Low-income beneficiaries in a system of competitively-determined plan contributions

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Framework for discussion

- Should Part D be the model for subsidizing costs for low-income beneficiaries in CPC?
- Aspects that would be different in a CPC model for Medicare Parts A and B
- Comparison with treatment of dually-eligible beneficiaries in current programs (Medicare Advantage and traditional fee-for-service)
- Options other than CPC also possible

Competitively-determined plan contributions (CPC)

- CPC determines the government contribution towards a Medicare beneficiary's chosen plan
- Beneficiary can choose among plans in geographic area (FFS Medicare and private plans, where available)
- Government contribution determined through a bidding process
- Some plans will be more costly than others, and beneficiaries who choose such plans will pay an added premium
  - The beneficiary's current choice may not be the least costly option

Illustration of CPC system for Parts A and B of Medicare, with government contribution at weighted average of plan bids

- Plans 1 and 2 are full subsidy plans; beneficiaries can enroll in Plan 3 or Plan 4 by paying a premium
- If Part D model followed, auto-assignment into lowest-cost plan(s) for low-income beneficiaries; may involve significant movement from current options, and movement from year to year; there also may be plan capacity issues

Basic principle of CPC: Least costly option(s) subsidized for dually-eligible beneficiaries

- Determination of least costly option for full subsidization could consider all costs to the government:
  - Parts A and B and its cost sharing
  - Part D and its cost sharing
  - For full dually-eligible beneficiaries, Medicaid benefits (long-term care services and supports, transportation, vision, etc.)
- Possible feature of CPC could be that all plans required to bid on the entire package

Issues to address if a CPC system follows the Part D model

- Lack of uniformity across states in amounts Medicaid pays for Medicare Parts A and B cost sharing
- Lack of uniformity in Medicaid benefits across states
- Should the dually-eligible population be segmented in some ways for CPC?
- Plan readiness: Should there be standards for serving dually-eligible beneficiaries?

Lack of uniformity in cost-sharing

- Part D: Fixed (nominal) cost sharing levels applicable to low-income beneficiaries in every plan (by income levels); all remaining cost sharing fully subsidized

- FFS and MA: Beneficiaries protected from being billed for Medicare Part A and Part B cost sharing; Medicaid pays such cost sharing, but often below Medicare allowed levels

What types of subsidies do dually-eligible beneficiaries receive?

Non-dual out-of-pocket costs	Dually-eligible beneficiary ("full dual")
Premium for Part B if elected; premium for MA if elect a non-zero-premium plan	Medicaid pays Medicare premiums Some states pay MA premiums
Cost sharing for Part A and Part B services	Protected from being billed for cost sharing; Medicaid pays some or all
Premium for Part D benefit, if elected	Part D premium fully paid for, up to regional threshold
Cost sharing for Part D drugs	Lowest-income individuals pay only nominal cost sharing
Non-Medicare-covered benefits are beneficiary responsibility; some provided through MA	Non-Medicare-covered benefits, such as long-term care services and supports, and social services that are Medicaid benefits

Lack of uniformity in Medicaid payments for Medicare Parts A and B cost sharing

Consequences under current system and CPC

- Providers declining to accept dually-eligible beneficiaries in FFS and MA plans
- Within MA, potentially higher bids because providers want to make up revenue shortfall if some enrollees not paying full cost sharing; across states, varies by level of cost sharing Medicaid pays
- Within MA, non-duals subsidizing cost sharing of other enrollees

Potential remedy in CPC

- Level the playing field by "federalizing" cost sharing at uniform level (would apply to both FFS (a plan in CPC) and private plans)

How to finance?

- Part D federalization of drug benefit included maintenance of effort via "clawback" from states
- Other options possible

Lack of uniformity in Medicaid benefits across states

- Part D, which "federalized" each state's different levels of drug coverage, has a uniform standard national benefit; low-income and non-low-income beneficiaries have same standard benefit
- Current Medicaid benefit packages for "full duals" vary across the states
- To determine least costly option for subsidization if following Part D model, all plans would bid on benefits for the dually-eligible population
- Rationale for uniformity in benefits similar to rationale for cost sharing uniformity: level playing field, comparability ensured
- Uniformity would facilitate bidding for combined A/B, D, & Medicaid benefits in CPC

Lack of uniformity in Medicaid benefits across states: issues

- **Determination of least costly option assumes good risk adjustment system to compare bids of plans**
  - Facilitated by plans bidding on standardized benefit package
- **Given the state variation in Medicaid benefits, what would the uniform benefit package be?**
  - State variation includes greater use of home and community-based care over institutional care in some states. Is national uniformity possible or desirable?
- **What are the financing implications for the states and federal government?**
  - Similar to issues in federalizing cost sharing

Should dually-eligible population be segmented in some ways for CPC?

- **Should all plans bid to cover all populations for Medicaid services (long-term care services and supports, behavioral health, and social services)?**
  - That is, like the expansion of Medicare to include a drug benefit under Part D, would the Medicare benefit be expanded to include the Medicaid services, which would be made available to all?
- **If offered to non-duals, the unsubsidized premium for the equivalent of Medicaid benefits would be very high.**
  - Possible adverse selection; other pricing issues for dually-eligible beneficiaries as well as for non-duals
- **Instead, should benefit be available only to "full duals"?**

Plan readiness and expectations for serving all populations

- **Proportion of dually-eligible beneficiaries enrolling in MA has increased over the years**
  - In 2001, 1 percent in MA (16 percent among non-duals)
  - In 2011, 20 percent in MA (27 percent among non-duals)
- **Much higher proportion of dually-eligible beneficiaries are under 65 (entitled to Medicare based on disability)**
  - 41 percent, compared to 12 percent among non-duals (2011)
- **Beneficiaries under 65 tend not to enroll in MA; as of 2011:**
  - 10 percent of non-duals under 65 in MA
  - 14 percent of dually-eligible beneficiaries under 65 in MA
- **How does the program ensure that all bidding plans are able to serve dually-eligible beneficiaries?**

Issues to discuss

- **Should Part D be the model for subsidizing costs for low-income beneficiaries in CPC?**
- **Lack of uniformity across states in cost sharing rules**
- **Lack of uniformity in benefits across states**
- **Should the dually-eligible population be segmented in some ways for CPC?**
  - Combined bid for Medicare A/B, Part D and Medicaid benefits? Separate bid for Medicaid benefits?
  - Not all plans bidding on this population?
  - Could the non-dual beneficiaries purchase the Medicaid benefit package for a premium, or is it not offered to non-duals?
- **Plan readiness and expectations for serving dually-eligible beneficiaries**