

*Advising the Congress on Medicare issues*

# Reforming Medicare's benefit design

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# Goals for today's presentation

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- Work toward draft recommendations in spring
- Define the key characteristics of the new benefit design
- Address policy questions relative to implementing new benefit design

# Objectives for reforming Medicare's benefit design

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- Reduce beneficiaries' exposure to risk of unexpectedly high out-of-pocket spending
- Require some cost sharing to discourage use of lower-value services
- Be mindful of effects on low-income beneficiaries and those in poor health

# Review of previous presentations

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- Began with 3 alternative benefit packages
  - 1) OOP maximum of \$5000
  - 2) Combined deductible for Part A and Part B services
  - 3) Copayments by type of service
  
- Combined beneficiary liability–neutral package with 3 options related to supplemental coverage
  - 1) Remaining unchanged
  - 2) Not allowed to fill in any cost sharing
  - 3) Not allowed to fill in the deductible but can fill in 50% of copayments

# Outline of today's presentation

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- Review illustrative FFS benefit packages
  - Keep aggregate beneficiary cost-sharing liability the same (program spending would increase)
  - Keep Medicare program spending the same (beneficiary cost sharing would increase)
- Discuss excise tax on supplemental insurance

# Redesigned FFS benefit package

Design elements	Medicare Advantage-like package from November
OOP maximum	\$5000
A & B deductible	\$750
Hospital (per stay)	\$600
Physician (per visit)	\$25
Outpatient (per visit)	\$100
SNF (per day)	\$100
DME	20%
Hospice	0%
Home health	5%*

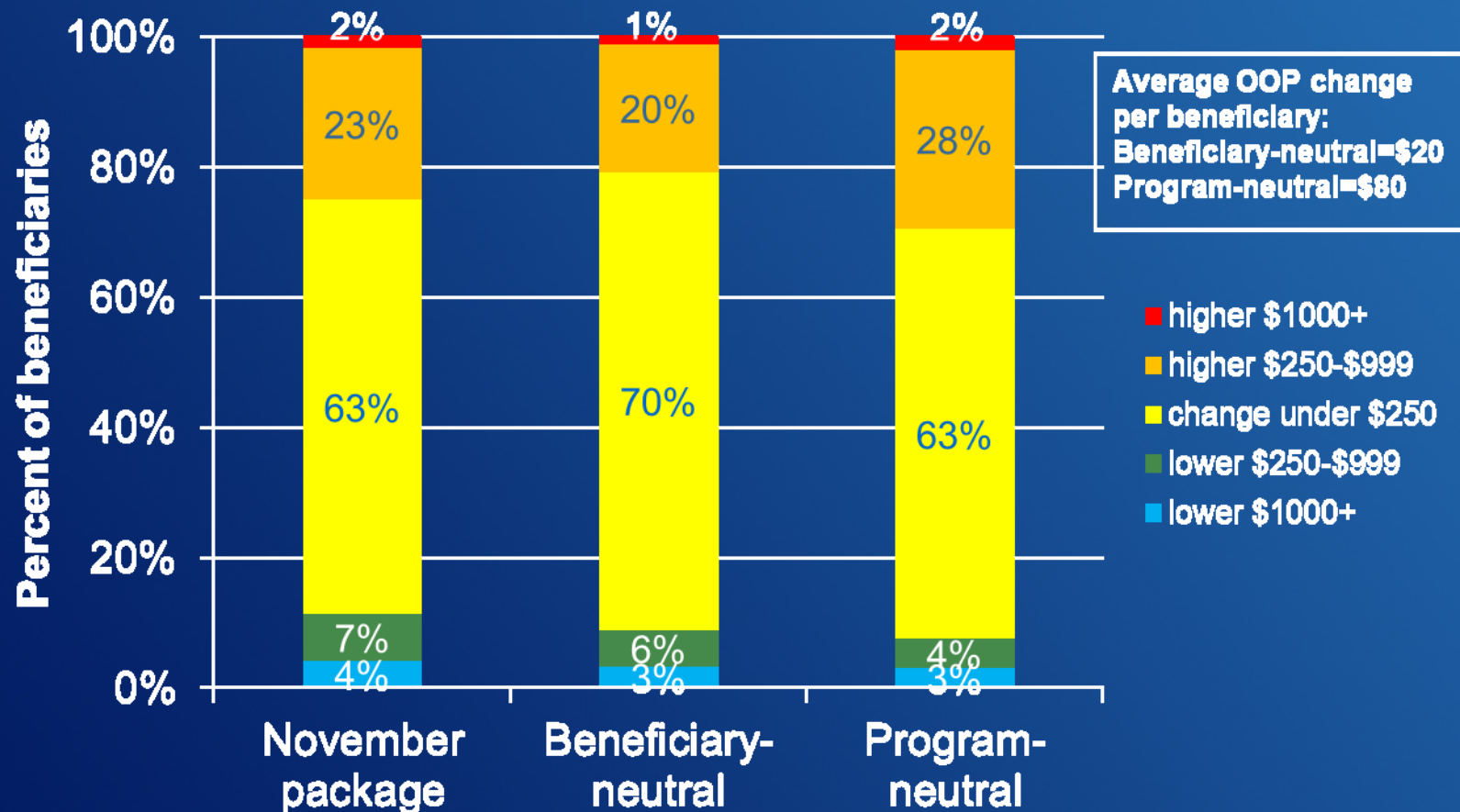
Note: We modeled the \$150 copayment considered by the Commission as a 5% coinsurance on home health services for simplicity.

# Redesigned FFS benefit package: illustrative alternatives

Design elements	“Beneficiary-neutral” package	“Program-neutral” package
OOP maximum	\$5000	\$5000
A & B deductible	\$500	\$750
Hospital (per stay)	\$750	\$750
Physician – PCP/specialist (per visit)	\$20/\$40	\$20/\$40
Part B drugs	20%	20%
Advanced imaging (per study)	\$100	\$100
Outpatient (per visit)	\$100	\$100
SNF (per day)	\$80	\$100
DME	20%	20%
Hospice	0%	0%
Home health	5%*	5%*

Note: We modeled the \$150 copayment considered by the Commission as a 5% coinsurance on home health services for simplicity.

# Changes in Medicare OOP spending and premiums under alternative benefit packages, 2009



Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year and not enrolled in private Medicare plans and Medicaid in 2009.

Source: MedPAC based on data from CMS.

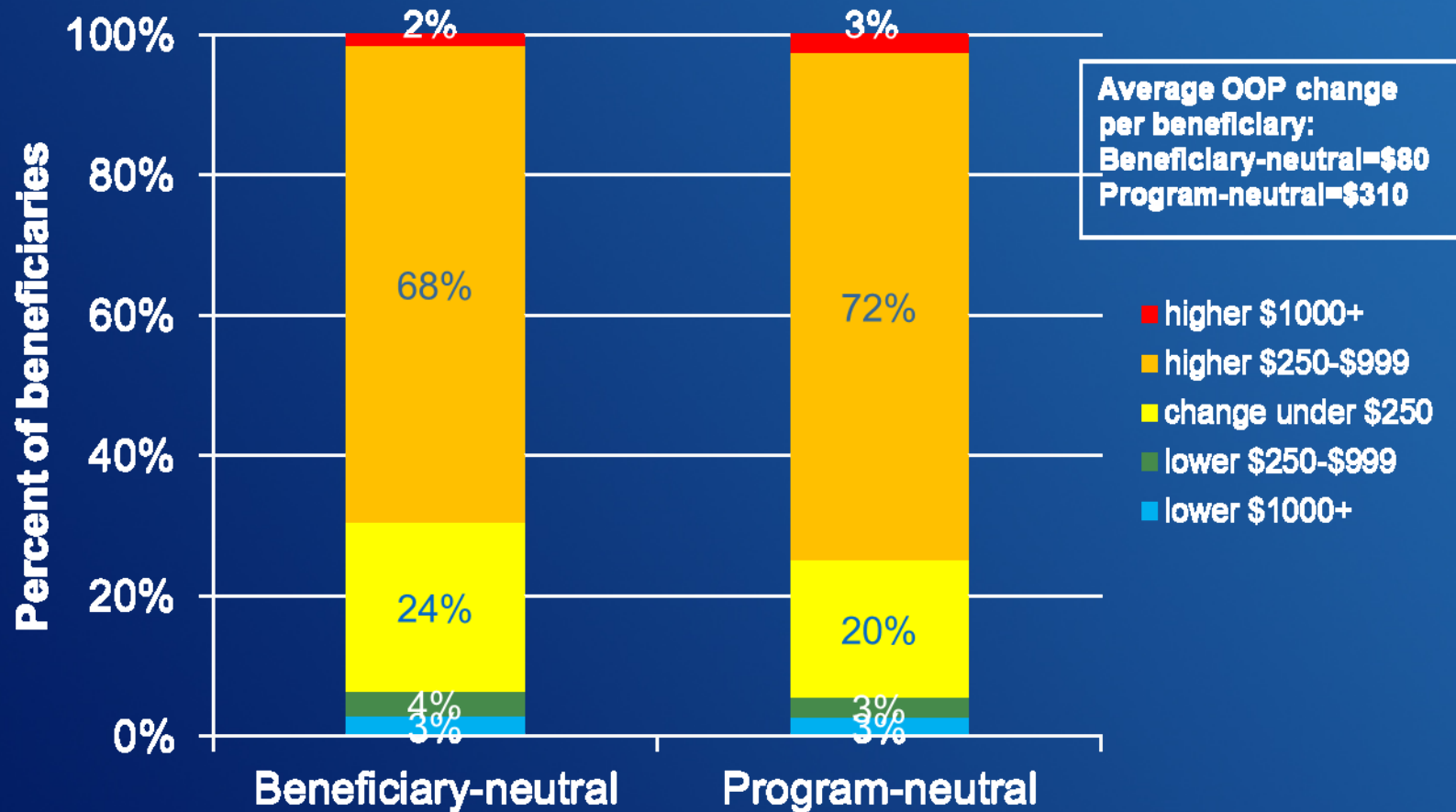


# Excise tax on supplemental insurance

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- Tax approach over regulatory approach
- Modeled a simple 20 percent tax on premiums of medigap and employer-sponsored retiree plans
  - Provides revenues
  - Some might drop supplemental insurance
- Policy design questions
  - Tax rate
  - Base on the generosity threshold of the coverage
  - New vs. all supplemental insurance

# Changes in Medicare OOP spending and premiums under tax on supplemental coverage, 2009



Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year and not enrolled in private Medicare plans and Medicaid.

Source: MedPAC based on data from CMS.

# Budgetary implications

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## Change in annual program spending, 2009

	“Beneficiary-neutral” package	“Program-neutral” package
Medicare program spending	+1%	0%
Revenue offsets from a 20% tax	-1.5%	-1.5%
Net budgetary effect	-0.5%	-1.5%

*Preliminary and subject to change.*

# Caveats and limitations of our modeling

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- One-year snapshot of relative changes—not a budget score
- Excludes dually-eligible beneficiaries
- Sensitive to behavioral assumptions
- Simplifying assumptions on supplemental coverage
  - Average premiums
  - No reliable data on switching
- Does not capture the value of insurance for risk-averse beneficiaries

# Flexibility in benefit design

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- Identify key design elements that are “fixed” vs. those that are allowed to vary based on medical evidence
- Create appropriate incentives to discourage low-value services and encourage high-value services
- Give Secretary the authority to reduce cost sharing on high-value services

# Key components of illustrative recommendation

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- Direct the Secretary to develop a new FFS benefit design with
  - OOP maximum
  - combined deductible for Part A and Part B services
  - copayments that may differentiate by type of service and provider (e.g., primary care vs. specialist visits)
- Authorize the Secretary to reduce cost sharing on high-value services
- Changes in the benefit should be beneficiary-neutral vs. program-neutral?
- Establish excise tax on supplemental coverage