

### Reforming Medicare's fee-for-service benefit design

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# Context for reforming Medicare's benefit design

- FFS benefit design leads to few individuals owing most of the 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



#### Example of Medicare cost sharing

- 89-year-old woman, single
- Medigap coverage for all of 2007
- Paid \$1122 in Part B premiums and \$2080 in medigap premiums

Allowed charge	Cost-sharing liability	Beneficiary payment
\$16,653 7,307 7,303 20 20,514	\$992 0 0 4 5,508	\$0 0 0 0 465
\$51,798	\$6 504	\$465
	charge \$16,653 7,307 7,303 20	charge liability   \$16,653 \$992   7,307 0   7,303 0   20 4   20,514 5,508

#### Medicare cost-sharing liability in 2008

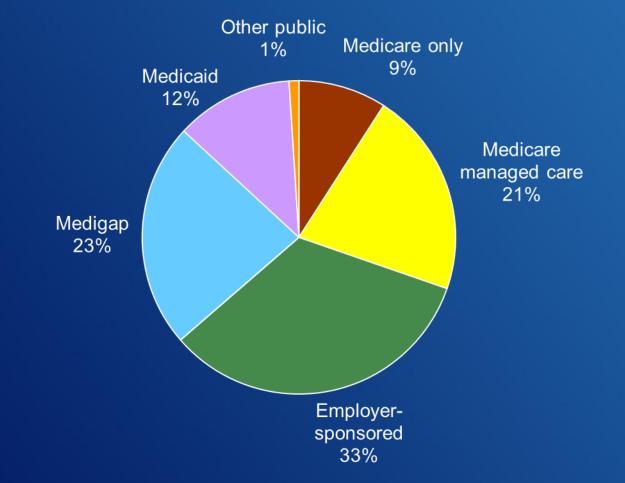
Amount of cost-sharing liability per person	Percent of FFS beneficiaries	Average amount of cost sharing per beneficiary
\$1 to \$499	42%	\$250
\$500 to \$1,999	36%	\$1,071
\$2,000 to \$4,999	16%	\$3,036
\$5,000 to \$9,999	4%	\$6,879
\$10,000 or more	2%	\$15,402

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.

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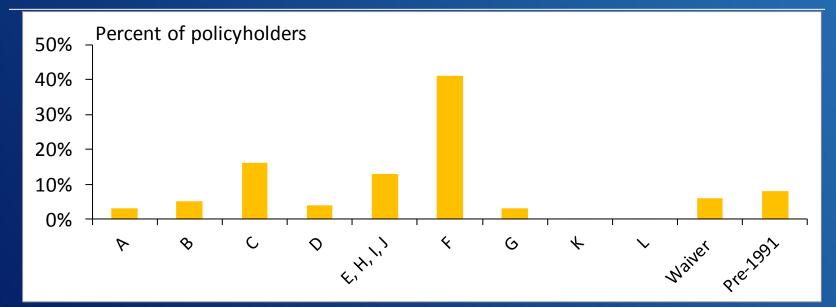
### Most FFS beneficiaries have supplemental coverage that fills in Medicare cost sharing



Note: Excludes beneficiaries who were institutionalized and for whom Medicare was secondary payer. Source: MedPAC analysis of Medicare Current Beneficiary Survey, cost & use files, 2007.



### Medigap plans C and F fill in most all of Medicare's cost sharing (2009 data)



Part A deductible		Х	Х	Х	Х	Х	Х	X (50%)	X (50%)	?	?
Part B deductible			Х			Х				?	?
Average annual premium	\$1,400	\$1,800	\$2,000	\$2,100	\$2,000	\$2,000	\$1,900	\$900	\$1,500	\$2,300	\$2,700



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

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

#### Medigap provision in PPACA

- 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

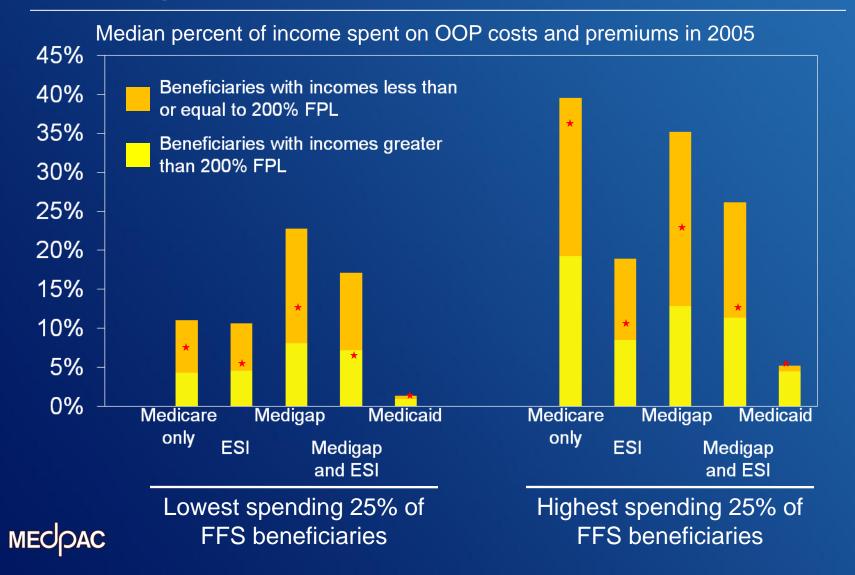


#### Lower-income FFS beneficiaries tend to have Medicaid or no supplemental coverage

- 47% of all Medicare beneficiaries have incomes below 200% of poverty
- Of Medicare beneficiaries covered by Medicaid:
  - 64% have incomes below poverty
  - 97% have incomes below 200% of poverty
- Of Medicare beneficiaries without supplemental coverage:
  - 21% have incomes below poverty
  - 66% have incomes below 200% of poverty



## Wide variation in financial burden among beneficiaries



## How does cost-sharing affect service use?

- RAND Health Insurance Experiment found that:
  - Cost sharing reduces the use of both necessary and unnecessary services
  - Cost sharing has no adverse effect on most participants but there were exceptions among the sickest and poorest individuals
  - Once patients chose to initiate care, cost sharing only modestly affected the intensity or cost of an episode of care
- Research shows that Medicare beneficiaries with supplemental coverage tend to have higher service use



## Innovative benefit designs in the public and private sector

#### 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



## Lowering cost sharing for high-value services

- Most used for preventive services and prescription drugs to treat chronic conditions
- Targeting increases likelihood program will be cost saving but is challenging to implement
- Many payers only reduce cost-sharing if enrollee participates in disease management or other support program

## Raising cost sharing for low-value services

- Less common than other strategies
- Reference pricing e.g. drugs, colonoscopies
- Benefit package developed and offered by several insurers in Oregon includes 3 tiers for services:
  - 1<sup>st</sup> level with no cost-sharing
  - 2<sup>nd</sup> level with typical copayments
  - 3<sup>rd</sup> level for preference-sensitive services

#### MECIPAC

### Incentivizing enrollees to see highperforming providers

- Preferred provider networks
- Site of care incentives
  - Lower copayments for primary care visits
  - Centers of excellence for specialized treatments
- Second opinions
- Information to consumers on efficient providers and sites of care



#### Incentivizing healthy behaviors

#### Health risk assessments

- Care management and other programs to teach enrollees to manage their care
- Gradually increasing requirements for wellness incentives
- Higher premiums for smokers coupled with access to no-cost smoking cessation programs



#### Integrating design innovations

- All interviewees used more than one innovation and stressed the need to coordinate multiple strategies and align enrollee and provider incentives
- Interviewees cited success of their initiatives but research is limited and many programs are too new to evaluate
- Outcomes also depend on population and ability to implement programs



### Discussion questions: short term issues

#### 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?



## Discussion questions: Intermediate issues

- Should Medicare simplify its cost sharing structure by moving to copayments?
- Should Medicare incentivize efficient provider arrangements e.g. lower copayments for ACOs?
- Should Medicare use cost sharing to encourage beneficiaries to choose efficient providers?
- Should Medicare vary copays for high and low value services?



## Discussion questions: Long term issues

- What strategies can be used in a managed environment vs. fee-for-service?
- Beneficiaries have to choose between more and less managed plans. Should the government subsidy be affected by beneficiary choice?

