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

<table>
<thead>
<tr>
<th>Part A</th>
<th>Part B</th>
<th>Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td><strong>Deductible</strong></td>
<td><strong>Deductible</strong></td>
</tr>
<tr>
<td>$1,184/spell of illness</td>
<td>$147/year</td>
<td>$325/year</td>
</tr>
<tr>
<td><strong>Inpatient hospital</strong></td>
<td><strong>Physician and other services</strong></td>
<td><strong>Initial coverage</strong></td>
</tr>
<tr>
<td>No coinsurance, for days 1-60; $296/day, for days 61-90; $592/day, for days 91-150; No coverage after day 150</td>
<td>20% coinsurance</td>
<td>25% coinsurance (up to $2,970 in total drug costs)</td>
</tr>
<tr>
<td><strong>Skilled nursing facility</strong></td>
<td><strong>Outpatient mental health</strong></td>
<td><strong>Coverage gap</strong></td>
</tr>
<tr>
<td>No coinsurance, for days 1-20; $148/day for days 21-100;</td>
<td>35% coinsurance</td>
<td>47.5% coinsurance for brands, 79% coinsurance for generics between $2,970 and $6,955 in total drug costs</td>
</tr>
<tr>
<td><strong>Home health, hospice</strong></td>
<td><strong>Annual “wellness” visit, clinical laboratory services, home health care</strong></td>
<td></td>
</tr>
<tr>
<td>No coinsurance</td>
<td>No coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive services</strong></td>
<td><strong>No coinsurance for many services, 20% for some</strong></td>
<td></td>
</tr>
<tr>
<td><strong>No limit on cost-sharing for Part A services</strong></td>
<td><strong>No limit on cost-sharing for Part B services</strong></td>
<td><strong>Catastrophic coverage</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Minimum of $2.65/generic, $6.60/brand, or 5% coinsurance above $4,750 in out-of-pocket spending</td>
</tr>
</tbody>
</table>
Exhibit 3

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

- Medicare Advantage: 25%
- Traditional Medicare: 75%
- Employer-Sponsored: 41%
- Medigap: 21%
- Medicaid: 21%
- Other: 1%

47 Million total Medicare beneficiaries
35 Million Traditional Medicare beneficiaries

NOTE: Some Medicare beneficiaries have more than one 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.
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.
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
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
A small share of Medicare beneficiaries would pay less than under current law; most would face higher costs

**Exhibit 7**

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

- 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)

Traditional Medicare beneficiaries, 2013: 40.8 million

**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.

- **Physician but no hospital services**:
  - 78% Spending increase
  - 21% No/nominal change
  - 1% Spending reduction
  - 30 million beneficiaries

- **Hospitalization and SNF services**:
  - 26% Beneficiaries paying more
  - 11% Beneficiaries paying less
  - 63% Beneficiaries paying... (not fully visible)
  - 2 million beneficiaries

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

### SPENDING DECREASES
- **Medicare**
  - Total = $4.2 billion decrease

### SPENDING INCREASES
- **Beneficiaries**
  - Total = $2.3 billion increase
- **Employers and other supplemental insurers**
  - Total = $1.3 billion increase

### NET CHANGE
- **Total = $0.7 billion decrease**

### EXAMPLES
- **Medicaid (Federal and State)**
  - Total = $0.1 billion increase

### 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.
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
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
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
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

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): 79%

Share of Medigap policyholders expected to see costs rise (because cost sharing increases would be greater than expected premium reductions): 21%

Exhibit 15

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

<table>
<thead>
<tr>
<th>Health Status</th>
<th>Percent with cost reduction</th>
<th>Percent with cost increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>79%</td>
<td>21%</td>
</tr>
<tr>
<td>Excellent/very good/good</td>
<td>83%</td>
<td>17%</td>
</tr>
<tr>
<td>Fair/poor</td>
<td>63%</td>
<td>37%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Federal Poverty Level (FPL)</th>
<th>Percent with cost reduction</th>
<th>Percent with cost increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 200% FPL</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>200% – 299% FPL</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>300% – 399% FPL</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>400% FPL and over</td>
<td>86%</td>
<td>14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Use During Year</th>
<th>Percent with cost reduction</th>
<th>Percent with cost increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>No admissions</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>One or more admissions</td>
<td>34%</td>
<td>66%</td>
</tr>
</tbody>
</table>

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
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)

No/nominal change 26%
Spending Increase 50%
Spending reduction 24%

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

Traditional Medicare beneficiaries, 2013:
40.8 million

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.