by collecting premium surcharges**
  - Increased exposure to cost sharing may lead to reduced use of both necessary and unnecessary care; the former would lead to efficiencies, but the latter would lead to health complications and additional costs in the long run
- **Limits beneficiaries' ability to fully insure against the risk of unexpected medical expenses and to simplify their paperwork or would tax them to do so**
  - May especially be a challenge for those with modest incomes
- **Makes paying bills more complex (without supplemental coverage that coordinates with Medicare)**
- **Effects would vary based on several key differences between specific proposals:**
  - Restrictions on first dollar coverage versus premium surcharge
  - Medigap policies versus both Medigap/employer
  - All Medigap versus first-dollar Medigap
  - All Medigap policyholders versus new enrollees

Exhibit 17

Option 3: Restructure the Medicare benefit design and prohibit and/or discourage supplemental coverage

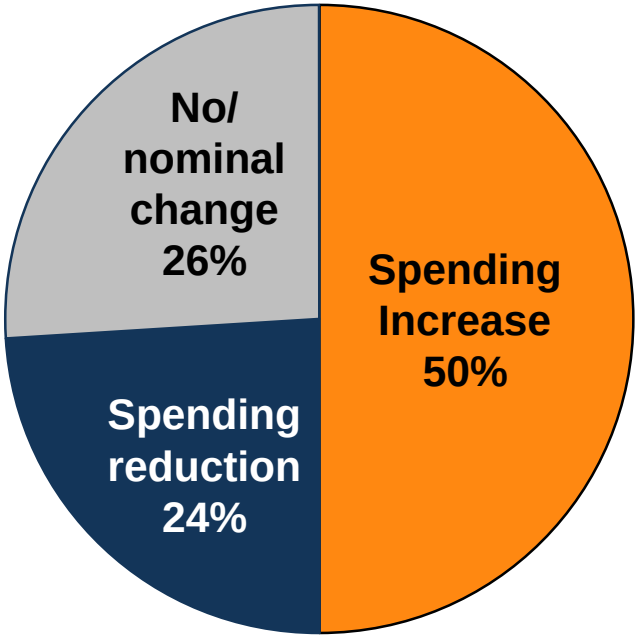
- **CBO option (March 2011):** Restructures Medicare benefit design, **AND** prohibits first-dollar Medigap coverage
  - — Reduces Medicare spending by $92.5 billion over 10 years (from 2012 to 2021, assuming implementation in 2013, CBO)
  - — Similar options: Bowles-Simpson, Rivlin-Ryan, Burr-Coburn, Corker, and Hatch

- **MedPAC (June 2012):** Restructures Medicare benefit design, **AND** imposes premium surcharge on supplemental coverage (both Medigap and employer-sponsored retiree plans)

Exhibit 18

About a quarter of beneficiaries would spend less, but half would spend more, including many who would spend $250+ more

Medicare: $550 deductible, 20% coinsurance for all services, $5,500 cost-sharing limit
Medigap: Plans prohibited from covering the deductible and more than half of the 20% coinsurance (CBO March 2011 option)



Traditional Medicare beneficiaries, 2013: 40.8 million

Nearly a quarter expected to see costs decline

— More than under the benefit redesign alone, due in part to drop in Medigap and Part B premiums

Half of beneficiaries expected to see cost increases

— But not as many as under the benefit redesign option alone

An estimated six million beneficiaries would see costs increase by $250+

— More beneficiaries in poor health would see costs increase by $250+ relative to the benefit redesign alone, mainly because Medigap restrictions would expose them to more cost sharing

SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: Out-of-pocket costs includes premiums and cost-sharing requirements. No/nominal change group includes beneficiaries with changes in spending no more than $25.

Exhibit 19

Summary

- If designed to achieve Medicare savings, benefit restructuring proposals would be likely to create winners and losers among the current Medicare population in any given year
- It remains a challenge to find an approach to reform the Medicare benefit design that achieves multiple goals:
  - Reduce Medicare spending/the federal deficit
  - Simplify Medicare benefits
  - Protect beneficiaries from relatively high cost-sharing expenses
  - Coax beneficiaries toward high-value providers and services
  - Discourage supplemental coverage
- Careful attention is needed at the same time to avoid shifting excessive costs onto beneficiaries with modest incomes
  - Many low-income beneficiaries do not qualify for Medicaid assistance
  - Several analysts have noted the need to protect the disadvantaged from deficit reduction
  - Adding low-income protections could erode savings
- Not all Medicare benefit restructuring proposals are alike; it is important to understand the expected implications of various proposals for beneficiaries and assess which goals they can be expected to achieve