



*Advising the Congress on Medicare issues*

# Medicare's fee-for-service benefit design

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# Context for discussion of Medicare's benefit design

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- Fee-for-service (FFS) benefit design leads to unlimited exposure to cost sharing
- Cost-sharing requirements are uneven and vary by site of care
- Premiums for supplemental coverage are often expensive and vary widely
- Supplemental insurance masks price signals and leads to higher use of services

# Outline of today's presentation

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- MA plan benefit design
- Cost-sharing liability burden as a percent of income
- Combined deductible and OOP cap
- Medicare's experience encouraging beneficiaries to use high-quality, low-cost providers within FFS Medicare

# Comparing FFS Medicare and typical MA plan cost-sharing

Type of cost-sharing	FFS Medicare	Typical MA plan
Hospital	\$1,132 deductible Per spell of illness	\$0-\$400 per hospital day, often with limits per stay
Physician services	\$162 annual deductible, 20 percent of Medicare allowed charges	Flat copayments <ul style="list-style-type: none"> <li>• \$12.50 average primary care visits</li> <li>• \$30 average specialty care visits</li> </ul>
Durable medical equipment and Part B prescription drugs	20 percent of Medicare allowed charges	20 percent of Medicare allowed charges

# Other differences between MA plans and FFS Medicare benefits

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- MA plans must have out-of-pocket caps of \$6,700 or less per year
- Most MA enrollees are in plans that waive the SNF three-day hospital stay requirement
- Most MA enrollees are in plans that require prior approval of SNF and home health admissions by the plan's medical director

# Financial burden among beneficiaries, 2007

Variables	Medicare only	ESI	Medigap	Medicaid
Total Medicare A&B spending	\$6,765	\$9,422	\$10,940	\$11,938
OOP + premiums	2,284	3,020	4,199	787
Income	21,307	42,066	35,031	10,129
Median burden	11%	8%	15%	1%

Note: Financial burden is defined as percent of income spent on out-of-pocket (OOP) expenses and premiums. This analysis excludes Part D. OOP spending includes only cost-sharing amounts paid by the beneficiary—it excludes any cost-sharing paid through supplemental coverage. OOP also excludes any premiums for Part A, Part B, and supplemental coverage. Excludes beneficiaries who were institutionalized, enrolled in managed care or in Parts A and B for less than a year, and for whom Medicare was secondary payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, cost & use files, 2007.

# Examples of combined FFS deductible and OOP cap under budget neutrality

Catastrophic limit on OOP spending	Combined deductible required to break even	Percent of FFS beneficiaries whose OOP spending would differ from baseline		
		No appreciable change*	Higher	Lower
None — current law	\$595	66%	28%	6%
\$7,000	960	61	33	6
5,000	1170	59	34	7
4,000	1,328	58	35	6
3,000	1,635	57	36	7

Note: FFS (fee for service), OOP (out of pocket). Percents may not sum to 100 due to rounding. This analysis excludes Part D. OOP spending includes only cost-sharing amounts paid by the beneficiary—it excludes any cost-sharing paid through supplemental coverage. OOP also excludes any premiums for Part A, Part B, and supplemental coverage.

\* Change of \$50 or less. Includes beneficiaies with no spending.

Source: Actuarial Research Corporation, based on 2004-2006 Medical Expenditure Panel Survey data calibrated to 2011 spending and utilization statistics for Medicare's FFS population from the 2009 Medicare Trustees Report.

# Proposed changes to FFS benefits

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- Range of ideas proposed
  - Generally combine OOP cap, A & B deductible, and uniform coinsurance
  - Restrict first-dollar coverage in medigap plans
- Implications for ESI and Medicaid that wrap around Medicare benefits
- Alternative proposals include excise tax on medigap plans



# Innovative benefit designs in the public and private sector

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- Four design strategies
  - Lowering cost sharing for high-value services
  - Raising cost sharing for low-value services
  - Incentivizing enrollees to see high-performing or low-cost providers
  - Incentivizing enrollees to adopt healthier behaviors
- No interviewee relied on a single strategy

# Demonstrations to encourage beneficiaries to use high-quality providers

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- CABG demonstration (1991-1996) to examine the effects of selecting facilities on the basis of quality and discounted prices to receive a bundled payment for selected procedures
- Demonstration selected 7 sites on basis of competitive bidding and negotiation
- Produced savings for the program and improved quality
- Beneficiaries saved money and had high satisfaction rates
- Demonstration sites did not increase market share

# Demonstrations (cont'd): Acute care episode (ACE) demonstration

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- Bundled payment for specified orthopedic and cardiovascular procedures
- Sites chosen by competitive bidding
- Hospital and physician gain-sharing
- Beneficiaries share 50 percent of Medicare savings up to annual Part B premium
- Participating sites can market themselves as Value-Based Care Centers

# Discussion questions: short term issues

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- As a first priority, should Medicare:
  - Rationalize cost sharing?
  - Provide better financial protection to beneficiaries?
  - Set some cost sharing for all services?
- Should limits be placed on the ability of supplemental coverage to cover all cost sharing?
- Should Medicare incentivize beneficiaries to see efficient providers?