

CHAPTER

1

**Reforming Medicare's
benefit design**

R E C O M M E N D A T I O N

The Congress should direct the Secretary to develop and implement a fee-for-service benefit design that would replace the current design and would include:

- an out-of-pocket maximum;
- deductible(s) for Part A and Part B services;
- replacing coinsurance with copayments that may vary by type of service and provider;
- secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum;
- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on supplemental insurance.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Reforming Medicare's benefit design

Chapter summary

The Commission has been considering ways to reform the traditional benefit package with two main goals: to give beneficiaries better protection against high out-of-pocket (OOP) spending and to create incentives for them to make better decisions about their use of discretionary care.

The current fee-for-service (FFS) benefit design includes a relatively high deductible for inpatient stays, a relatively low deductible for physician and outpatient care, and a cost-sharing requirement of 20 percent of allowable charges for most physician care and outpatient services. Under this design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. Without additional coverage, the FFS benefit design exposes Medicare beneficiaries to substantial financial risk.

In part due to the lack of comprehensiveness in the FFS benefit design, almost 90 percent of FFS beneficiaries receive supplemental coverage through medigap, employer-sponsored retiree plans, or Medicaid. This additional coverage addresses beneficiaries' concerns about the uncertainty of OOP spending under the FFS benefit. However, it also reduces incentives to weigh their decisions about the use of care. As currently structured, many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, regardless of whether there is evidence that the service is ineffective or, conversely, whether it might prevent a hospitalization.

In this chapter

- Cost sharing under Medicare's FFS benefit
- Design issues for reforming Medicare's benefit
- Commission's views on FFS benefit design reform
- Illustrative benefit package

Moreover, most of the costs of increased utilization are borne by the Medicare program.

Much of the Commission's work focuses on changing Medicare's payment systems to give providers incentives to maintain access to care and improve quality and efficiency in light of limited financial resources. However, to control program expenditures in a way that protects access and quality, provider and beneficiary incentives should be aligned. To date we have devoted most of our attention to provider payments and delivery system reform; it is equally important to consider how beneficiary choices affect the program.

In this chapter, we focus on key design issues related to restructuring cost sharing under the FFS benefit. We present an illustrative benefit package that shows one way to address each of the key design issues. We also present the budgetary and distributional effects of this illustrative package.

The chapter concludes with the Commission's recommendation on the redesign of the FFS benefit package. The goal of the recommendation is to protect beneficiaries against high OOP spending, thus enhancing the overall value of the FFS benefit and mitigating the need for beneficiaries to purchase supplemental insurance. The recommendation creates clearer incentives for beneficiaries to make better decisions about their use of care while holding the aggregate beneficiary cost-sharing liability about the same as under current law. It also allows for ongoing adjustments and refinements in cost sharing as evidence of the value of services accumulates and evolves. Finally, by adding a charge on supplemental insurance, the recommendation aims to recoup at least some of the additional costs resulting from the higher service use supplemental insurance imposes on the Medicare program while still allowing risk-averse beneficiaries the choice to buy supplemental coverage if they wish to do so.

Many recently proposed changes to the Medicare program would require beneficiaries to pay more. By contrast, the Commission's recommendation to hold beneficiary liability neutral reflects our position that beneficiaries' costs in the aggregate should not increase in the redesign of the FFS benefit. Furthermore, we believe that the actuarial value of the benefit package should not be reduced while protecting beneficiaries against high OOP spending. At the same time, in recommending an additional charge on supplemental insurance, we maintain that it is reasonable to ask beneficiaries to pay more when their decision to get supplemental coverage imposes additional costs on the program—those costs are currently paid for by taxpayers and all Medicare beneficiaries. ■

Introduction

The design of fee-for-service (FFS) Medicare's Part A and Part B benefits affects program spending and value through coverage policies and cost-sharing requirements. For certain situations and conditions, Medicare's cost sharing can affect beneficiaries' decisions about whether to initiate care, whether to continue care, what types of providers to see, and which treatments to use. While Medicare Advantage (MA) plans have multiple ways to influence beneficiary behavior, under FFS, variation in cost sharing is the primary option available to the program to encourage efficient use of program resources.

Reforming the FFS benefit presents an opportunity to improve the benefit package while aligning beneficiary incentives and program goals to obtain high-quality care for the best value. Of particular importance, reforms could improve financial protection for individuals who have the greatest need for services and who currently have very high cost sharing. Under the current design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. In addition, the use of coinsurance based on charges that the patient does not know in advance creates uncertainty for beneficiaries about how much they owe. As a result, most beneficiaries purchase supplemental coverage. However, the prevalence of supplemental coverage eliminates beneficiary incentives at the point of service and limits Medicare's ability to use cost sharing as a policy tool.

Because of the high rates of cost growth experienced by the health care sector, the Medicare program and other health care payers are on an unsustainable financial path. In light of limited financial resources, much of the Commission's work focuses on changing Medicare's payment systems to give providers incentives to maintain access to care and improve quality and efficiency. The treatment recommendations of medical providers strongly influence the amount of care beneficiaries receive. However, to control program expenditures in a way that protects access and quality, provider and beneficiary incentives should be aligned. To date, we have devoted most of our attention to provider payments and delivery system reform; it is equally important to consider how beneficiary choices affect the program.

The basic benefit design has changed little since Medicare's inception in 1965. But since that time, employers and private insurers have experimented with benefit design to influence when and from whom patients

seek care, to guide patients toward preferred providers or more valuable therapies, and to shift the incidence of health care costs to patients.

In the future, FFS benefit design and cost sharing could be used to pursue policy goals, such as encouraging the use of providers with better track records on quality and resource use, encouraging patients to adhere to certain treatments, and encouraging provision of high-value services. Moreover, a benefit package that meets beneficiaries' need to lower financial risk and uncertainty could lessen their desire to purchase supplemental coverage. These considerations are particularly important as employer-sponsored supplemental benefits erode over time. Aligning the benefit design with what beneficiaries value and consider important could reinforce more effective use of cost sharing as a policy tool in aligning beneficiary incentives.

Cost sharing under Medicare's FFS benefit

The current FFS benefit has considerable cost-sharing requirements. For Part A services, it includes a relatively high deductible for inpatient hospital care (\$1,156 in 2012) and daily copayments for long stays at hospitals and skilled nursing facilities. Patients with more than one hospital admission in a year can owe more than one hospital deductible for the year. For Part B services, the FFS benefit has a relatively low deductible (\$140 in 2012) and requires beneficiaries to pay 20 percent of allowable charges for most services, except for home health, clinical laboratory, and certain preventive services. Annual changes in the deductibles and copayments under Part A and Part B are linked to average annual increases in Medicare spending for those services. (Tables 1-1 and 1-2 summarize Part A and Part B premiums and cost sharing in 2012.)

Under this design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. As a result, a small percentage of Medicare beneficiaries incur very high levels of cost-sharing liability each year (Table 1-3, p. 8). For example, among FFS beneficiaries who enrolled in Part A and Part B for 12 months in 2009, 6 percent had a cost-sharing liability of \$5,000 or more. Without additional coverage, they would be subject to significant financial risk from very high levels of out-of-pocket (OOP) spending.¹

**TABLE
1-1****Premiums and cost-sharing requirements for Part A services in 2012**

Category	Amount
Premiums	\$0 if entitled to Social Security retirement or survivor benefits, railroad retirement benefits, Social Security or railroad retirement disability benefits, or end-stage renal disease benefits. \$248 per month for individuals who are not eligible for premium-free Part A and have 30–39 quarters of Medicare-covered employment. \$451 per month for individuals who are not eligible for premium-free Part A and have fewer than 30 quarters of Medicare-covered employment.
Hospital care	\$1,156 deductible for days 1–60 each benefit period. \$289 per day for days 61–90 each benefit period. \$578 per “lifetime reserve day” after day 90 each benefit period (up to 60 days over lifetime).
Skilled nursing facility care	\$0 for the first 20 days each benefit period. \$144.50 per day for days 21–100 each benefit period. All costs for each day after day 100 in the benefit period.
Home health care	\$0 for home health care services.
Hospice care	\$0 for hospice visits. Up to a \$5 copay for outpatient prescription drugs.
Blood	All costs for the first 3 pints (unless donated to replace what is used).

Note: A benefit period begins the day a beneficiary is admitted to a hospital or skilled nursing facility and ends when the beneficiary has not received hospital or skilled nursing care for 60 days in a row. If the beneficiary is admitted to the hospital after one benefit period has ended, a new benefit period begins and the beneficiary must again pay the inpatient hospital deductible. There is no limit to the number of benefit periods. Part A cost sharing increases over time by the same percentage update applied to payments to inpatient hospitals and adjusted to reflect real change in case mix.

Source: Centers for Medicare & Medicaid Services 2012b.

But for most Medicare beneficiaries, their OOP spending is much smaller than their cost-sharing liability. In part due to the lack of comprehensive coverage in the FFS benefit design, about 90 percent of beneficiaries receive supplemental benefits that fill in some or all of Medicare’s cost sharing. For example, almost one-quarter of Medicare beneficiaries enrolled in Part A and Part B in 2007 had medigap policies and 31 percent had employer-sponsored retiree policies (Medicare Payment Advisory Commission 2011a).²

Supplemental plans include medigap plans and employer-sponsored retiree plans. Low-income beneficiaries can receive supplemental benefits through Medicaid and other programs. Most beneficiaries can also choose MA plans that include some supplemental benefits and variations on cost sharing. These four sources of supplemental benefits are briefly described below.

Medigap plans

Medigap plans are individually purchased from private insurance companies and are offered in 10 standard packages of benefits, identified by letters of the alphabet.

Standard medigap policies vary in how they wrap around Medicare’s cost sharing (Table 1-4, p. 9).³ The most popular types of medigap policies—standard Plan C and Plan F—fill in nearly all of Medicare’s cost-sharing requirements, including the Part A and Part B deductibles.⁴ More recent enrollment trends, however, show that the newer standardized medigap plans, which include enrollee cost sharing, are becoming more popular. For example, Plan N represented 15 percent of new medigap policies purchased in early 2011 and is the most popular of the newer standardized plans (America’s Health Insurance Plans 2011).

Employer-sponsored retiree plans

Employer-sponsored insurance typically provides beneficiaries with broader coverage for lower premiums than medigap policies, but it requires retirees enrolled in Medicare to pay deductibles and cost sharing just as active workers and younger retirees do. Retiree policies through large employers typically include a lower deductible for hospitalizations than Medicare’s deductible; a cap on OOP spending; and sometimes benefits that FFS Medicare does not cover, such as dental care (Yamamoto 2006).

**TABLE
1-2**

Premiums and cost-sharing requirements for Part B services in 2012

Category	Amount
Premiums	<p>\$99.90 per month: All beneficiaries with incomes below the thresholds shown below or with premiums paid by state Medicaid programs or Medicare Savings Programs.</p> <p>\$139.90 per month: Single beneficiaries with incomes between \$85,001 and \$107,000. Couples with incomes between \$170,001 and \$214,000.</p> <p>\$199.80 per month: Single beneficiaries with incomes between \$107,001 and \$160,000. Couples with incomes between \$214,001 and \$320,000.</p> <p>\$259.70 per month: Single beneficiaries with incomes between \$160,001 and \$214,000. Couples with incomes between \$320,001 and \$428,000.</p> <p>\$319.70 per month: Single beneficiaries with incomes above \$214,000. Couples with incomes above \$428,000.</p>
Deductible	The first \$140 of Part B–covered services or items.
Physician and other medical services	20% of the Medicare-approved amount for physician services, outpatient therapy (subject to limits), and durable medical equipment.
Outpatient hospital services	A coinsurance or copayment amount that varies by service, projected to average 21% in 2012. These rates are scheduled to phase down to 20% over time. No copayment for a single service can be more than the Part A hospital deductible (\$1,156 in 2012).
Mental health services	40% of the Medicare-approved amount for outpatient mental health care. This coinsurance rate is scheduled to phase down to 20% by 2014.
Clinical laboratory services	\$0 for Medicare-approved services.
Home health care	\$0 for home health care services.
Durable medical equipment	20% of the Medicare-approved amount.
Blood	All costs for the first 3 pints, then 20% of the Medicare-approved amount of additional pints (unless donated to replace what is used).

Note: Medicare began phasing in income-related premiums over a three-year period beginning in 2007. As of 2012, higher income individuals pay monthly premiums equal to 35 percent, 50 percent, 65 percent, or 80 percent of Medicare’s average Part B costs for aged beneficiaries, depending on income. Normally, all other individuals pay premiums equal to 25 percent of average costs for aged beneficiaries. About 5 percent of Medicare beneficiaries currently pay the higher premiums. For individuals paying standard premiums, an increase in Part B premiums cannot exceed their cost-of-living adjustments in Social Security benefits. The Part B deductible changes over time by the rate of growth in per capita spending for Part B services.

Source: Centers for Medicare & Medicaid Services 2012b.

Employers that offer retiree plans often pay much of the premium for supplemental coverage. One 2007 survey found that, on average, large employers subsidized 60 percent of the total premium for single coverage; retirees paid 40 percent (Gabel et al. 2008).

Although the percentage of Medicare beneficiaries with employer-sponsored retiree coverage has remained fairly constant since the early 1990s (Merlis 2006), the number of large employers offering such coverage to new retirees

has been declining, which will affect future cohorts of Medicare beneficiaries. For example, among large employers offering health benefits to active workers, the percentage offering retiree health benefits has declined from 66 percent in 1988 to 26 percent in 2011 (Kaiser Family Foundation and Health Research & Educational Trust 2011). Moreover, some employers might offer retiree coverage to new retirees only until they become eligible for Medicare. As those cohorts replace older ones

**TABLE
1-3****Distribution of Medicare beneficiaries' cost-sharing liability in 2009**

Range of cost-sharing liability per beneficiary	Percent of FFS beneficiaries	Average amount of cost-sharing liability per beneficiary
\$0	6%	\$0
\$1 to \$135 (2009 Part B deductible)	3	85
\$136 to \$499	34	289
\$500 to \$999	19	713
\$1,000 to \$1,999	16	1,456
\$2,000 to \$4,999	16	3,048
\$5,000 to \$9,999	4	6,869
\$10,000 or more	2	15,536

Note: FFS (fee-for-service). 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. 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.

Source: MedPAC based on data from CMS.

in Medicare, employer-sponsored supplemental coverage will play less of a role than it does today.

Supplemental coverage for beneficiaries with low incomes

Medicare and Medicaid provide supplemental coverage for low-income Medicare beneficiaries but the eligibility criteria vary by state. Beneficiaries with incomes below 75 percent of the federal poverty level with assets no greater than \$2,000 for individuals (\$3,000 for couples) are entitled to full Medicaid benefits as well as coverage for the Medicare Part B premium and Medicare cost sharing.⁵ Additionally, Medicare Savings Programs help beneficiaries with limited incomes pay for Medicare premiums and cost sharing: Beneficiaries with incomes below 100 percent of the federal poverty level who meet their state's resource limits can enroll in the qualified Medicare beneficiary program with Medicaid covering their Part B premium and cost sharing, and beneficiaries with incomes below 135 percent of the poverty level can have their Part B premium covered under the specified low-income beneficiary or the qualifying individual program. About 9.9 million individuals were dual-eligible beneficiaries in 2010.⁶

For Medicare's Part D drug benefit, the Congress designed a low-income subsidy to provide supplemental coverage to individuals with limited incomes. Beneficiaries who meet resource limits and have incomes below 135 percent of poverty have full coverage of Part D premiums and nominal cost sharing. In addition, beneficiaries with

incomes between 135 percent and 150 percent of poverty who meet resource limits can apply for a partial subsidy with sliding scale premiums and reduced cost sharing. In 2011, about 10.5 million beneficiaries (36 percent of Part D enrollees) received the low-income subsidy.

Medicare Advantage plans

About one-quarter of Medicare beneficiaries receive supplemental benefits through private health plans under the MA program. MA plans must cover all Medicare benefits, but they can also provide extra benefits, including lower cost sharing.⁷ Plans can also limit the choice of providers through networks, use utilization management techniques, and establish different cost-sharing requirements than those in FFS Medicare. Although cost sharing is substantially lower in MA plans than in FFS Medicare on an actuarial basis, cost sharing for particular services in some MA plans can be higher.

As MA plans have the flexibility to design their own benefit packages (within actuarial and nondiscrimination limits), there is variation in MA benefit designs. In general, plans have been able to adopt designs similar to employer-sponsored plans for the under-65 population. Beneficiaries are familiar with these designs and accept them as they age into Medicare. Some plans mimic FFS Medicare's benefit package, while others offer no in-network cost sharing at a substantial premium. Also of note, beneficiaries in FFS Medicare may buy a medigap policy that covers some or all Medicare cost sharing, but MA enrollees may not be sold medigap policies.

**TABLE
1-4**

Benefits offered under standard medigap policies in 2012

Benefit	Plan type										
	A	B	C	D	F	F (high deductible)	G	K	L	M	N
Part A hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓* (\$2,070)	✓	✓	✓	✓	✓
Part B cost sharing for other than preventive services	✓	✓	✓	✓	✓	✓	✓	✓** (50%)	✓** (75%)	✓	✓** (\$20/\$50)
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	✓	✓** (50%)	✓** (75%)	✓	✓
Hospice care cost sharing	✓	✓	✓	✓	✓	✓	✓	✓ (50%)	✓ (75%)	✓	✓
SNF coinsurance			✓	✓	✓	✓	✓	✓ (50%)	✓ (75%)	✓	✓
Part A deductible		✓	✓	✓	✓	✓	✓	✓ (50%)	✓ (75%)	✓ (50%)	✓
Part B deductible			✓		✓	✓					
Part B excess charges					✓	✓	✓				
Foreign travel emergency (up to plan limits)			✓	✓	✓	✓	✓			✓	✓

Note: SNF (skilled nursing facility). Insurers began offering standard Plan M and Plan N in June 2010.
 * High-Deductible Plan F pays the same benefits as Plan F after one has paid a calendar year deductible of \$2,070 in 2012. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A and Part B but do not include the plan's separate foreign travel emergency deductible.
 ** Plan K and Plan L require the insured to pay 50 percent and 75 percent, respectively, of cost-sharing payments other than cost sharing for extended hospital stays. After meeting an out-of-pocket limit of \$4,660 in Plan K or \$2,330 in Plan L, the plan pays 100 percent of Medicare cost sharing for covered services for the rest of the calendar year. Plan N has set dollar amounts that beneficiaries pay in lieu of certain Part B coinsurance payments (\$20 for office visits and \$50 for emergency room visits).

Source: Centers for Medicare & Medicaid Services 2012a.

Design issues for reforming Medicare's benefit

Several key design issues are broadly related to beneficiary cost sharing. Generally, the overall structure of cost sharing is defined by three "zones" of relative financial responsibility between the beneficiary and the payer: the OOP maximum, above which the beneficiary pays no (or minimal) costs; the deductible, under which the beneficiary pays all costs; and in between, where the beneficiary pays for some portion according to a specified set of rules. Design issues in restructuring the benefit can be boiled down to deciding where to draw the boundaries

between these three zones and how to organize the rules for the middle zone. Those decisions will affect the overall cost of the program.

OOP maximum

An OOP maximum is a classic feature of an insurance program. It provides financial protection against an unlikely but highly costly event. Because the current FFS benefit does not have a limit on the amount of beneficiaries' cost sharing, a small percentage of Medicare beneficiaries incur very high levels of cost sharing each year. Adding an OOP maximum to the FFS benefit would protect those beneficiaries from very high Medicare cost sharing.⁸

In general, an OOP maximum is valuable to beneficiaries in two ways. First, those who actually incur catastrophic levels of Medicare costs in a given year would be able to limit their liability at the specified OOP maximum. Therefore, their cost sharing would be lower with the OOP maximum than without it. Moreover, as one considers insurance coverage over a period of several years, a larger percentage of beneficiaries would reach the OOP maximum at some point. For example, the percentage of beneficiaries with annual cost-sharing liability of \$5,000 or more at least once over a four-year period is about double the number for a single year—13 percent compared with 6 percent.

Second, even if beneficiaries did not reach the OOP maximum, they still were subject to less risk of paying for very high OOP spending. For risk-averse beneficiaries, the uncertainty and variability in medical spending are an exposure to be protected from. Therefore, an OOP maximum that makes very high OOP spending less uncertain and variable has real value, regardless of whether the actual OOP spending for a given beneficiary is high enough to benefit from it. Although beneficiaries may vary in the level of protection they desire and may even have difficulty quantifying how much the value of insurance protection is worth to them, the value of an OOP maximum would be the peace of mind some beneficiaries get from having such protection if they need it. (See text box, opposite page, on the value of insurance.)

According to the focus groups we conducted in summer of 2011, current and future Medicare beneficiaries (between the ages 55 and 64 years) wanted to reduce uncertainty about their OOP costs in making their health insurance decisions.⁹ Of all the benefit design features we discussed, they were most interested in having an OOP maximum on annual spending for this reason. Some said that fear of costs that would exceed their ability to pay is a primary motivation for purchasing supplemental coverage. Some beneficiaries also liked that their supplemental plans allowed them to simplify the paperwork and budget their expenses through monthly premiums. Some individuals, particularly future beneficiaries, thought a cap on costs would reduce their need to purchase supplemental coverage.

Although a limit on spending was clearly important to them, individuals were not able to articulate specific amounts they would pay for an OOP maximum through higher deductibles, cost sharing, or premiums. Their individual choices were based on their economic situation

and their current health status. They were aware that health risks and costs will grow as they age. For this reason, most wanted the ability to reconsider their choices in future years.

Beneficiaries' perceptions of potential changes in benefit design were closely tied to their current insurance and health status, based on how much they would spend or save compared with their current situation. For Medicare beneficiaries with supplemental coverage, including generous retiree benefits, any potential benefit change was often perceived as a loss. They expressed a desire for more protection against high costs and liked the idea of an OOP limit on spending.

In contrast, future beneficiaries were more likely to consider trade-offs. They generally said they would choose a product that would cost them the least money overall, taking into account premiums and cost sharing for the coming year. There was considerable discussion of trading higher deductibles for lower premiums in the context of an OOP cap on spending. Several noted similar trade-offs between deductibles and premiums in automobile insurance. Some participants seemed comfortable with much higher deductibles (in the thousands of dollars) if they thought they could set aside the money they would need in advance. This option was particularly attractive if the money came from savings on premiums. The above differences point out the importance of what people expect from the Medicare program: Future beneficiaries who were not familiar with the FFS benefit design and had few preconceptions about it were more flexible in considering changes in it, whereas current beneficiaries who were used to the existing benefit were not.

Deductibles for Part A and Part B services

A deductible is a fixed dollar amount that a beneficiary pays in a given year before Medicare starts paying for covered services. Its use in benefit design is more pragmatic than intrinsic. If the goal of an OOP maximum is to provide insurance protection against very high medical costs and the goal of cost sharing—copayments and coinsurance—is to provide incentives at the point of service, the role of a deductible is mainly to reduce the cost of other aspects of the benefit package, such as premiums, copayments, and coinsurance. (However, compared with copayments and coinsurance, a deductible can have a different effect on incentives at the point of service.) While beneficiaries might consider a deductible to be financially burdensome, their overall cost might be

Value of insurance

One key purpose of insurance is to reduce the financial risk posed by catastrophic medical expenses. Risk-averse individuals want protection from the risk of very high and unpredictable medical expenses. To avoid such risks, they are willing to pay a premium higher than the average cost of care they might face. The more risk-averse they are, the more willing they are to pay for the insurance. And the more variable potential outcomes are, the more valuable the insurance protection will be.

The overall spending patterns of Medicare beneficiaries show that in a given year, Medicare spending is highly concentrated, with a small number of beneficiaries accounting for a large proportion of the program's annual expenditures (Congressional Budget Office 2005). This pattern is characteristic of insurance programs in general. However, only about half of beneficiaries with high spending one year continue to incur high spending the next year. (Most of the remaining beneficiaries have lower spending the next year, but some of them die and a small number of them disenroll from fee-for-service Medicare.) Although the presence of serious chronic illness can predict high spending, much of very high spending is largely random, due to health costs that are unpredictable. This spending pattern implies that the probability of catastrophic spending over time is higher than the probability in one year would indicate. Even beneficiaries with low spending in a particular year would benefit from the financial protection of insurance as they face greater odds of having a high-spending year over time. Therefore, additional insurance protection

that mitigates the risk under Medicare will be valuable to beneficiaries.

Premiums on supplemental insurance imply that Medicare beneficiaries highly value the extra protection such plans provide from the potentially unlimited cost-sharing liability under Medicare. In theory, the difference between the premiums and the expected benefit of the supplemental insurance beneficiaries choose could provide a lower bound estimate of the value of reducing uncertainty, or their "risk premium." However, there are several complicating factors. For example, in the case of medigap policies, the actuarial value excludes the implicit subsidy that Medicare pays on additional services beneficiaries get because they have medigap insurance. In the case of employer-sponsored retiree plans, the actuarial value excludes the tax preference of the retiree health benefit.

Although most people are risk averse and are willing to pay to reduce risk, an optimal benefit design does not mean no risk at all. There is a fundamental trade-off between two opposing forces: risks and incentives. On the one hand, more generous benefits offer lower risk for risk-averse individuals. On the other hand, more generous benefits raise moral hazard and induced demand. Although the value of insurance in reducing uncertainty is real and important, it must be balanced against the positive effect that cost sharing can have on moderating the use of lower value care. This factor means that the ideal level of cost sharing is probably above zero but below the uncapped liability in the current Medicare benefit. ■

lower due to a lower premium and cost sharing with a deductible than without it. For example, beneficiaries with low spending might be better off with a higher deductible and lower premiums, whereas beneficiaries with high spending might not be.

The current FFS benefit has separate deductibles for Part A and Part B services: \$1,156 for inpatient services and \$140 for Part B services in 2012. This structure of having two distinct parts is mainly historical, reflecting the structure of private insurance as it existed in the 1960s. Since then, the norms in private insurance have changed and a single deductible for all medical services is typical. (Most plans

still have a separate deductible for drug benefits.) From a perspective of using cost sharing to create appropriate incentives for beneficiaries, the current structure of deductibles is not ideal: a relatively high deductible for inpatient care, which is usually not optional and less likely to be influenced by cost sharing, coupled with a low deductible for physician and outpatient care, which are more discretionary and more likely to be influenced by cost sharing. A single combined deductible for both types of services might lessen the effects of the current structure on beneficiary incentives somewhat. In addition, it would be easier for beneficiaries to understand and track

all Medicare services together, rather than to track them in separate categories.

However, a combined deductible would affect individual beneficiaries' cost sharing differently, depending on their use of services. In general, beneficiaries who use only Part B services—the majority of beneficiaries in a given year—would see an increase in their deductible amount compared with their currently low Part B deductible. In contrast, under a combined deductible (depending on its level), beneficiaries who received inpatient services—roughly 20 percent in a given year—could see a decrease in their deductible amount compared with their currently high Part A deductible. Given these dynamics, beneficiaries' desire for a low combined deductible based on their individual circumstances is certainly understandable. However, their circumstances can change suddenly and unpredictably, and their calculations may turn out very wrong. For example, if individuals who have few health problems get sick unexpectedly, they may be better off under a benefit package with a higher deductible coupled with lower copayments and a lower OOP maximum.

In addition to being unpredictable, the risk of paying a high Part A deductible can increase over time. Beneficiaries' circumstances change as they get older. While about 19 percent of full-year FFS beneficiaries had at least one hospital admission in 2009, the odds of having one or more hospital admissions increase considerably over several years. For example, 46 percent of beneficiaries who were in FFS Medicare had at least one hospital admission at some point during the four years from 2006 to 2009.

Because the role of a deductible is to reduce the cost of other aspects of the benefit package—such as premiums, copayments, and coinsurance—a lower deductible would not necessarily lower total costs for a given beneficiary. For example, trading off higher premiums for a lower deductible would spread the cost of reducing the deductible equally among all beneficiaries. In contrast, trading off higher copayments and coinsurance for a lower deductible would spread the cost proportionally by service use. Alternatively, trading off a higher OOP maximum for a lower deductible would impose a higher cost on beneficiaries with very high spending. To keep aggregate beneficiary cost sharing the same, the cost of reducing the deductible would be paid for by increasing cost sharing through other parameters of the benefit package.

Combining Part A and Part B deductibles presents important challenges for implementation. Under current law, Part A benefits are automatic for individuals who receive benefits from Social Security on the basis of age or disability, whereas Part B enrollment is voluntary. As a result, a small percentage of beneficiaries do not participate in both parts of the program. About 93 percent of beneficiaries enrolled in Part A also enroll in Part B. For the 7 percent of beneficiaries who participate in Part A or Part B only, issues related to how a combined deductible and OOP maximum would apply need to be resolved. Moreover, a separable participation in Part A and Part B could increase adverse selection in response to the new benefit design and raise additional issues, especially those related to financing the program. (For a more detailed discussion, see American Academy of Actuaries (2012).)

Copayments for services above the deductible

Copayment is a form of cost sharing that specifies a fixed dollar amount paid by the beneficiary at the point of service, whereas coinsurance specifies a fixed percentage of medical expense paid by the beneficiary. The current FFS benefit uses both forms of cost sharing: daily copayments for long stays at hospitals and skilled nursing facilities and 20 percent coinsurance of allowable charges for most Part B services, except for home health, clinical laboratory, and certain preventive services.

Because copayments are set dollar amounts known in advance, they are more clearly understood by beneficiaries and they reduce uncertainty. Especially if the amounts are set to create incentives for beneficiaries to make better decisions about their use of care, copayments are easy to understand, compare, and respond to. Their simplicity makes copayments more effective in influencing people's use of services. Participants in our focus groups echoed these positive qualities of copayments. In contrast, the idea of paying 20 percent of an unknown total bill worried many participants, who considered coinsurance an open-ended liability for which they could not budget in advance.

Compared with the current FFS benefit, any changes in cost sharing—in the form of a deductible or copayments—will bring about changes in beneficiaries' use of services. Ideally, perfectly rational and informed beneficiaries would respond to changes in cost sharing selectively—decreasing the use of nonessential services that are unlikely to improve their health but not changing the use of essential services that are necessary for maintaining good health despite the increase in cost sharing. Not surprisingly, beneficiaries

do not conform to the ideal. As discussed in our previous reports, extensive literature about the effects of cost sharing on the use of health care services shows that people generally reduce their use of health care when they have to pay more (see text box, pp. 14–15). Their responses tend to vary by type of service—larger responses for discretionary care and smaller responses for urgent care—but not necessarily based on whether the service is appropriate or essential. Reduction in the use of both effective and ineffective care raises the question of whether any potential negative effects from reducing essential care could lead to higher rates of hospitalization and ultimately to higher total spending. This issue of “offset effects” may be particularly important if low-income people in poorer health were more likely to forgo needed care, along with nonessential care, as cost sharing increased.

Two recent studies raise concern about such offset effects among Medicare beneficiaries. One analysis involved retired California public employees who faced increased copayments for physician visits and prescription drugs (Chandra et al. 2010). The study found that increases in copayments for ambulatory care modestly increased hospital use for the average elderly person, but hospital spending increased significantly for chronically ill patients as physician visits and drug use decreased. Overall, the size of this offset was not large enough to overcome the savings of copayment changes on physician visits and prescription drugs.

A separate study observed enrollees in MA plans that increased ambulatory care copayments and matched them to control plans with no copayment increases (Trivedi et al. 2010). In the year after the copayment increases, researchers found a significant drop in outpatient visits and a significant rise in hospital admissions and inpatient days. This finding cannot be generalized to FFS Medicare, however. In managed care, cost-sharing requirements typically work in conjunction with established rules and limits on beneficiaries’ use of services and providers. In other words, if a plan is well managed, there may be less use of unnecessary care to begin with. Consequently, increased cost sharing in an MA plan is more likely to reduce the use of necessary care. The effects of cost-sharing changes, therefore, could differ from those in the FFS environment where very few restrictions on services and providers exist.

Although questions remain about the degree to which their results can be generalized, the above two studies suggest the need for attention to cost-sharing changes, as they can

have beneficial and detrimental effects. The RAND Health Insurance Experiment (HIE) did not show adverse health effects due to reductions in the use of health care for the average person in the study, but those findings are unlikely to hold true for everyone. (The HIE excluded the elderly population from the study.) In fact, although the results were not statistically significant, the HIE found that low-income people with chronic conditions were at greater risk of adverse health outcomes. Because the elderly are more likely to be both low income and have chronic conditions, changes in cost sharing could have an impact on health outcomes among the Medicare population. Cost sharing may be too blunt a tool—although it may be one of the few policy tools available in the FFS program—for encouraging efficient and appropriate use of health care.

Over the long term, the Medicare program needs to move toward benefit designs that give individuals incentives to use higher value care and discourage using lower value care. These determinations must be evidence based. Several years ago, the Commission recommended that policymakers establish an independent, public–private entity that would produce information to compare the clinical effectiveness of a health service with its alternatives (Medicare Payment Advisory Commission 2008). Along the same lines, the Patient Protection and Affordable Care Act of 2010 established the Patient-Centered Outcomes Research Institute to identify national priorities for and sponsor comparative clinical-effectiveness research. In addition, Medicare could examine the factors that affect beneficiaries’ health care decisions and use that information to help transform the structure of health care delivery.

Policymakers have become more aware that not all health care services have the same value—or the same value for everyone—but identifying which services are of higher or lower value for a given individual is difficult. The term “value based” is used in two ways. Value-based purchasing refers to strategies for paying providers, and value-based insurance design refers to cost-sharing options designed to encourage beneficiaries to use high-value health care services or providers and discourage use of low-value services or providers (value-based insurance design). Testing these approaches would help policymakers decide which of them could steer beneficiaries more effectively toward the use of high-value services or away from low-value services.

Some insurers have begun setting different levels of cost sharing for the same medical intervention based on its clinical benefit to the individual (Chernew et al. 2007,

Evidence on effects of cost sharing

Extensive literature about the effects of cost sharing on the use of health care services shows that people generally reduce their use of health care when they have to pay more. The RAND Health Insurance Experiment (HIE), a large-scale randomized experiment conducted between 1971 and 1982, remains the gold standard on this subject because its randomized design allowed researchers to measure the effects of insurance coverage while limiting selection bias (RAND Corporation 2006). All participants in the HIE were under the age of 65. Overall, the HIE results suggested that individuals are moderately sensitive to price: A 10 percent increase in cost sharing led to about a 2 percent decline in patients' use of services (Newhouse 1993). The main findings were:

- Participants who paid a share of their health care used fewer health services than a comparison group given free care.
- Cost sharing reduced the use of both highly effective and less effective services in roughly equal proportions. Cost sharing did not significantly affect the quality of care participants received.
- In general, cost sharing had no adverse effect on participant health but there were exceptions: free care led to improvements in hypertension, dental health, vision, and selected serious symptoms. These improvements were concentrated among the sickest and poorest patients.
- Participants with cost sharing made one or two fewer physician visits annually and had 20 percent fewer hospitalizations than those with free care. Declines were similar for other types of services.
- Reduced use of services was attributed mainly to participants declining to initiate care. Once patients entered the health care system, cost sharing only modestly affected the intensity or cost of an episode of care.

A recent review of the literature on cost sharing since the HIE found that the key results of the HIE are still valid (Swartz 2010). In general, people reduce their use of health care in response to higher cost sharing. Their responses tend to vary by type of service, although not necessarily based on whether the service is appropriate or essential. Their responses also tend to differ by their income and health status. In particular, low-income people in poorer health may be more likely to forgo needed care as cost sharing increases.

Effects of cost sharing on the Medicare population

There is reason to believe that the Medicare population's response to cost-sharing requirements may differ from the non-Medicare population's response. Price sensitivity to goods and services without substitutes is generally low. Medicare beneficiaries, who tend to have a higher disease burden than other populations, may perceive few substitutes for medical care. Thus, as a group, Medicare beneficiaries may be less sensitive to cost-sharing requirements, although considerable variation in the health status of Medicare beneficiaries suggests that cost sharing could affect the health care decisions of some.

Studies that attribute at least a portion of higher spending observed among Medicare beneficiaries with supplemental coverage to an insurance effect find a spending increase of about 25 percent, with estimates ranging from 6 percent to 44 percent (Atherly 2001). One often-cited estimate based on data from the mid-1990s suggests that use of services ranged from 17 percent higher for those with employer coverage to 28 percent higher for those with medigap policies (Christensen and Shinogle 1997). Estimates for the effects of medigap policies are generally higher than for employer-sponsored retiree coverage, and they tend to show larger effects for outpatient than for inpatient services.

Another set of studies finds small or statistically insignificant induced demand for care resulting from supplemental insurance after controlling for selection bias (Long 1994, Wolfe and Goddeeris 1991).

(continued next page)

Evidence on effects of cost sharing (continued)

Some contend that previously reported differences in spending might be overstated, as supplemental coverage encourages beneficiaries to adhere to medical therapies that prevent hospitalizations or future use of other services. Because most studies on supplemental coverage are cross sectional or have short time horizons, they may not detect lower use of services over a longer period (Chandra et al. 2007). Another line of research suggests that the responsiveness of beneficiaries to cost sharing is varied and the effects of supplemental coverage are more modest for individuals in poorer health (Remler and Atherly 2003). Differences in the methodologies used to control for selection bias have contributed to the wide range of expenditure differences found in the literature.

In general, studies that examine whether cost sharing affects health outcomes among the elderly are few and their findings are mixed. Among seven studies reviewed by Rice and Matsuoka, four support the idea that increased cost sharing is correlated with worsened health status, as measured by mortality rates (two studies) and health status (two studies) (Rice and Matsuoka 2004). Two of the remaining three studies, which showed no effect on health outcomes, focused on myocardial infarction (Magid et al. 1997, Pilote et al. 2002). In those studies, individuals' perceptions about being in a life-threatening emergency may have made them less responsive to price changes (Rice and Matsuoka 2004).¹⁰

Commission-sponsored study

A recent Commission-sponsored study showed evidence that when elderly beneficiaries are insured against Medicare's cost sharing, they use more care and have higher Medicare spending (Hogan 2009). The study estimated that total Medicare spending was 33 percent higher for beneficiaries with medigap policies than for those with no supplemental coverage after controlling for demographics, income, education, and health status. Beneficiaries with employer-sponsored coverage had 17 percent higher Medicare spending, and those with both types of secondary coverage had 25 percent higher spending.

That analysis found that the effects of supplemental coverage differed depending on the service. For example, having secondary insurance was not associated with higher spending for emergency hospitalizations, but it was associated with higher Part B spending that ranged from 30 percent to over 50 percent more. Overall, beneficiaries with private supplemental insurance spent more on elective hospital admissions, preventive care, office-based physician care, medical specialists, and services such as minor procedures, imaging, and endoscopy.

By contrast, other findings from the study indicate that beneficiaries with only Medicare coverage and no secondary insurance obtain less health care. These beneficiaries appear to use acute care services in response to serious illness, but they appear to get less well-patient care, less preventive care, fewer scheduled inpatient admissions, and fewer procedures that are costly but do not address life-threatening conditions. On the basis of Medicare Current Beneficiary Survey data, the study estimated that 20 percent of elderly individuals with no supplemental coverage had no Part B spending during the year, compared with 5 percent of beneficiaries who had private secondary insurance. Whether Medicare's cost sharing impedes the use of care for people without secondary coverage, who typically have lower incomes, or whether cultural reasons or other factors make these beneficiaries less inclined to seek care have important implications for how to address this concern.

The Commission's analysis suggests that individuals with a severe illness are somewhat less sensitive to cost sharing, but they do not ignore it entirely. Even among the seriously ill, cost sharing can affect when and from whom patients seek care. The analysis also found that lower income beneficiaries were somewhat more sensitive to cost sharing than higher income individuals. In general, when either lower income or higher income beneficiaries had supplemental insurance, their Medicare spending was higher than that of individuals without supplemental coverage but with a similar income. However, the presence of secondary insurance had a somewhat stronger effect on spending for lower income beneficiaries. ■

Fendrick et al. 2001) When there is evidence that specific therapies are comparatively more effective and appropriate for certain patients, lowering their cost sharing could improve health outcomes. If greater adherence leads to fewer exacerbations of the patient's condition, this approach could offset some of the additional spending. However, many services do not save money, although they are cost-effective, and encouraging their use will not reduce total spending. At the same time, where evidence suggests that medical therapies are less effective, increasing beneficiaries' cost sharing could deter use of those services. In previous reports, we discussed the literature testing key elements of this benefit design (Medicare Payment Advisory Commission 2010). In sum, the extent to which lowering copayments for high-value services could reduce Medicare program spending would depend on beneficiaries' underlying health risk, the cost of adverse outcomes, beneficiaries' responsiveness to copayments, and the effectiveness of medical therapies at reducing risk (Chernew et al. 2010). Increased cost sharing for low-value services could save money with few detrimental consequences on health outcomes.

To examine ways to identify the value of services and the implications for Medicare, we convened a technical panel in 2010, including academics, employers, benefit consultants, a consumer advocate, and health plan representatives (Medicare Payment Advisory Commission 2011b). They suggested strategies to encourage use of high-value, high-quality health care: lowering cost sharing for services identified as high value (e.g., preventive care) and raising cost sharing for services identified as low value, providing incentives for beneficiaries to see high-quality efficient providers, and encouraging beneficiaries to adopt healthier behaviors.

Panelists also noted that Medicare supplemental policies must be aligned with these benefit changes. They were concerned that first-dollar coverage would blunt any incentives created by variable cost sharing. Panelists mentioned not just medigap but also employer-sponsored retiree plans. Some panelists suggested that, to the extent that private payer incentives are also aligned, the effect on utilization of high-value and low-value services would be magnified. Others suggested that medical management needs to be synchronized with the identification of services. For example, one plan charges higher copayments for advanced imaging without precertification. Panelists mentioned that medical management is particularly important for lower income beneficiaries because higher cost sharing would be impractical.

The Commission continues to be interested in innovative benefit designs being tested in the private sector. Although changes in cost sharing are a key lever to encourage use of high-value services and efficient providers, beneficiaries also need sufficient educational resources to make informed decisions. Thus, providing information that is objective, comprehensible, and useful needs to support a value-based approach.

Overall cost of the benefit design

There are many different ways to combine the three design elements discussed above. Within the general structure of cost sharing defined by a deductible, a set of copayments by type of service, and an OOP maximum, there are—in theory—many possibilities consisting of different levels of cost-sharing amounts and definitions of services to which they are applied. In practice, however, a set of feasible design combinations would be constrained by the overall cost of those choices.

For example, adding an OOP maximum can be paid for by increasing the deductible amount, or copayments on certain services, or both. (Alternatively, policymakers could also trade off increasing the Part B premium with adjusting the deductible and copayments. The premium approach would spread the cost of adding an OOP maximum equally among all beneficiaries, whereas adjustments in cost sharing would spread the cost by beneficiaries' use of services.) The science of benefit design may identify the set of feasible trade-offs between various design parameters, but the art of benefit design may be needed to find a reasonable compromise among competing policy goals.

Mitigating the effects of first-dollar coverage

For most Medicare beneficiaries, their actual OOP spending is much smaller than their cost-sharing liability under FFS Medicare because they have additional coverage. In fact, the lack of comprehensive coverage of the FFS benefit design leads many beneficiaries to take up supplemental coverage that fills in some or all of Medicare's cost sharing and protects them from catastrophic financial liability.

At the same time, supplemental coverage can lead to more use of services and spending. In general, there are two possible reasons for the higher spending. First, many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, regardless of whether there is evidence that a given service is ineffective or, conversely, whether it might prevent a hospitalization. Under such

minimal exposure to cost sharing, beneficiaries have incentives to receive more care without experiencing many additional costs, and providers have no incentives to manage utilization. Therefore, some portion of the higher spending observed among beneficiaries with supplemental coverage is arguably due to an insurance effect (also called moral hazard). Second, beneficiaries who are sicker and likely to use more services are more likely to buy supplemental coverage. Conversely, beneficiaries who are healthy and do not expect to use many services are more likely to risk potentially high cost sharing without supplemental coverage. It is likely that this selection effect is also partly responsible for the higher spending observed among those with supplemental coverage.

Preliminary analysis of CMS administrative and claims data shows how both insurance and selection effects might be in play. For example, the average Medicare spending in 2009 for full-year beneficiaries with medigap coverage was significantly higher (over \$9,700) than that for beneficiaries with Medicare only (about \$7,000). The observed higher spending was partly due to medigap beneficiaries' being older and having higher risk scores. However, such differences in beneficiary characteristics are unlikely to account for all difference in spending (see text box, pp. 14–15, on the effects of cost sharing).

Since the FFS benefit provides indemnity insurance, cost sharing is one of the few means by which the Medicare program can provide incentives to affect beneficiaries' behavior with regard to use of medical services. But almost 90 percent of FFS beneficiaries have supplemental coverage that fills in some or all of Medicare's cost sharing, effectively nullifying the program's tool for influencing beneficiary incentives. By effectively eliminating FFS Medicare's price signals at the point of service, supplemental coverage generally masks the financial consequences of beneficiaries' choices about whether to seek care and which types of providers and therapies to use. Therefore, unless supplemental policies were restructured to retain some cost sharing, any changes in cost sharing in the FFS benefit package would have a limited effect on beneficiaries with supplemental coverage.

There are two philosophically different approaches to address the insurance effect of supplemental coverage. One approach is to regulate how supplemental policies can fill in FFS cost-sharing requirements. Another approach is to impose an additional charge on supplemental policies. Rather than prohibiting supplemental insurance from filling in all of Medicare's cost sharing, this approach

would not change the use of Medicare services among beneficiaries who choose to keep their supplemental coverage. However, it would change the effective price of their coverage. These two approaches are discussed below in more detail. (Additionally, see text box, p. 18, on public supplemental plan.)

Regulatory approach

One strategy is to redefine medigap policies so that they no longer completely fill in FFS cost-sharing requirements. For example, the Congressional Budget Office (CBO) estimated that if medigap insurers were barred from paying any of the first \$550 of a policyholder's cost sharing and medigap coverage was limited to 50 percent of the next \$4,950 in Medicare cost sharing with all further cost sharing covered by the policy, the option would lower federal spending by over \$5 billion per year beginning in 2014 (Congressional Budget Office 2011).¹¹ This CBO option would apply only to medigap policies—it would not affect beneficiaries with employer-sponsored retiree coverage.

Another strategy to prohibit first-dollar coverage is to regulate how supplemental insurance can fill in FFS cost sharing. For example, an approach used by medigap Plan N and commonly used by MA plans and commercial insurers is to require beneficiaries to pay a fixed-dollar copayment for services such as office visits and use of hospital emergency rooms. Copayments could be set to change beneficiaries' incentives toward certain types of care—for example, by setting lower copayments for office visits to primary care providers.

Additional charge on supplemental policies

A separate approach imposes an additional charge on supplemental policies that fill in Medicare's cost sharing, including medigap and employer-sponsored retiree plans. This approach uses a different philosophy in that it does not prohibit supplemental policies from filling in all of Medicare's cost sharing but instead charges the insurer for at least some of the added costs imposed on Medicare for having such comprehensive coverage. If the regulatory approach can be described as not allowing beneficiaries to add costs to Medicare through supplemental coverage, the additional charge approach can be described as allowing beneficiaries to add costs to Medicare but requiring them to pay for at least some of those additional costs.

In theory, changes in the FFS benefit and the additional charge on supplemental insurance could alter the individual cost–benefit analysis of having supplemental coverage. First, for some individuals, the benefit of extra

Public supplemental plan

Some policymakers have suggested that Medicare develop a public medigap plan to supplement the basic fee-for-service benefit (Aaron and Lambrew 2008, Davis et al. 2005). The proposals have many features in common. In all cases, the plan would be voluntary and enrollees would pay the full cost of the supplement for Part A and Part B services. Unlike most current medigap plans, the public medigap plan would not provide first-dollar coverage. In these plans, the supplement would be based on a combined deductible, an out-of-pocket (OOP) cap on expenditures, and reduced coinsurance for Part B services. The Commission also considered a public medigap option but did not issue recommendations (Medicare Payment Advisory Commission 2002).

Davis et al. (2005) provided the most detailed analysis of a public medigap plan, which they called Medicare Extra or Part E.¹² In this proposal, coinsurance for Part B services would be reduced to 10 percent, hospital coinsurance would be eliminated, and there would be no cost sharing for home health or selected preventive services. Drug coverage would be included in the benefit. The drug benefit would include no deductible, no coverage gap, and coinsurance averaging 25 percent. The overall annual OOP cap on expenditures would be \$3,000 including drug costs. Although the supplement is meant to be beneficiary financed, Medicare would subsidize drug costs at the same rate as under Part D.

Proponents of a public medigap plan argue that it should be less expensive than current Medicare supplements, simpler for beneficiaries to understand, and facilitate care coordination. They contend that

Medicare Extra should be able to lower administrative costs, which would be the main source of savings. In particular, costs would be lower because most current supplements are sold in the individual market, which entails high marketing and enrollment costs. Savings would also accrue because it would no longer be necessary to coordinate between multiple sources of coverage (e.g., Medicare, medigap, and Part D drug plans).

The authors devoted less attention to how a transition to Part E could be implemented but they considered ways to prevent adverse selection. This option assumes that many current beneficiaries would switch from traditional medigap plans to Part E if it did not experience adverse selection. All beneficiaries would pay the same premium for Part E except for those late enrollees who refused coverage when they enrolled in Medicare. Most current medigap plans base premiums on an enrollee's age, leading to lower premiums for younger beneficiaries that increase with age. This policy could result in higher Part E premiums for beneficiaries at age 65 compared with private medigap plans. Under this plan, medigap insurers would be required to community rate their products to prevent this selection against the Part E plan.

The plan would not eliminate the role of private insurers but would reduce their role in Medicare. Private medigap plans would still be permitted but the analysts assume they would become less viable over time. Private insurers would still offer Medicare Advantage plans. In addition, insurers would serve as fiscal intermediaries for Part E. ■

protection provided by supplemental insurance would be lower if the FFS benefit were to have an OOP maximum. Without a larger decrease in supplemental premiums to offset the lower value, those beneficiaries would choose to drop supplemental policies. Second, holding the FFS benefit constant, the additional charge on supplemental insurance would increase the effective premiums on those plans and provide an incentive for beneficiaries to switch to medigap policies that required paying more of Medicare's cost sharing or to drop supplemental coverage altogether. If beneficiaries were to drop supplemental insurance, they could choose to stay in traditional FFS or

switch to MA. Implementation of an additional charge would need to be combined with a process through which beneficiaries can make their changes without a penalty.¹³ If dropping all supplemental coverage led some beneficiaries to forgo necessary care, it could worsen their health outcomes.

As an example, CBO has estimated that if a 5 percent "excise tax" were levied on medigap plans, revenues would increase on the order of \$1 billion per year and Medicare spending would decrease by \$100 million to \$200 million per year (Congressional Budget Office

2008). Such a tax would need to be significantly greater than 5 percent to recoup the induced demand attributable to medigap coverage. However, because of the difficulty in disentangling the effects of a pure insurance effect from selection bias, the exact percentage is uncertain. If the excise tax encouraged beneficiaries to change to the newer medigap policies that required paying more of Medicare's cost sharing at the point of service, that change could lead to slower growth in Medicare spending.

Commission's views on FFS benefit design reform

The Commission and its predecessor commissions have explored problems with traditional Medicare's benefit design for many years (Medicare Payment Advisory Commission 2009, Medicare Payment Advisory Commission 2010, Medicare Payment Advisory Commission 2011b, Physician Payment Review Commission 1997). In particular, the Commission believes that protecting beneficiaries against the economic impact of catastrophic illness is very important. Providing an OOP maximum on spending would reduce the financial risk for beneficiaries with very high spending and could mitigate the need to purchase supplemental insurance, a significant expense for many beneficiaries. In addition, reforming the FFS benefit design offers an opportunity to align beneficiary incentives and program goals to obtain high-quality care for the best value.

There are many different ways to "pay for" an increase in the benefit—such as adding an OOP maximum—in one dimension or the other. Therefore, the ultimate implementation of changes to the FFS benefit design must not only specify a set of cost-sharing requirements and define services to which those requirements would apply but also allow for flexibility to alter or eliminate cost sharing based on the value of services. To encourage the use of high-value services and discourage the use of low-value services, the Congress may wish to consider giving the Secretary authority to reduce cost sharing on services if evidence indicates that doing so would reduce Medicare spending or lead to better health outcomes without increasing costs or to raise cost sharing on low-value services. This authority would be exercised through the usual notice and comment rulemaking process. For example, under current law, there are no cost-sharing requirements for many preventive services, and the Secretary has administrative authority to modify

or eliminate coverage of preventive services based on evidence. This flexibility to adjust and refine cost sharing is especially important as evidence evolves. This provision does not diminish congressional authority. If the Congress disagreed with the Secretary's proposed actions, it could act to stop the changes.

The Commission considers it important to allow for different possible combinations of design elements and subsequent adjustments and refinements by the Secretary. However, the Commission does not wish to shift the cost of improving the benefit package to provide better protection against high OOP spending to the beneficiary in the aggregate. The Commission has decided, therefore, to hold the average cost-sharing liability of the beneficiary about the same as under current law. In effect, this approach allows the Congress to set the expenditure target for the Secretary's benefit package and the Secretary is then given discretion within a budgetary constraint established by the Congress.

In considering policies related to supplemental coverage, the Commission prefers the additional charge approach over the regulatory approach. The additional charge would apply to most sources of supplemental coverage, including medigap and employer-sponsored retiree plans. (However, implementing consistent changes with respect to medigap and employer-sponsored retiree plans would require different legislative changes. The additional charge would not apply to MA plans because they are at risk for benefit designs that increase costs relative to their capitation payments and are able to employ other tools for managing their enrollees' costs.) The Commission considers it important that risk-averse beneficiaries who wish to buy first-dollar coverage or reduce the uncertainty in their OOP spending through supplemental insurance should be allowed to do so but effectively at a higher price. Regulating supplemental benefits, in contrast, would prevent even those beneficiaries who very much value extra insurance from buying such policies at any price.

The additional charge would reflect more appropriately the additional costs imposed on the program due to the insurance effect of supplemental coverage. By setting the additional charge as a fixed percentage of premiums or the value of supplemental benefits, in a given market, the additional charge would be proportional to the generosity of supplemental benefits and the additional costs imposed on the program as a result. Across markets or insurers, a fixed percentage charge would mean that those areas with the highest utilization would bear the largest share of the recoupment represented by the additional charge. Such an

**TABLE
1-5****Illustrative benefit package**

FFS benefit package	Illustrative package keeping beneficiary liability neutral
Out-of-pocket maximum	\$5,000 per year
Part A & Part B deductible	\$500 per year
Hospital (inpatient)	\$750 per admission
Physician	\$20 PCP/\$40 specialist visit \$100 advanced imaging
Part B drugs	20% coinsurance
Outpatient hospital	\$100 per visit
Skilled nursing facility	\$80 per day
Durable medical equipment	20% coinsurance
Hospice	0% coinsurance
Home health care	\$150 per episode*

Note: FFS (fee-for-service), PCP (primary care physician).

*For simplicity, we modeled the \$150 copayment per episode considered by the Commission in 2011 as a 5 percent coinsurance on home health services.

approach is in contrast to increasing the Part B premium, which would affect all beneficiaries equally. Alternatively, the formulation of the additional charge could be modified to include a minimum threshold of generosity and be limited to some, rather than all, medigap and employer-sponsored retiree plans.¹⁴

In summary, the Commission believes that a new FFS benefit design should include:

- an OOP maximum (measured in cost-sharing liability incurred by the beneficiary) to protect beneficiaries from the financial risk of very high Medicare costs;
- deductible(s) for Part A and Part B services that may be combined or separate;
- copayments, rather than coinsurance, that may vary by type of service and provider;
- secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services;
- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on supplemental insurance to recoup at least some of the added costs imposed on Medicare.

Many recently proposed changes to the Medicare program would require beneficiaries to pay more: reducing the actuarial value of the benefit package, increasing Part B premiums, increasing premiums only for high-income beneficiaries, increasing the age of eligibility,

and recalculating the beneficiary contribution under a premium support system. By contrast, the Commission's recommendation to hold beneficiary liability neutral reflects our position that beneficiaries' costs in the aggregate should not increase in the redesign of the FFS benefit. Furthermore, we believe that the actuarial value of the benefit package should not be reduced while protecting beneficiaries against high OOP spending. At the same time, in recommending an additional charge on supplemental insurance, we maintain that it is reasonable to ask beneficiaries to pay more when their decision to get supplemental coverage imposes additional costs on the program that are not fully reflected in their supplemental premiums. Those costs are currently paid for by all Medicare beneficiaries through higher Part B premiums and taxpayers. The additional charge is not the only way to involve beneficiaries. Aside from preserving the actuarial value of the benefit package, the Commission has not expressed a position with respect to other proposed changes noted above that require beneficiaries to pay more.

Illustrative benefit package

Table 1-5 presents an illustrative benefit package consistent with the Commission's views on FFS benefit design reform. The package is modeled after the MA-style benefits that include the following copayments: \$20 for each primary care physician visit, \$40 for each specialist physician visit, \$100 for each hospital outpatient visit, \$750 for each inpatient hospital admission, and \$80 for each skilled nursing facility day.¹⁵ We also included 20 percent coinsurance for durable medical equipment and a \$150 copayment per episode for home health care.¹⁶ The annual OOP maximum is \$5,000. To keep cost sharing relatively reasonable, the package includes a \$500 combined deductible.¹⁷ We kept the overall beneficiary cost sharing of this package roughly equal to that of the current FFS benefit. We want to emphasize that this package is for illustration only, to analyze the trade-offs between design elements. It does not represent the Commission's recommended benefit package.

In general, the set of copayments in the illustrative benefit package is within the range of typical copayments we see in MA plans. However, MA plans tend to use medical management to complement their use of cost sharing and to mitigate the potentially negative effects from reducing essential care or increasing less essential care. While copayments can make beneficiaries aware of the price

of care at the point of service, thus creating incentives to make better decisions about their use of discretionary care, medical management can mitigate the effects of reducing care indiscriminately.

We modeled the effects of the above illustrative benefit package using Medicare claims data from 2009.¹⁸ Here is the list of assumptions underlying our estimates.

- Assumptions on the change in utilization in response to cost-sharing changes come from CBO's model of Medicare spending: a 10 percent increase in cost sharing leads to a 0.5 percent decrease in Part A spending; a 10 percent increase in cost sharing leads to a 1.5 percent decrease in Part B spending.¹⁹
- We assumed that medigap plans, on average, fill in all of Part A cost-sharing liability and 80 percent of Part B cost-sharing liability. Analogous assumptions for employer-sponsored retiree plans are that they cover, on average, 50 percent of Part A and Part B cost-sharing liabilities. (Retiree plans through large employers typically include some cost sharing and are less generous than medigap plans.)
- The scope of our modeling excludes dual-eligible beneficiaries because we assumed that Medicaid would fill in any changes under the alternative benefit package and would keep the cost sharing the same for those beneficiaries.
- We assumed a simple 20 percent additional charge on supplemental policies. For revenue effects, we calculated 20 percent of the average premiums on medigap and employer-sponsored retiree plans (\$2,100 and \$1,000 per year, respectively).²⁰

For modeling changes in the take-up of supplemental insurance in response to higher premiums, we consulted the Actuarial Research Corporation. It estimates that take-up of medigap insurance would decrease by about 2 percentage points in response to a 20 percent tax on medigap premiums. Unfortunately, there are few data on this specific question. The conventional assumption seems to be that the response to a premium increase among those who have purchased medigap policies would be minimal, at least in the short term. The lack of plan switching among Part D beneficiaries in the past in response to premium changes is consistent with this view.

However, there are reasons to believe that the take-up of supplemental insurance would change over time. With more baby boomers turning 65, the Medicare population

is changing rapidly. The program will see a net increase in enrollment of about 3 percent per year in the next decade. The younger population aging into the program is accustomed to health insurance that includes deductibles, a cap on OOP expenditures, and copayments. They are also less likely to have retiree health insurance. Therefore, although actuaries believe that only a small number of current beneficiaries would drop supplemental coverage under a new benefit design, new beneficiaries are more likely to make different choices. In the focus groups we conducted with individuals age 55 to 64 in 2010 and 2011, many future beneficiaries discussed the possibility of declining supplemental coverage depending on the size of the OOP maximum and copayment structure. A number of them pointed out that the money they would save on medigap premiums could finance copayments for most of their routine medical needs.

Recent data on medigap coverage and enrollment also suggest that beneficiaries' preferences for supplemental coverage would change over time. America's Health Insurance Plans reported that in the first quarter of 2011, 23 percent of new beneficiaries chose coverage under the following medigap plans, which require beneficiary cost sharing: high-deductible Plan F, Plan K, Plan L, Plan M, and Plan N (America's Health Insurance Plans 2011). Plan N, which includes cost sharing of up to \$20 for physician office visits and up to \$50 for certain emergency room visits, is the most popular of the new policies and accounted for 15 percent of all new medigap policies in early 2011. These data suggest that over time, more beneficiaries will be comfortable with some cost sharing and may choose to forgo some or all supplemental coverage.

With respect to employer-sponsored supplemental coverage, beneficiaries' decisions are more indirect. Changes in retiree benefits in response to the new Medicare benefit package are more likely to be driven by what employers decide to offer, especially in relation to benefits for active workers, rather than what retirees want. If the new Medicare benefits were to become similar to what is offered in employer-sponsored insurance, employers may be more inclined not to offer retiree benefits at all. We expect that the benefits, coverage, and offer rates of employer-sponsored supplemental plans will continue to erode over time.

In modeling the effects of the illustrative benefit package, given the uncertainty in beneficiaries' decisions related to supplemental insurance, we considered four levels of take-up rates: Among beneficiaries who currently have medigap or employer-sponsored retiree benefits, we

**TABLE
1-6**

Budgetary effects of the illustrative benefit package, 2009

Percent keeping supplemental coverage	Percent change in Medicare program spending in 2009	Revenue offset generated by 20% additional charge	Net percent change in Medicare program spending
100%	+1.0%	-1.5%	-0.5%
75%	0.0	-1.0	-1.0
50%	-1.5	-0.5	-2.0
0%	-4.0	0.0	-4.0

Note: Numbers are rounded to the nearest 0.5 percent. Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We estimated a one-year snapshot of relative changes in Medicare program spending, compared with the actual spending in 2009, if the illustrative benefit package had been in place. Additional charge on supplemental insurance represents revenue to the program and is shown as a decrease in program spending. These estimates do not represent a budgetary score, which would take additional factors into account.

Source: MedPAC based on data from CMS.

assumed that all, three-quarters, half, or none of them keep their current supplemental coverage under the new benefit package. (This characterization is very stylized because beneficiaries can also decide to switch to supplemental insurance with higher cost sharing and lower premiums rather than drop supplemental coverage altogether.) Those beneficiaries who keep their supplemental insurance would pay a 20 percent additional charge on their premiums or the value of the benefit. In contrast, those beneficiaries who drop their supplemental insurance would pay their cost-sharing liability OOP but would save on their supplemental premiums.

Spending impacts

Table 1-6 shows the relative change in annual Medicare program spending under the illustrative benefit package, combined with a 20 percent additional charge on supplemental insurance. It presents only a one-year snapshot of relative changes. Most importantly, it does not represent a budgetary score, which would take additional factors into account.

Under the illustrative benefit package, which holds average beneficiary cost-sharing liability roughly equal to current law, program spending would increase by about 1 percent if beneficiaries kept their current supplemental coverage. Given the OOP maximum—which made the illustrative benefit package more generous compared with current law—the same level of cost-sharing liability would correspond to higher total spending under the illustrative benefit package. As a result, program spending would also be higher. In addition, the 20 percent charge on supplemental insurance would generate about 1.5 percent in revenue offsets. The net budgetary effect would be about 0.5 percent in savings. In contrast, if all beneficiaries dropped their current supplemental coverage, program

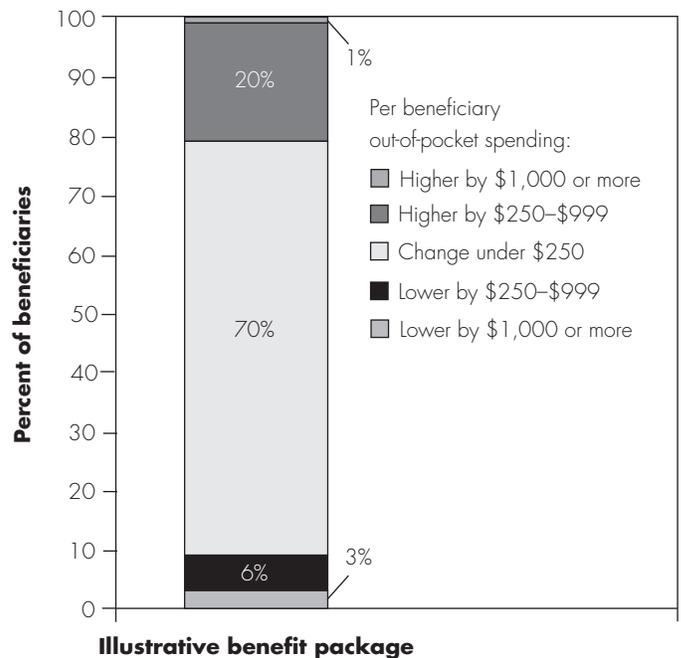
spending would decrease by about 4 percent, with a net budgetary effect of about 4 percent in savings.

Distributional impacts

Overall, the average beneficiary cost-sharing liability under the illustrative benefit package would be roughly

**FIGURE
1-1**

Changes in Medicare out-of-pocket spending under the illustrative benefit package, 2009



Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We assumed no change in supplemental coverage among beneficiaries who currently have supplemental coverage. Out-of-pocket spending excludes Part B premium.

Source: MedPAC based on data from CMS.

**TABLE
1-7**

More beneficiaries would be better off with an out-of-pocket maximum over time

Full-year fee-for-service beneficiaries who had:	2009	2006-2009
1 or more hospitalizations	19%	46%
2 or more hospitalizations	7	19
\$5,000 or more in annual cost-sharing liability	6	13
\$10,000 or more in annual cost-sharing liability	2	4

Note: Includes beneficiaries who were enrolled in fee-for-service Medicare for four full years, from 2006 to 2009. Excludes those who had any months of private Medicare plan enrollment.

Source: MedPAC based on data from CMS.

equal to current law by design. However, it would be much less variable because of the OOP maximum. For example, assuming no change in current supplemental coverage, the standard deviation of cost-sharing liability in 2009 among beneficiaries included in our analysis decreased from \$2,370 under current law to \$1,250 under the illustrative benefit package, around the mean liability of \$1,380.

The effects of the illustrative benefit package on beneficiaries in 2009 would vary by their use of services. First, those beneficiaries with cost-sharing liability above the \$5,000 OOP maximum and no supplemental coverage would see their OOP spending go down. In Figure 1-1, this group would be included in the 9 percent of beneficiaries whose OOP spending decreased by \$250 or more. (Results in Figure 1-1 assume no change in supplemental coverage among beneficiaries who currently have supplemental coverage.²¹) By contrast, those beneficiaries with no hospitalization and not much use of Part B service would see their cost sharing go up, since the revised benefit design would effectively lower the Part A deductible and raise the Part B deductible compared with current law. In Figure 1-1, this group would be included in the 21 percent of beneficiaries whose OOP spending increased by \$250 or more. In general, beneficiaries with at least one hospital admission would see their cost sharing go down under the illustrative benefit package compared with the current benefit package. For the majority of beneficiaries, their OOP spending would not change much because for many of them, their supplemental insurance would dampen the changes in their cost-sharing liability.

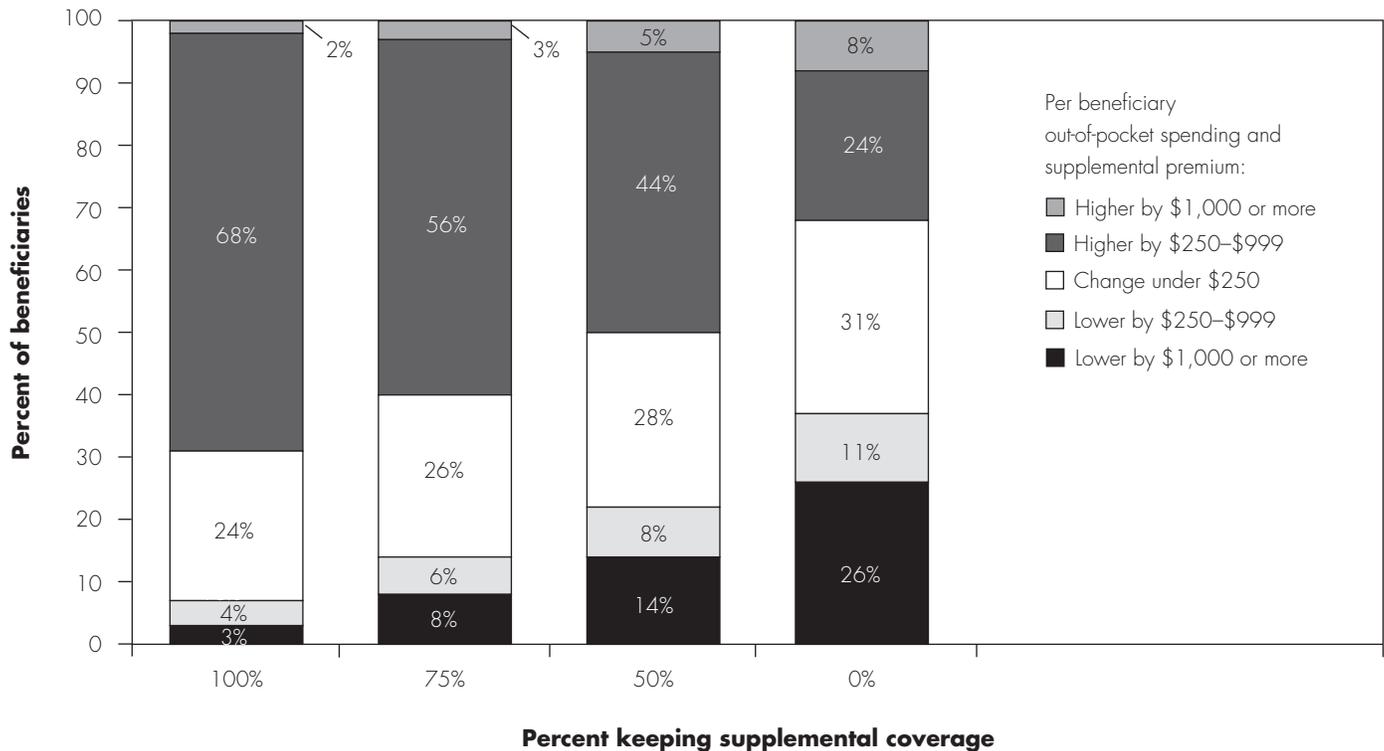
Figure 1-1 highlights that a small percentage of beneficiaries incur very high cost sharing in a given year and thus would benefit from the OOP maximum under

the illustrative benefit package. But a larger percentage of beneficiaries would reach the OOP maximum at some point over a longer period of time. Table 1-7 compares beneficiaries' hospitalization and spending over one year versus four years. For example, in 2009, 19 percent of full-year FFS beneficiaries had at least one hospitalization, whereas 46 percent did from 2006 to 2009. Similarly, 6 percent of full-year FFS beneficiaries had \$5,000 or more in cost-sharing liability in 2009, whereas 13 percent had at least one year of \$5,000 or more in cost-sharing liability over four years.

Some beneficiaries who currently have supplemental insurance would drop their coverage in response to higher premiums and the new Medicare benefits. Figure 1-2 (p. 24) shows the estimated distributional impact of changes in total OOP costs—the sum of OOP spending and supplemental premium—under the four scenarios: Among beneficiaries who currently have medigap and employer-sponsored retiree insurance, we assumed that all, three-quarters, half, or none of them keep their current supplemental insurance. Compared with Figure 1-1, the distributional impacts in Figure 1-2 are noticeably different. For beneficiaries who keep their supplemental coverage, total OOP costs would be higher because of the 20 percent additional charge on supplemental insurance: At 2009 premium levels, the 20 percent additional charge would translate into a \$420 increase per year on medigap plans and a \$200 increase per year on employer-sponsored retiree plans. In contrast, for beneficiaries who drop their supplemental coverage, total OOP costs would be the net effect of higher cost sharing paid OOP and savings on their supplemental premiums (\$2,100 per year on medigap plans and \$500 per year on employer-sponsored retiree plans, assuming a 50 percent employer subsidy rate).

FIGURE 1-2

Changes in Medicare out-of-pocket spending and supplemental premium under a 20 percent additional charge on supplemental insurance, 2009



Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We assumed four different levels in take-up rates among beneficiaries who currently have medigap insurance: 100%, 75%, 50%, and 0%. Out-of-pocket spending excludes Part B premium. The change in supplemental premium includes the 20% additional charge on supplemental insurance. Percentages may not sum to 100 due to rounding.

Source: MedPAC based on data from CMS.

If all beneficiaries kept their current supplemental coverage, the 20 percent additional charge on supplemental insurance would increase the total OOP cost significantly. Whereas 70 percent of beneficiaries have very little change in OOP costs under the illustrative benefit package in Figure 1-1, 70 percent of beneficiaries have an increase of \$250 or more under the illustrative benefit package because of the 20 percent additional charge on supplemental insurance in Figure 1-2. The distribution shifts as fewer beneficiaries keep their current supplemental coverage, as the savings from dropping their medigap or employer-sponsored retiree plans decrease their total OOP costs. If all beneficiaries dropped their current supplemental coverage, 32 percent would experience an increase of \$250 or more, compared with 70 percent if all beneficiaries kept their current supplemental coverage. The remaining 68 percent would have little change in their OOP costs or a decrease of \$250 or more.

RECOMMENDATION 1

The Congress should direct the Secretary to develop and implement a fee-for-service benefit design that would replace the current design and would include:

- an out-of-pocket maximum;
- deductible(s) for Part A and Part B services;
- replacing coinsurance with copayments that may vary by type of service and provider;
- secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum;
- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on supplemental insurance.

RATIONALE 1

Under the current FFS benefit design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. Without additional coverage, the FFS benefit design exposes Medicare beneficiaries to substantial financial risk. The recommended benefit design provides better protection against high OOP spending and thus enhances the overall value of the FFS benefit, mitigating the need for beneficiaries to purchase supplemental insurance. It also creates clearer incentives for beneficiaries to make better decisions about their use of discretionary care while holding the aggregate beneficiary cost-sharing liability about the same as under current law. It also allows for ongoing adjustments and refinements in cost sharing as evidence of the value of services accumulates and evolves. An additional charge on supplemental insurance would recoup at least some of the additional costs imposed on the Medicare program due to the insurance effect of supplemental coverage. However, it would still allow risk-averse beneficiaries to buy supplemental coverage if they wish to do so.

IMPLICATIONS 1

Spending

- The impact on Medicare program spending relative to current law depends on the levels of cost sharing, the additional charge on supplemental insurance, and which plans are subject to the additional charge, as specified in the ultimate benefit design implemented by the Secretary.

Beneficiary and supplemental insurer

- Under the recommended benefit design, the aggregate beneficiary cost-sharing liability would remain unchanged. Some beneficiaries who incur very high Medicare spending would see their liability reduced, while others who incur low Medicare spending may experience higher liability. If an individual's cost sharing were to increase, he or she might reduce both effective and ineffective care, and some beneficiaries may experience worse health as a result. Finally, the effects on beneficiaries with supplemental coverage would also depend on whether they retain their supplemental coverage, drop it, or switch to a plan with a lower premium. If beneficiaries decide to keep or purchase supplemental coverage, they will pay the additional charge on their supplemental insurance.
- For medigap plans, the additional charge will increase their premiums, and some beneficiaries might drop their medigap or move to MA in response to the benefit change and higher medigap premiums. The effects on employers that offer retiree benefits are uncertain. ■

Endnotes

- 1 Throughout this chapter, we use cost-sharing liability to refer to the amount of total spending on Medicare services not paid for by the Medicare program. This amount can be paid by the beneficiary, or additional insurance, or both. We use OOP spending to refer to the amount of cost-sharing liability actually paid by the beneficiary. Therefore, if the beneficiary has Medicare only, her OOP spending would be equal to her cost-sharing liability, whereas the former would be smaller than the latter if she has supplemental insurance. In addition, we use total OOP costs to refer to the sum of OOP spending and premiums on supplemental coverage paid by the beneficiary.
- 2 In addition, in 2007, 23 percent of Medicare beneficiaries were in MA plans, 12 percent were in Medicaid, 8 percent were in Medicare only, and 1 percent were in other public programs.
- 3 Over the years, standards for medigap policies have changed through introductions of new plans and revisions of existing plans. For example, the Medicare Prescription Drug, Modernization, and Improvement Act of 2003 created two types of standard products—Plan K and Plan L—that fill in less of Medicare’s cost sharing in return for lower premiums. In June 2010, medigap insurers introduced two new types of policies—Plan M and Plan N—that do not fill in all of Medicare cost sharing. Plan M covers 50 percent of the Part A deductible but none of the Part B deductible. Plan N covers all of the Part A deductible but none of the Part B deductible, and it requires copayments of up to \$20 for office visits and up to \$50 for emergency room visits. Plan N’s cost sharing is the lesser of a \$20 copayment or Medicare’s coinsurance amount for Part B evaluation and management services for specialist or nonspecialist office visits. The lesser of a \$50 copayment or Part B coinsurance applies for each covered emergency room visit. However, that cost sharing is waived if the beneficiary is admitted and the emergency visit is covered subsequently by Part A (National Association of Insurance Commissioners 2010a).
- 4 The Patient Protection and Affordable Care Act of 2010 directs the National Association of Insurance Commissioners (NAIC) to revise standards for medigap policies Plan C and Plan F to include requirements for nominal cost sharing to encourage the use of appropriate physician services under Part B. New standards are to be based on evidence published in peer-reviewed journals or current examples used in integrated delivery systems. NAIC’s revised standards are, to the extent practicable, to be in place as of January 1, 2015.
- 5 These criteria are tied to eligibility for the Supplemental Security Income program. States have the option to make their coverage more generous by raising the income level, disregarding certain types of income, or extending Medicaid benefits to additional categories of the elderly and disabled population, including the medically needy (Kaiser Commission on Medicaid and the Uninsured 2010).
- 6 This number includes both full and partial dual-eligible beneficiaries who had at least one month of enrollment in Medicaid or Medicare Savings Programs in 2010.
- 7 Few MA plans use FFS Medicare’s cost-sharing structure. For example, only 1 percent of MA enrollees are in plans that charge the Part A deductible. Moreover, all MA plans are required to have an OOP maximum of no more than \$6,700 for Medicare-covered services, and they can have lower OOP maximum amounts.
- 8 A variation on adding an OOP maximum is to apply the concept of “true” OOP, under which the OOP maximum counts only the OOP spending actually paid, rather than incurred, by the beneficiary (as in Part D). Under the true OOP concept, therefore, the portion of cost-sharing liability incurred by the beneficiary but paid by supplemental insurance would not count toward the OOP maximum. Consequently, supplemental plans would not be able to benefit from an OOP maximum in the Medicare program because they still would have to pay for cost sharing above the maximum amount until the beneficiary’s portion of cost sharing reached that amount.
- 9 We conducted 13 focus groups in Bethesda (Maryland), Dallas, and Boston in June and July 2011 as part of our annual round of beneficiary focus groups. There were seven groups of beneficiaries and six groups of future beneficiaries between the ages of 55 and 64 years. Each group consisted of 8 to 10 individuals and was facilitated by researchers from NORC (formerly National Opinion Research Center) and Georgetown University. Participants were recruited from certain income ranges to ensure that they had a financial stake in their insurance choices (e.g., they were not covered by Medicaid but also were not so wealthy that budgeting for health expenditures was unimportant). In addition, beneficiaries and future beneficiaries had a mix of health insurance arrangements. In terms of our future beneficiaries, 41 had employer-provided health insurance, 12 purchased individual insurance, and 3 were uninsured. Medicare beneficiaries included 32 with retiree coverage and 29 who purchased individual supplemental policies or were enrolled in MA plans. Ten beneficiaries did not specify their source of coverage but all had some supplemental coverage.
- 10 Rice and Matsuoka (2004) also reviewed studies that examined the relationships between cost sharing and use of appropriate care that are thought to improve health status.

- Among the nine studies examined, six found evidence that higher cost sharing tends to reduce the appropriate use of services. Evidence was strongest for prescription drugs and was less definitive for other services.
- 11 CBO prepared estimates for this option beginning in 2013, with the amounts of restrictions on medigap policies indexed each year to the average annual growth in Medicare costs. Because CBO assumed some ramp up of the policy in 2013, we present its fully implemented estimates for 2014.
 - 12 The current Medicare statute includes Part E, titled “Miscellaneous Provisions.” These provisions are unrelated to the proposed Medicare Extra.
 - 13 In general, purchasing a medigap plan is subject to underwriting after the initial period of guaranteed issue, or six months after enrolling in Part B. (Some states require community rating of medigap plans.) Therefore, an implementation process would need to allow for beneficiaries’ changing their supplemental coverage in response to the additional charge.
 - 14 This formulation of the additional charge may be effective if the incentives to use more services mainly come from the most generous plans offering first-dollar coverage rather than from plans with some cost sharing.
 - 15 Many plans charge separate copayments for emergency room visits. For modeling simplicity, we imposed copayments of \$100 on all outpatient visits, including emergency room visits.
 - 16 In 2011, the Commission recommended a per episode copayment for home health episodes that are not preceded by hospitalization or post-acute care use. At that time, the Commission considered an illustrative copayment of \$150 per episode (Medicare Payment Advisory Commission 2011c).
 - 17 The \$500 deductible amount is used for illustration only. Given the \$5,000 OOP maximum and the set of copayments that are typical under MA benefits, we solved for the deductible that would keep the average cost-sharing liability about the same as under current law. The Commission did not take a definitive position on combining Part A and Part B deductibles.
 - 18 We linked the claims data with Medicare administrative data on Medicare and Medicaid enrollment status and CMS coordination of benefits files to determine beneficiaries’ supplemental coverage. Our modeling was based on about 21 million beneficiaries who were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in Medicaid or MA.
 - 19 CBO assumptions expressed in terms of arc elasticities are: -0.05 for Part A services and -0.15 for Part B services. Arc elasticity is defined as the ratio of the percentage change in spending in response to the percentage change in cost sharing, and the percentage change is calculated relative to the average or midpoint of the two values before and after the cost-sharing change, rather than at the original value. Alternatively, assumptions more commonly used by actuaries are based on standard induction factors: A \$10 increase in cost sharing leads to a \$2 decrease in Part A spending, and a \$10 increase in cost sharing leads to a \$7 decrease in Part B spending (Cubanski et al. 2011). These estimates are expressed in terms of dollar changes. Both sets of assumptions are based on the RAND HIE. However, they have different implications for the magnitude of the spending response because elasticity is a relative measure. In other words, a \$10 change in cost sharing represents a larger percentage change to a beneficiary with low spending and cost-sharing liability than to a beneficiary with high spending and cost-sharing liability. Therefore, under the CBO assumptions, a \$10 change in cost sharing would result in a different percentage response in spending depending on the beneficiary’s level of spending. In contrast, under induction factors, a \$10 change in cost sharing would result in the same dollar response in spending independent of the beneficiary’s level of spending.
 - 20 In 2009, the average annual premium on medigap weighted by enrollment across all plan types was \$2,100 (National Association of Insurance Commissioners 2010b).
 - 21 We assumed no change in supplemental premiums from the change in Medicare’s benefit design because the illustrative package held the average beneficiary cost-sharing liability roughly equal to current law.

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