



*Advising the Congress on Medicare issues*

# Issues in fee-for-service Medicare's benefit design and cost sharing

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# Take away points from September

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- Important limitations in FFS benefit design (e.g., no catastrophic cap)
- Changes to FFS benefits need to take supplemental coverage into account
- Spending for health services is highly concentrated among relatively few beneficiaries
- Capping out-of-pocket spending for the sickest beneficiaries means spreading out-of-pocket liability around more evenly

# Design of health insurance

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- Reduce beneficiaries' exposure to risk
- Leave some spending unreimbursed to deter use of lower value services
  - Lower cost sharing when beneficiaries need most valued services
  - Higher cost sharing when beneficiaries are seeking lower-value services
  - Identifying relative value of services requires evidence of comparative effectiveness

# Important features of the literature

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- Most studies use nonexperimental design
  - Difficult to isolate insurance effects from selection bias
  - Result has been wide range of estimates
- Time horizon of the analysis
- Population studied
- Type of insurance product
  - Indemnity v. managed care
  - Medicare supplements
  - Medical services, prescription drugs, or both
- Outcome measures

# RAND health insurance experiment

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- People are moderately sensitive to cost sharing
  - On average, 10% increase leads to a 2% drop in spending
  - Some differences in response by type of service
  - Those with cost sharing initiated medical care less, but once under medical care, costs were only slightly lower
- Effects on health outcomes
  - On average, no adverse effects
  - Exception: people with both low income and poor health

# Medicare supplemental insurance

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- Studies agree that beneficiaries have higher average spending
- Two views after controlling for selection bias
  - Some say spending is 25% higher because people are shielded from out-of-pocket costs at the point of service
  - Others do not find higher spending

# Literature on prescription drug use among the elderly

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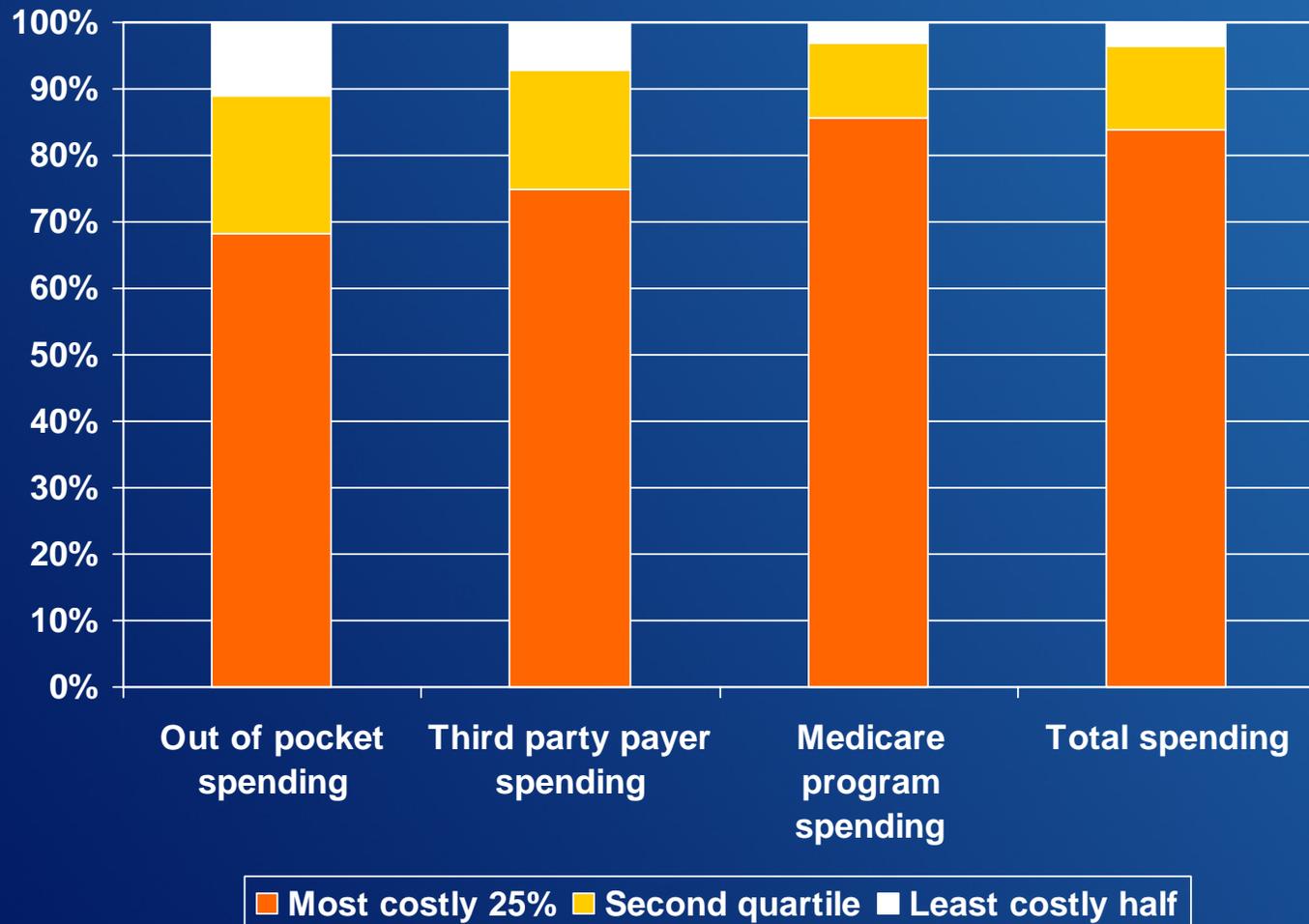
- Studies are usually in managed care context
- People are moderately sensitive to cost sharing
- Higher cost sharing associated with lower medication adherence
  - Can lead to negative health outcomes, higher overall costs for people in poor health or with specific chronic conditions
  - No strong evidence that this is the case for all elderly

# Were our estimates of the effects of covering Medicare's deductibles too low?

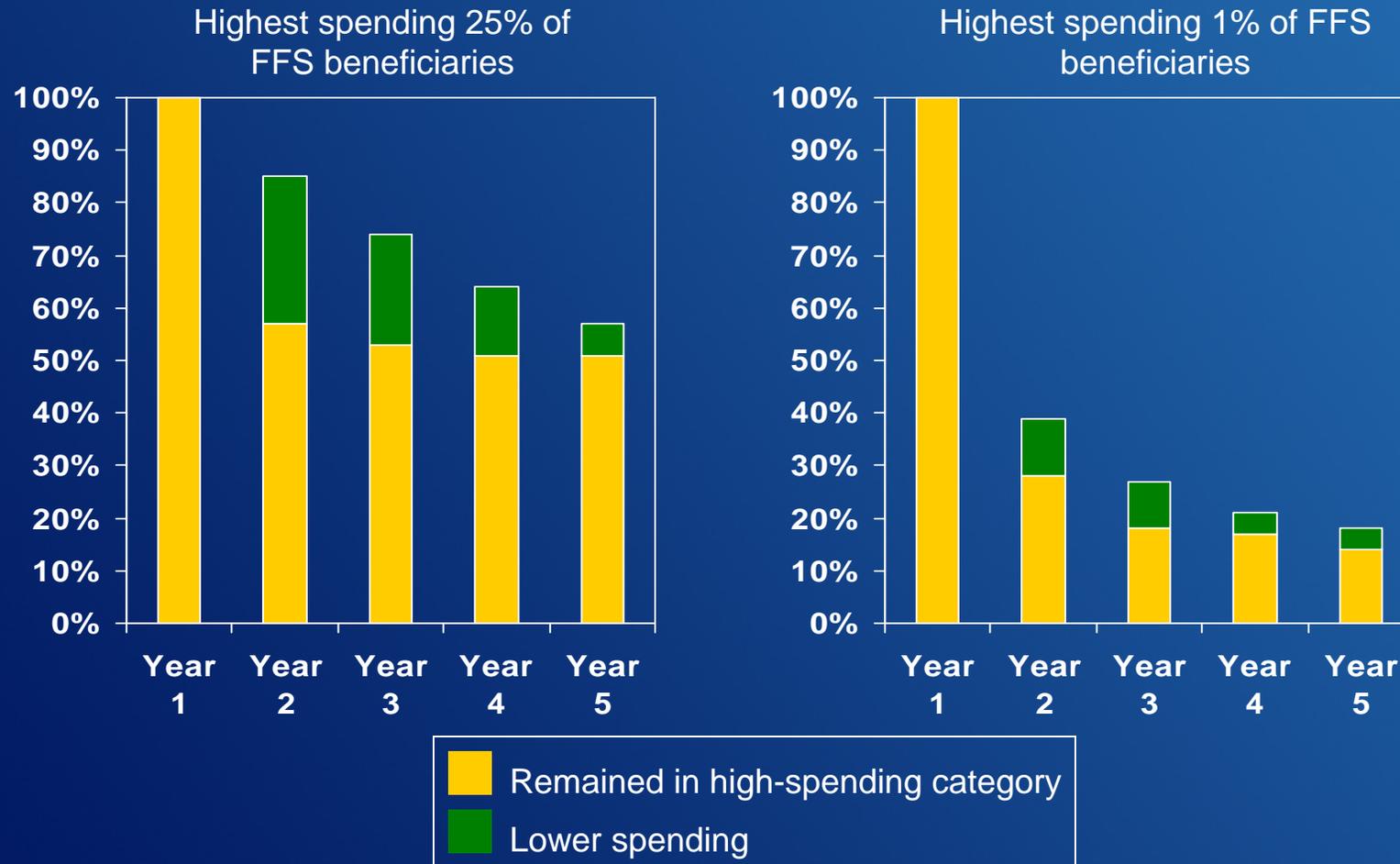
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- Mixed evidence from literature review
- Illustrative case from September:  
Medigaps and retiree plans may not cover Part A and Part B deductibles
  - Original estimate—policy would lower Medicare spending by ~\$2 billion in 2007
  - Estimate using assumptions consistent with HIE—Medicare spending \$10 billion lower

# Can changes to all beneficiaries' cost sharing affect total spending by much?



# Can we identify persistently high-spending beneficiaries?

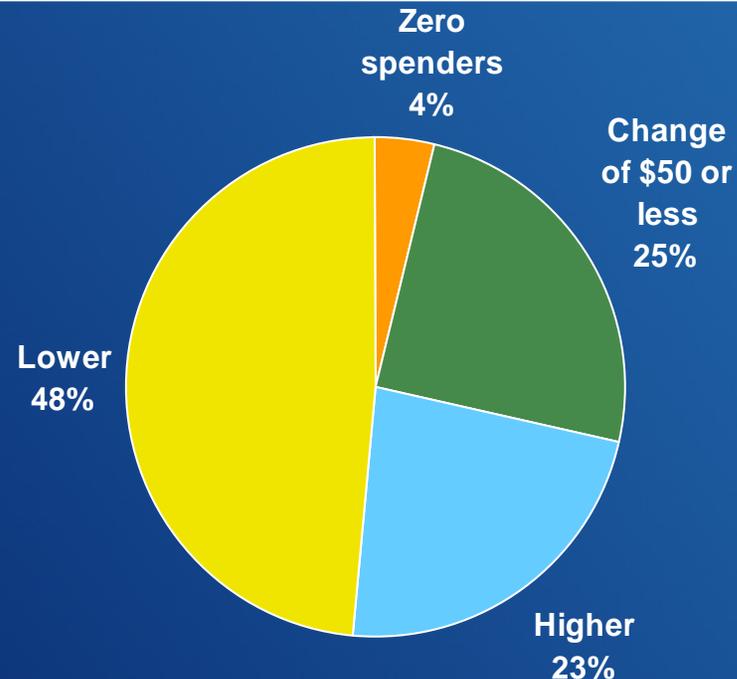


## Illustrative case:

A combined deductible, catastrophic cap, limits on medigap and retiree coverage, uniform cost sharing

- Under a combined deductible, beneficiaries would pay the first \$172.50 of covered services
- \$3,100 cap on out-of-pocket spending
- Medigap and retiree plans may not cover deductible
- 20% cost sharing on all services except hospice

Change in out-of-pocket spending plus simple estimate of changes in premiums for supplemental coverage

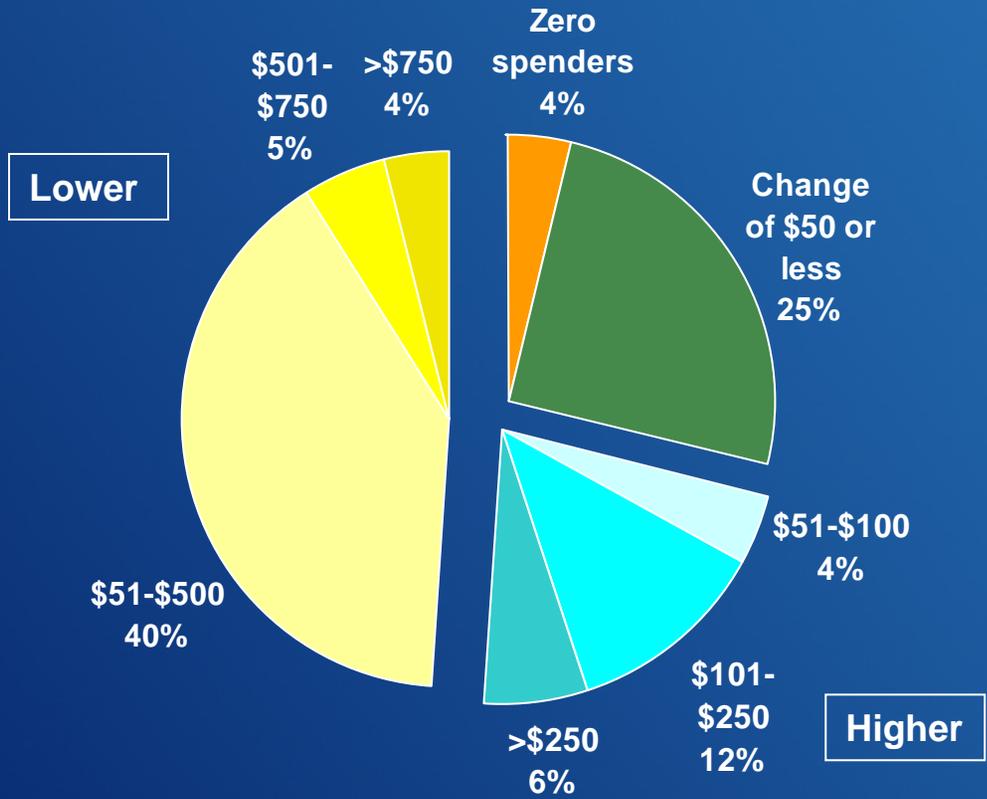


Note: Estimates are preliminary and subject to change. Assumes beneficiaries respond to cost sharing in a way consistent with estimates from the RAND health insurance experiment.

Source: Actuarial Research Corporation, based on 2004 MEPS data calibrated to spending and utilization for Medicare's FFS population from the 2007 Medicare Trustees Report.

# Intensity of redistributive effects

Change in out-of-pocket spending plus simple estimate of changes in premiums for supplemental coverage



Note: Estimates are preliminary and subject to change. Assumes beneficiaries respond to cost sharing in a way consistent with estimates from the RAND health insurance experiment.

Source: Actuarial Research Corporation, based on 2004 MEPS data calibrated to spending and utilization for Medicare's FFS population from the 2007 Medicare Trustees Report.

# Questions for discussion

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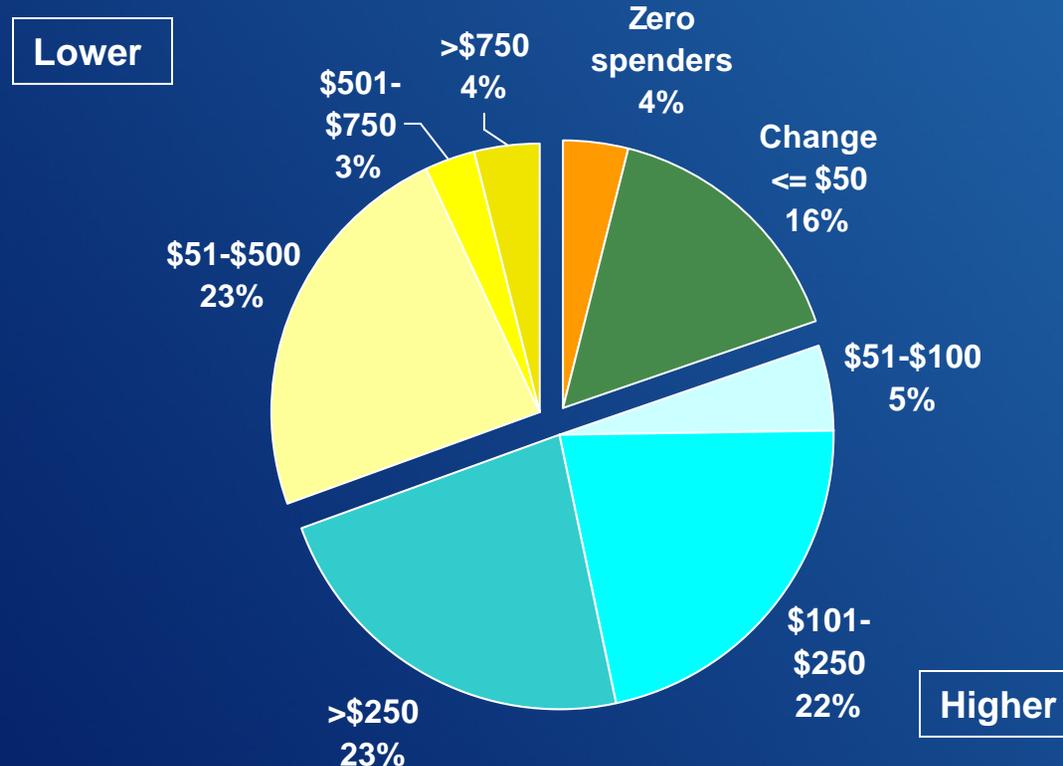
- Which features of the FFS benefit and supplemental coverage most need changing?
- Should we assume that beneficiaries respond to cost sharing in a way consistent with the health insurance experiment?
- Should changes to cost sharing for all FFS beneficiaries be paired with better incentives for providers who care for those with highest costs?
- How to phase in changes to FFS benefit design over time?

# Backup slides

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# Outcome with lower assumption of effects of supplemental coverage

Change in out-of-pocket spending plus simple estimate of changes in premiums for supplemental coverage



Note: Estimates are preliminary and subject to change. Assumes beneficiaries are less responsive to cost sharing than estimates from the RAND health insurance experiment.

Source: Actuarial Research Corporation, based on 2004 MEPS data calibrated to spending and utilization for Medicare's FFS population from the 2007 Medicare Trustees Report.

# 90% of Medicare beneficiaries had supplemental coverage in 2004

