



Advising the Congress on Medicare Issues

Improving traditional Medicare's benefit design

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Changes from March presentation

- Discussion of changing context in which beneficiaries take up supplemental coverage
- Less discussion of combined deductibles and more of using copays in supplemental coverage
- Description of medigap changes in health reform law

Problems with the status quo

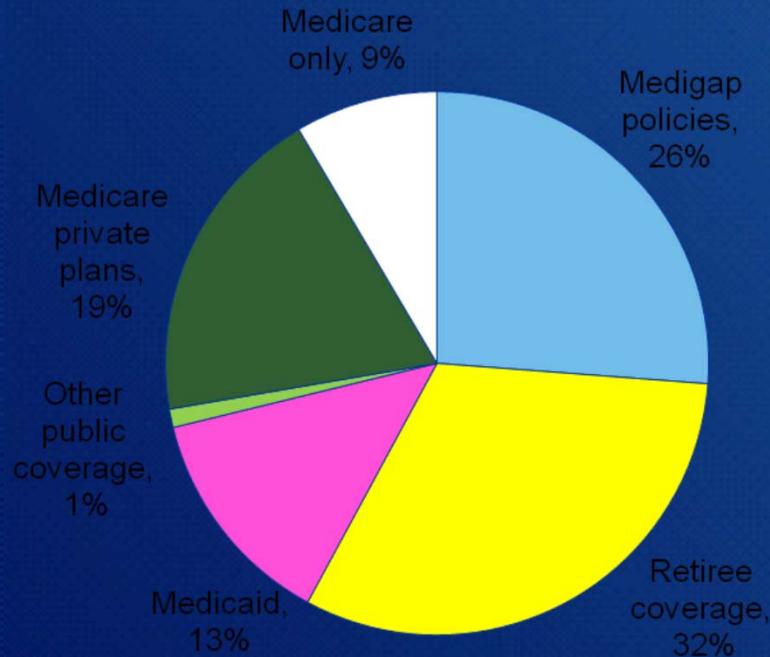
- FFS benefit design leads to few individuals owing most of the cost sharing
- Premiums for individually purchased policies are often expensive and vary widely
- Supplemental insurance masks price signals and leads to higher use of services

Opportunity to align beneficiary incentives and program goals

- Near-term aims
 - Provide better financial protection to beneficiaries
 - Give beneficiaries better price signals
- Longer term aims
 - Reinforce innovations in provider payments and encourage changes in health care delivery
 - Encourage use of high-value therapies, discourage use of low-value therapies

Options for supplemental insurance changing over time

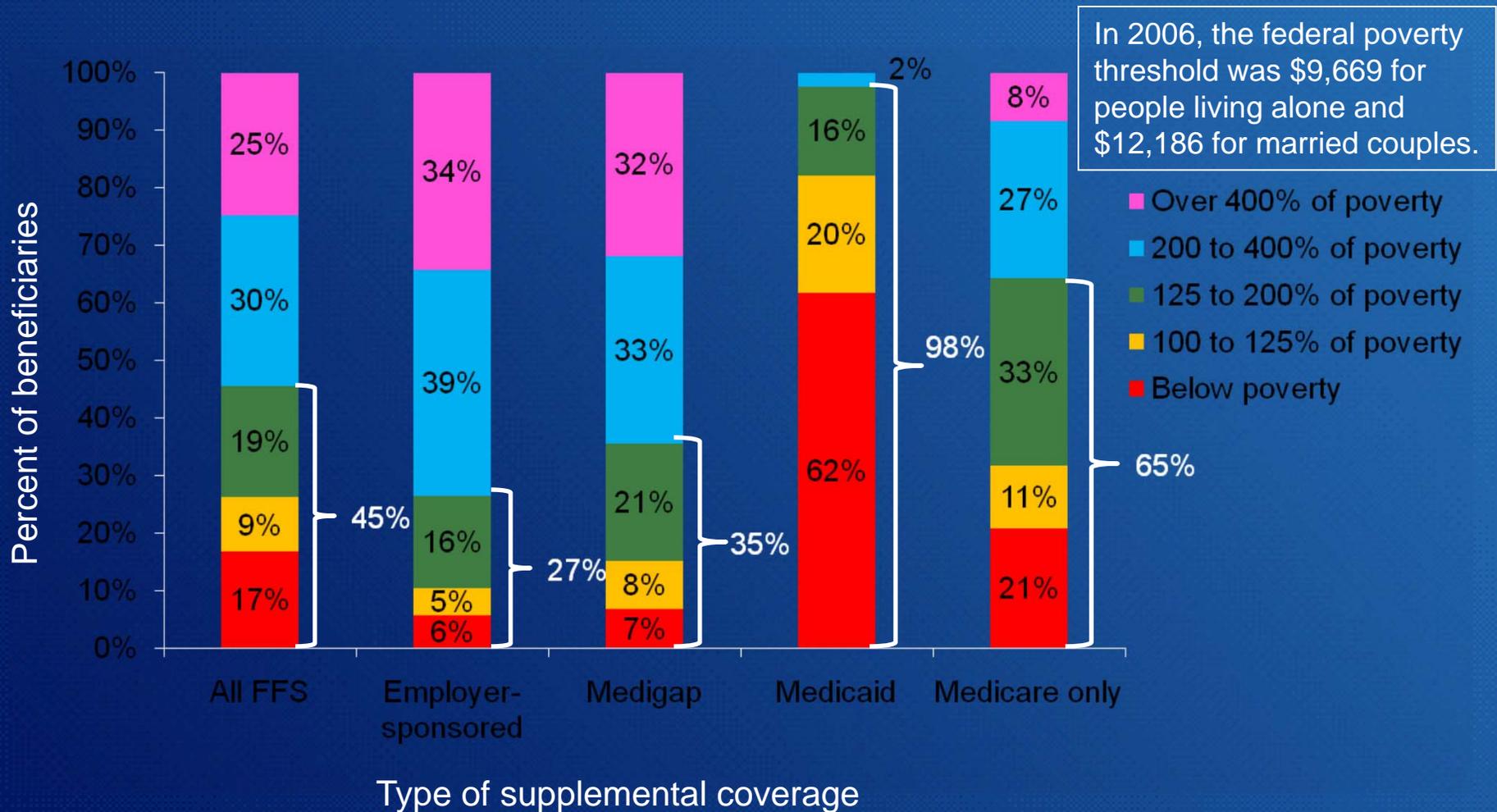
Supplemental coverage in 2006



Expected changes

- Less availability of retiree coverage
- Increasing premiums for medigap policies
- Fewer extra benefits or higher premiums in private Medicare plans?
- Effects of state financial constraints on Medicaid?

Lower-income FFS beneficiaries tend to have Medicaid or no supplemental coverage



Medicare cost-sharing liability in 2008

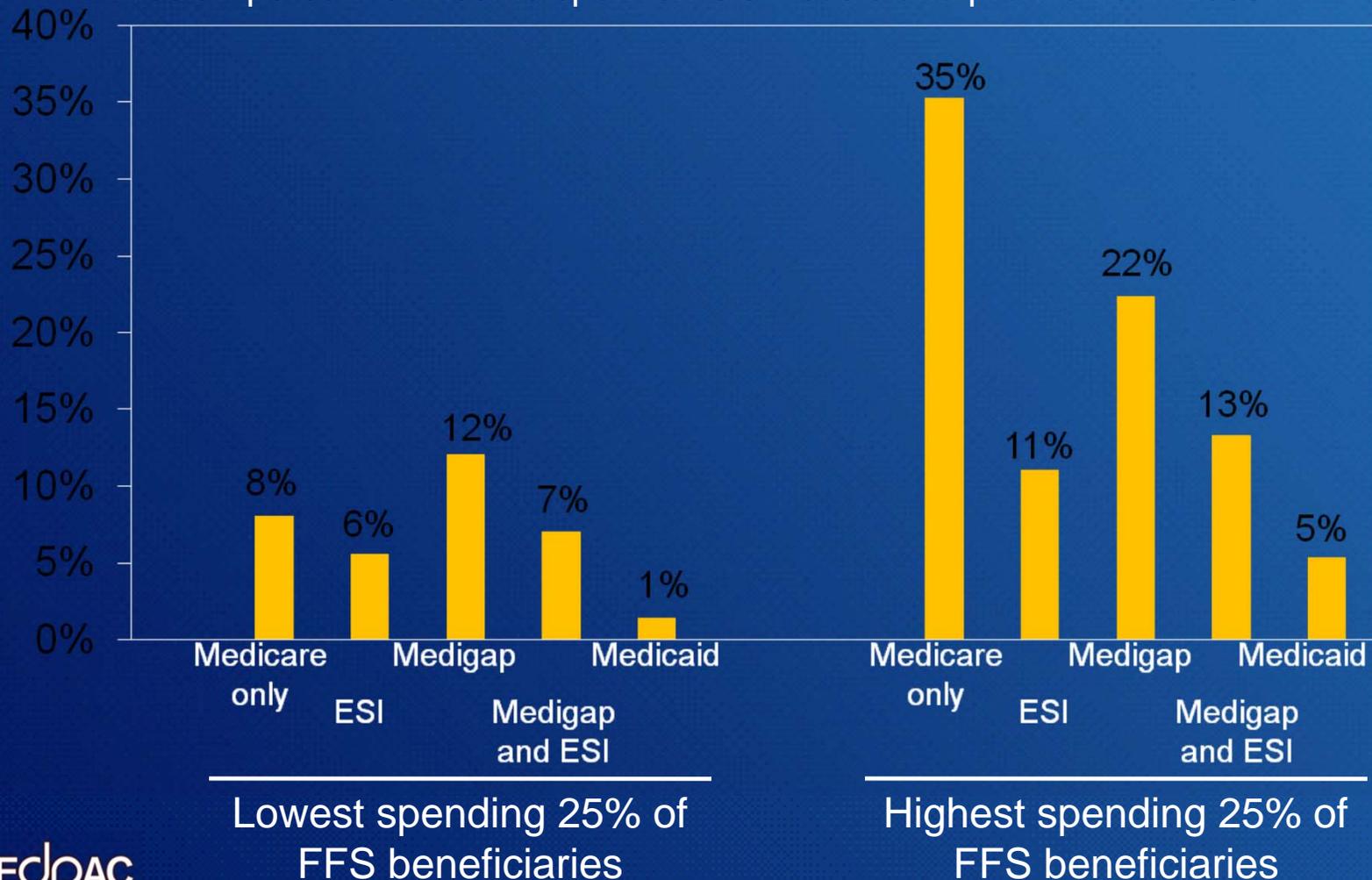
Amount of cost-sharing liability per person	Percent of FFS beneficiaries	Average amount of cost sharing per beneficiary
\$1 to \$499	42%	\$250
\$500 to \$1,999	36%	\$1,071
\$2,000 to \$4,999	16%	\$3,036
\$5,000 to \$9,999	4%	\$6,879
\$10,000 or more	2%	\$15,402

Note: 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.

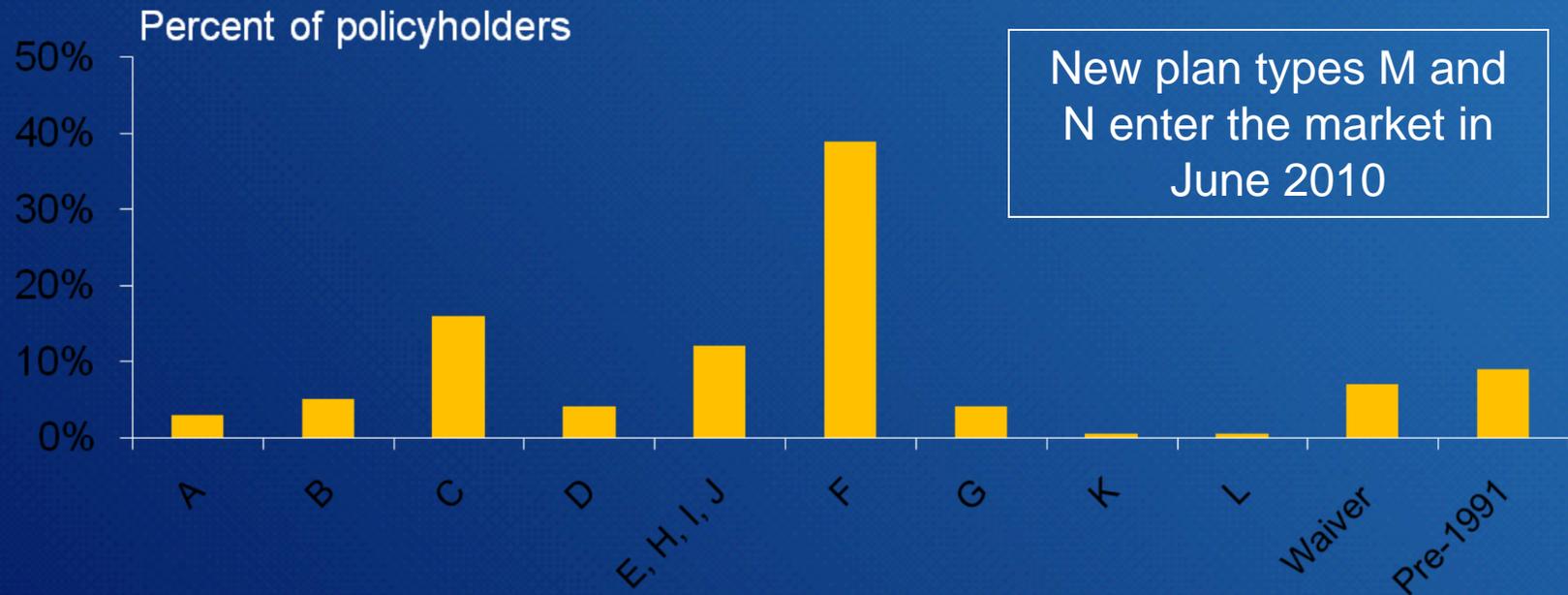
Source: MedPAC based on data from CMS.

Status quo leads to wide variation in financial burden among beneficiaries

Median percent of income spent on OOP costs and premiums in 2005



Medigap plans C and F fill in most all of Medicare's cost sharing

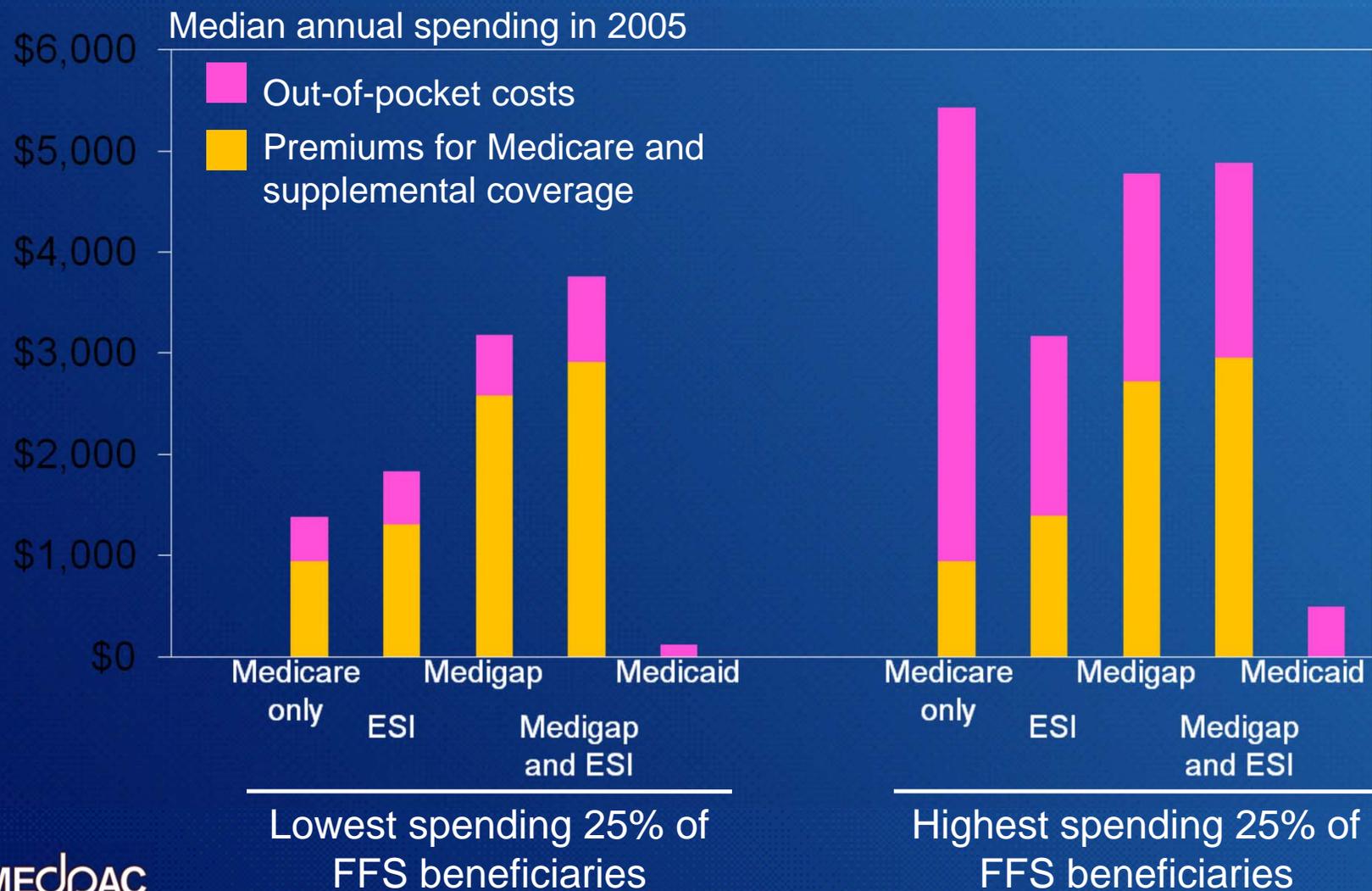


Part A deductible		X	X	X	X	X	X	X (50%)	X (50%)	?	?
Part B deductible			X			X				?	?
Average annual premium	\$1,500	\$1,800	\$1,900	\$2,000	\$2,000	\$2,000	\$1,900	\$800	\$1,300	\$2,200	\$2,600

Notes: Waiver states include Massachusetts, Minnesota, and Wisconsin. Plans E, H, I, and J will be closed to future enrollment in 2010.

Source: MedPAC analysis of data from the National Association of Insurance Commissioners.

Out-of-pocket costs and premiums vary by health spending and by type of coverage



Illustrative option with an out-of-pocket cap and copays in supplemental policies

- In 2011, no medigap or retiree policies could fill in nominal copays for office visits and emergency room use
- Unlike today's benefit, FFS Medicare's out-of-pocket cost sharing would be limited to no more than \$8,500 to \$9,000 for the year
- Small copays above the out-of-pocket cap

Medigap provision in health reform

- National Association of Insurance Commissioners to revise standards for medigap plan C and plan F policies
 - Include nominal cost sharing to encourage appropriate physician services under Part B
 - Standards to be in place by Jan. 1, 2015 for newly issued policies
- No such standards applicable to retiree coverage

Longer term potential improvements

- Build in incentives to reinforce innovations in provider payment systems
- Move toward value-based insurance design
 - Lower cost sharing for high-value services, higher cost sharing for low-value services
 - Requires solid evidence basis, careful targeting
- Introduce a more managed Medicare benefit?