Advising the Congress on Medicare issues

Recent changes that affect beneficiaries' financial liability

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Issues to consider

- Balance between providing insurance protection and maintaining sensitivity to health care costs
- How do premiums and cost sharing compare between fee-for-service (FFS) Medicare and Medicare Advantage (MA) plans?
- What can we learn from the experience of MA plans?

Few direct changes to FFS cost sharing

- Most FFS cost sharing takes form of percentage coinsurance
  - No out-of-pocket cap on FFS cost sharing
  - If effective, efforts to constrain growth in provider payments could also reduce growth in beneficiary premiums and cost sharing over time
- Removed all cost sharing for preventive services recommended with grade “A” or “B” by U.S. Preventive Services Task Force

Part B premiums

- In 2010
  - Three quarters of beneficiaries protected by hold-harmless provision (flat at $96.40 per month)
  - For 4 groups, base premium increased to $110.50
    - New to Part B
    - Premiums paid by Medicaid or Medicare Savings Plans
    - If subject to income-related premium
    - Part B enrollees who are not enrolled in Social Security
- Expect similar change for 2011
- Under PPACA, more beneficiaries will be subject to income-related premiums

Changes to private secondary insurance

- Secretary to request National Association of Insurance Commissioners to revise standards for Plan C and Plan F medigap policies to include nominal cost sharing
  - New standards would apply to policies sold after Jan. 1, 2015
  - Grandfathers current policyholders
- Broader effects of health reform on retiree health coverage not yet known

Cost sharing in Medicare Advantage

- On average, cost sharing for MA enrollees less than for FFS beneficiaries
- In part, reflects generosity of MA payments
  - Only HMO have bids that average less than FFS Medicare, with difference a component of "rebate" dollars that finance extra benefits
  - For all other plan types, rebates possible because of payments in excess of FFS
- May change in the future

General features of cost sharing in Medicare Advantage plans

- Typically quite different from Medicare FFS
- General statutory rules apply:
  - Actuarial value of cost sharing for Medicare Part A and Part B services cannot exceed FFS
  - Cost sharing cannot be discriminatory
- CMS has used non-discrimination provision to impose specific limits and benefit designs
- Recent statutory changes have also imposed specific limits

Typical differences between MA and FFS cost sharing

	FFS Medicare	Typical MA design
Physician services	20% coinsurance	Fixed dollar copay; higher copay for specialists
Inpatient hospital care	Deductible in benefit period, daily copays for lengthy stays, limit on days covered	No deductible; daily copays only at beginning of stay (up to 10th day, for example); no limit on number of days covered; higher cost sharing for inpatient mental health (and often same day limits for mental health as FFS)
Durable medical equipment	20% coinsurance	often same as FFS
Home health care	no cost sharing	some plans impose cost sharing
Protection against catastrophic expenses	no limit	voluntary and (newly) required limits on a member's out-of-pocket expenditures

Specific rules on MA cost sharing

- Rules/policy:
  - $50 emergency room limit
  - Cost sharing for certain services not to exceed FFS (e.g. Part B drugs)
  - Out-of-pocket caps now mandatory
- Recent legislation:
  - Cost sharing on certain services cannot exceed that of Medicare (chemotherapy administration, renal dialysis, skilled nursing facility, and “other services designated by the Secretary”)
  - Medicare-Medicaid dual eligibles have same protections as in FFS (law: in special needs plans; by regulation: all duals)

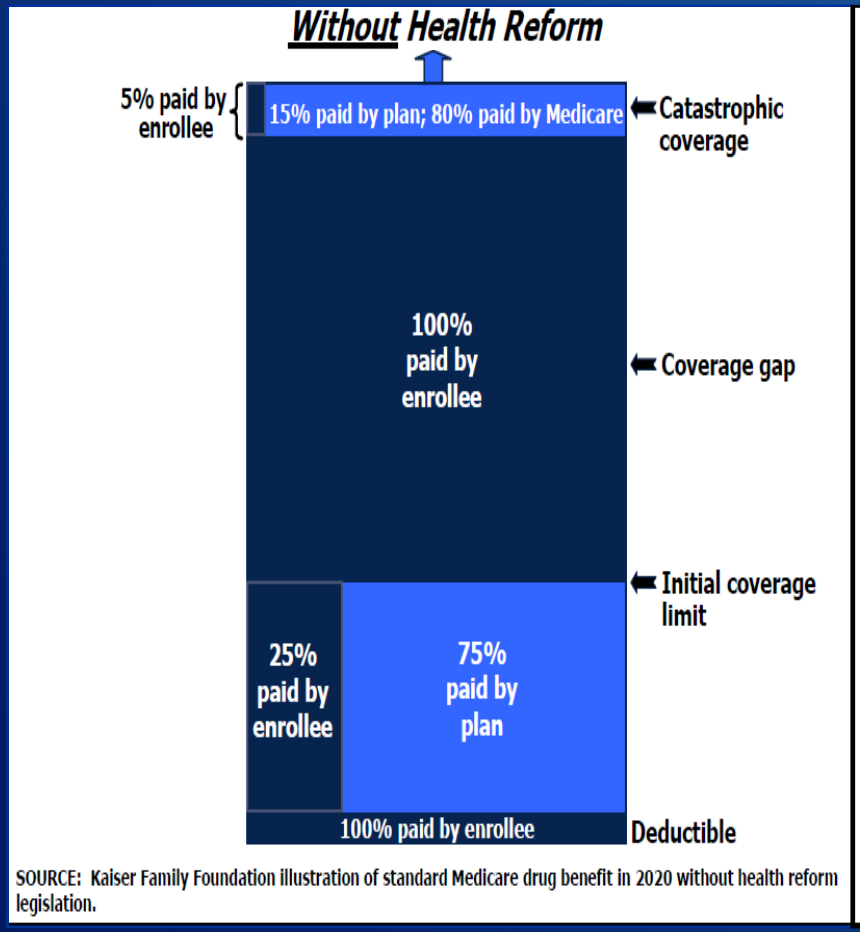
Out-of-pocket caps in MA

- Mandatory limits for all plans, with dollar limit set at the 95th percentile of FFS out-of-pocket expenditures ($6,700 for 2011)
- Voluntary limits allowing higher cost sharing for plan benefits—85th percentile (retained at $3,400 level for 2011)
- Preferred provider organizations (PPOs) must have in-network caps as well as combined caps for in- and out-of-network expenses.

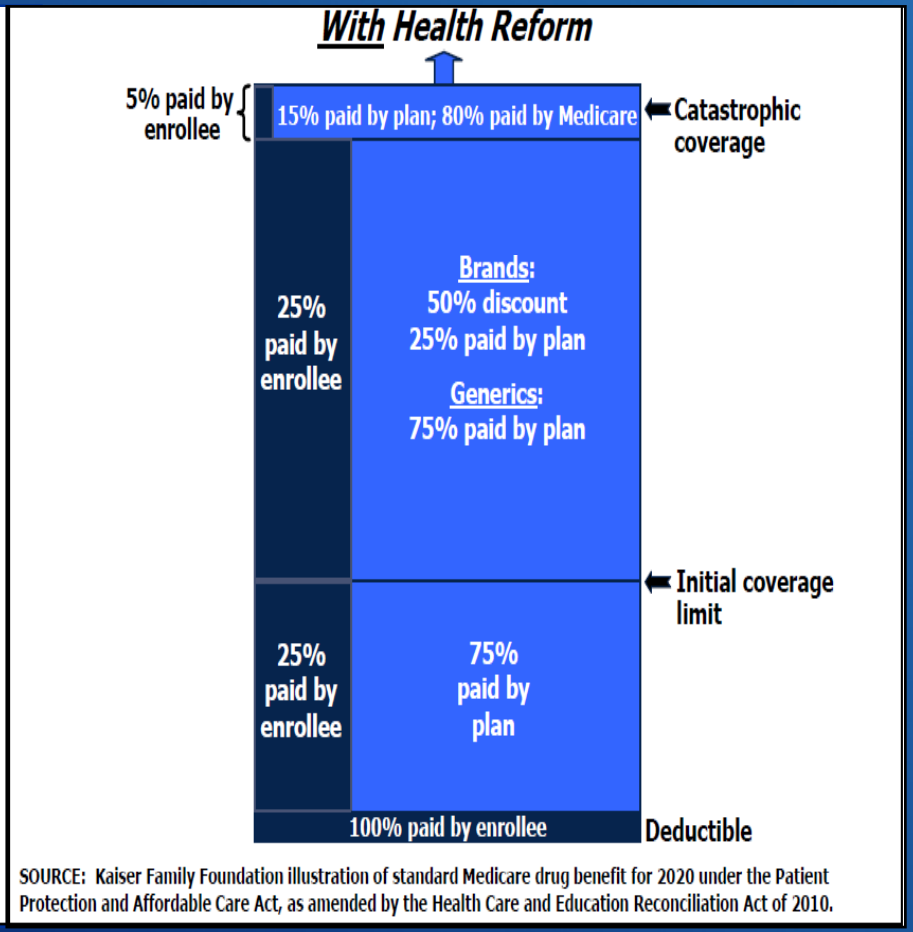
Phasing out the Part D coverage gap

- $250 rebate in 2010
- Coverage gap discount program beginning in 2011
- Cost sharing reduced from 100% to 25% by 2020
  - Beginning in 2011 for generics
  - Beginning in 2013 for brand-name drugs
- Slower growth in OOP threshold between 2014 and 2019

Standard Medicare Part D drug benefit with and without health reform



SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit in 2020 without health reform legislation.



SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2020 under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

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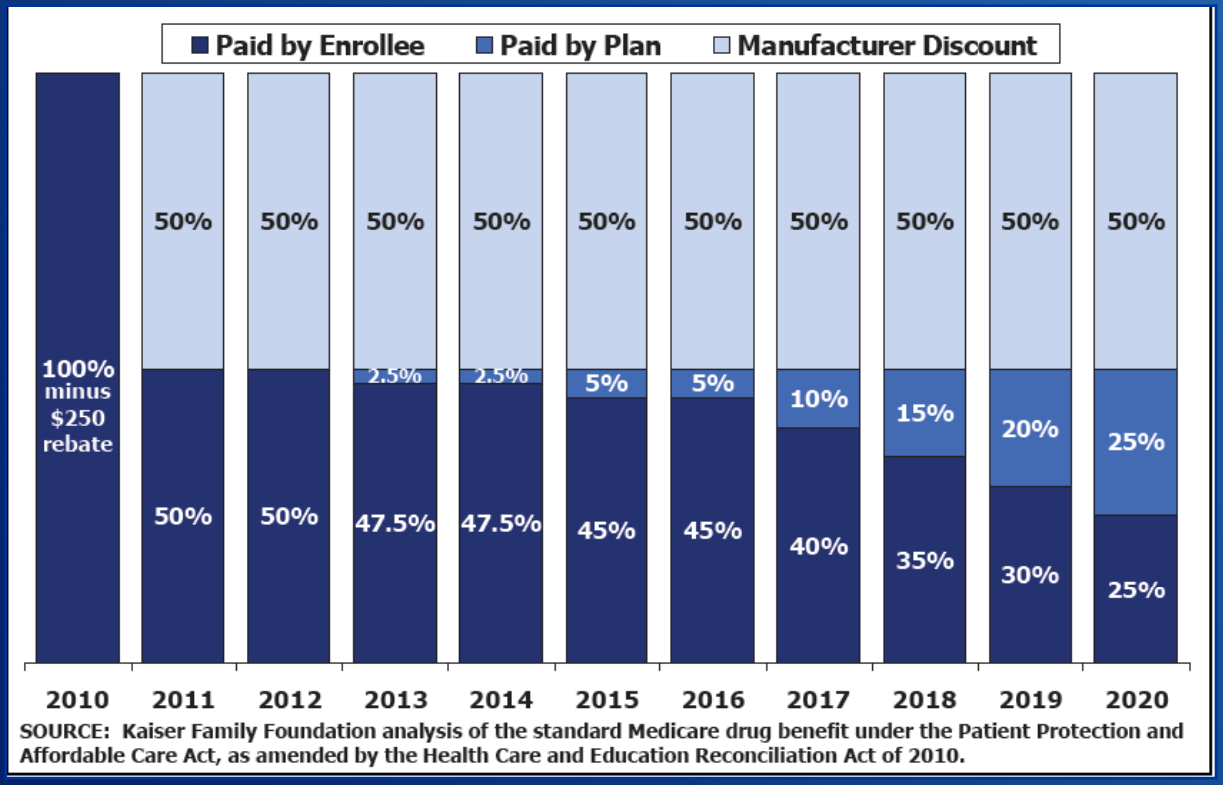
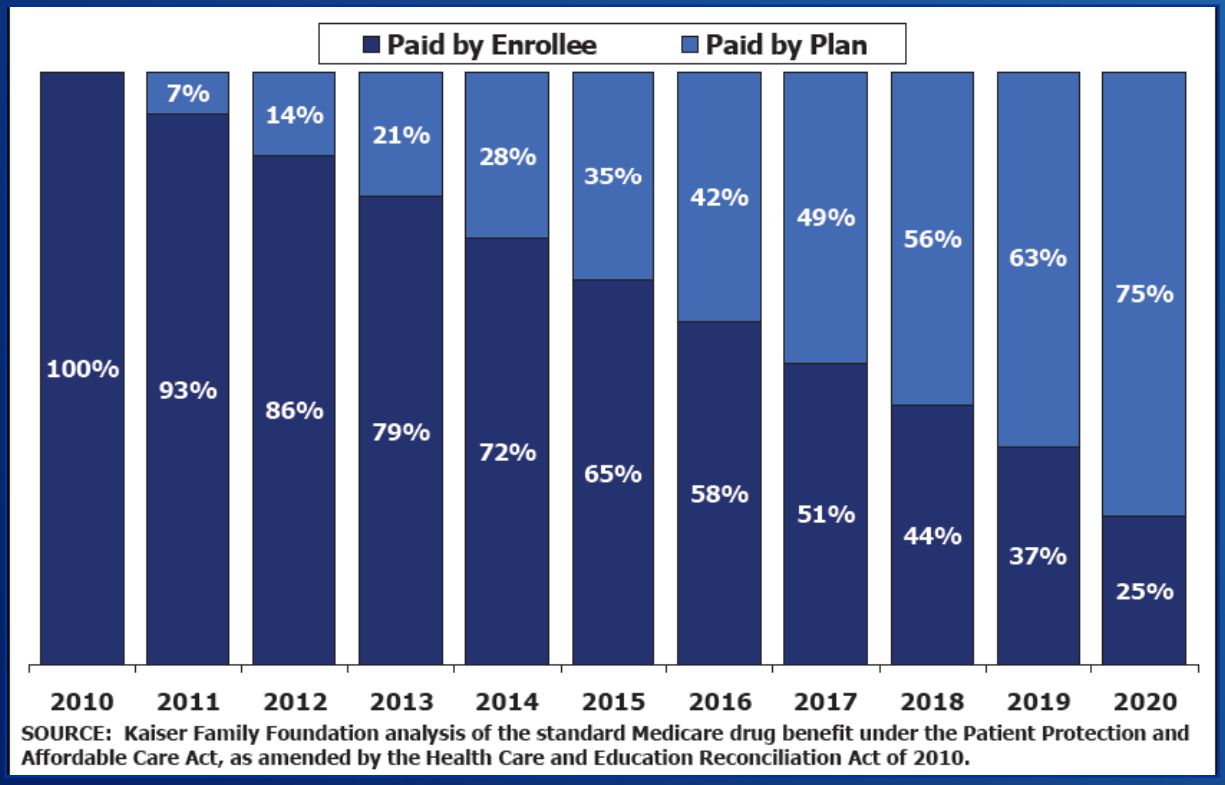
Cost sharing for brand-name drugs in the coverage gap, 2010-2020



SOURCE: Kaiser Family Foundation analysis of the standard Medicare drug benefit under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

Cost sharing for generic drugs in the coverage gap, 2010-2020



SOURCE: Kaiser Family Foundation analysis of the standard Medicare drug benefit under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

Coverage gap discount program

- Manufacturers provide 50% discount to enrollees who do not receive Part D's low-income subsidy
- Discount applies to plans' negotiated prices
- Once an enrollee is in the coverage gap, they pay pharmacy the discounted price
- Amount of discount counts toward enrollees' annual out-of-pocket threshold

Part D premiums

- PPACA income related these premiums beginning in 2011
- Same income thresholds as Part B premium
- No increase in thresholds between 2011 and 2019

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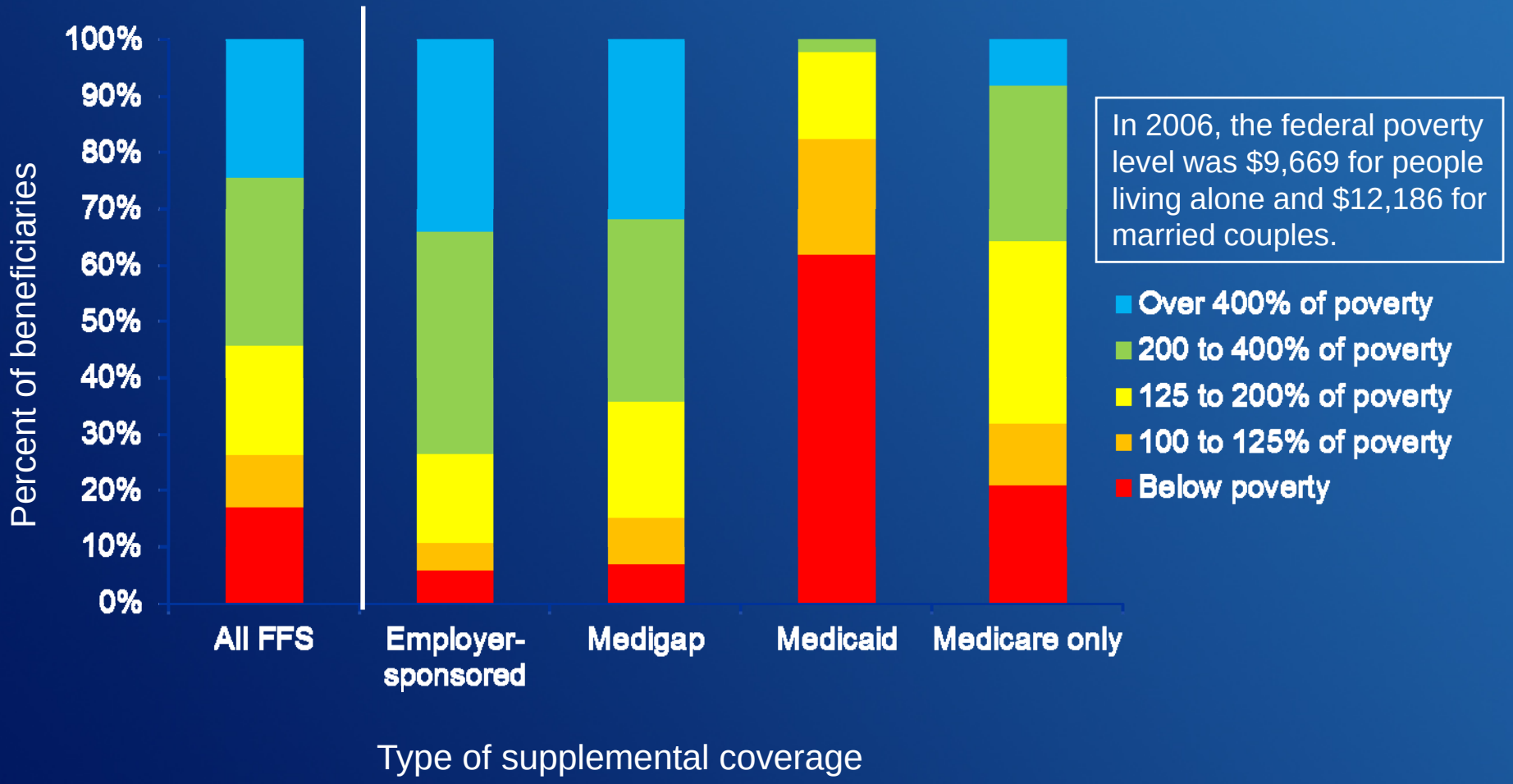
Backup slides

A plan's choice of a voluntary versus mandatory cap affects allowed cost sharing

	Voluntary cap amount (set by CMS, about 85th percentile)	Mandatory cap (set by CMS, 95th percentile)	Example of permitted cost sharing—days 1-6 of a hospital stay
Plan X, HMO choosing voluntary annual cap	**$3,400**	**---**	$2,016 maximum allowed
Plan Y, HMO choosing mandatory annual cap	**---**	**$6,700**	$1,613 maximum allowed

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



In 2006, the federal poverty level was $9,669 for people living alone and $12,186 for married couples.

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Source: MedPAC analysis of noninstitutionalized FFS beneficiaries in the 2006 Medicare Current Beneficiary Survey, Cost & Use files.