Reforming Medicare's fee-for-service benefit design

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Context for reforming Medicare's benefit design

- FFS benefit design leads to few individuals owing most of the cost sharing
- Cost-sharing requirements are uneven and vary by site of care
- Premiums for supplemental coverage are often expensive and vary widely
- Supplemental insurance masks price signals and leads to higher use of services

Example of Medicare cost sharing

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

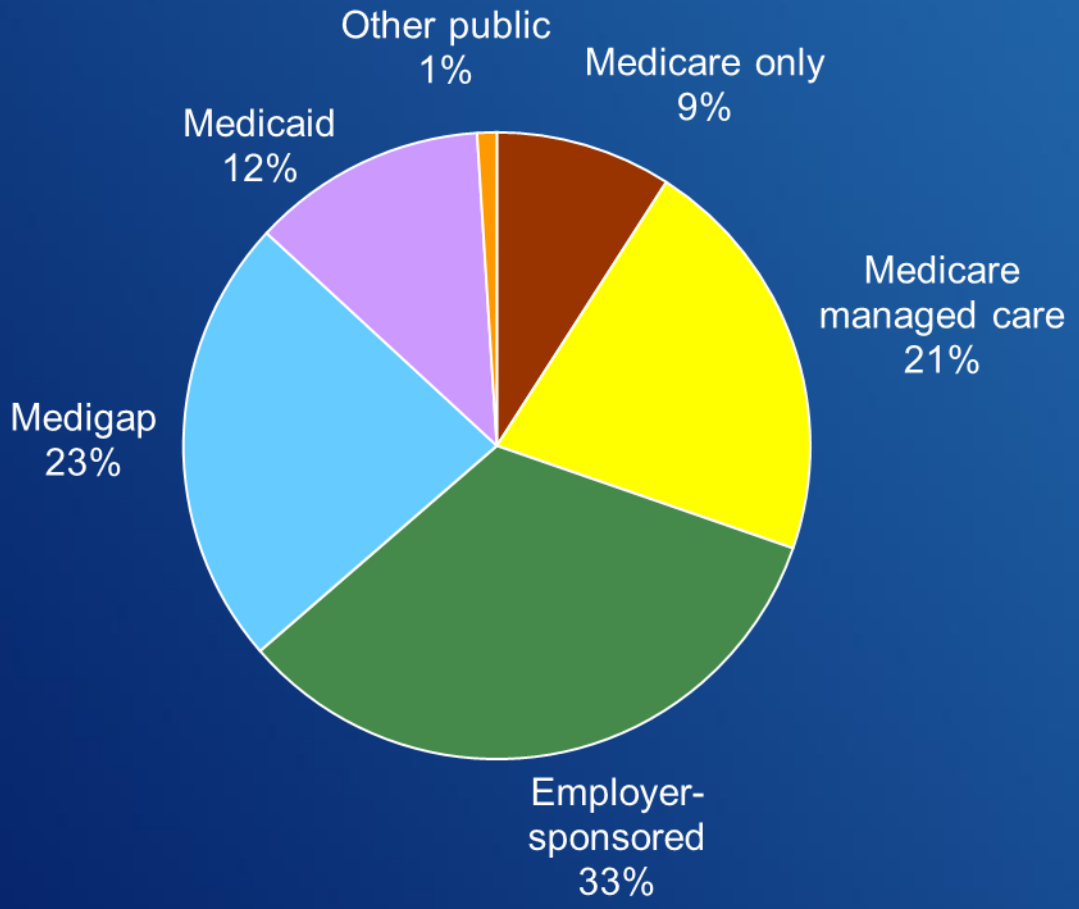
Service use in 2007	Allowed charge	Cost-sharing liability	Beneficiary payment
Medicare A & B services:			
Inpatient admission	$16,653	$992	$0
SNF stay	7,307	0	0
Home health visits	7,303	0	0
DME use	20	4	0
Physician & outpatient	20,514	5,508	465
Total A & B services	$51,798	$6,504	$465

Medicare cost-sharing liability in 2008

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

Note: Amounts reflect cost sharing under FFS Medicare—not what beneficiaries paid out of pocket. Most beneficiaries have secondary insurance that covers some or all of their Medicare cost sharing.
Source: MedPAC based on data from CMS.

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



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

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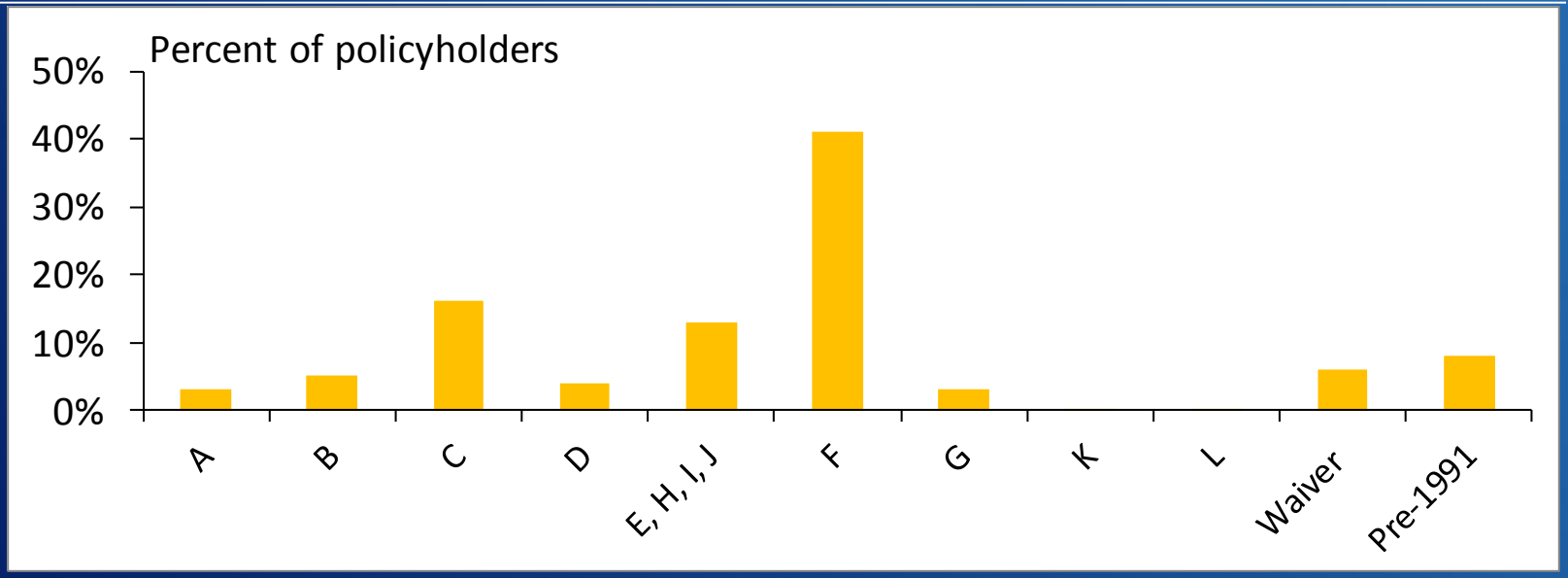
Medigap plans C and F fill in most all of Medicare's cost sharing (2009 data)



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

Notes: Waiver states include Massachusetts, Minnesota, and Wisconsin. Plans E, H, I, and J were closed to future enrollment in 2010.
Source: MedPAC analysis of data from the National Association of Insurance Commissioners.

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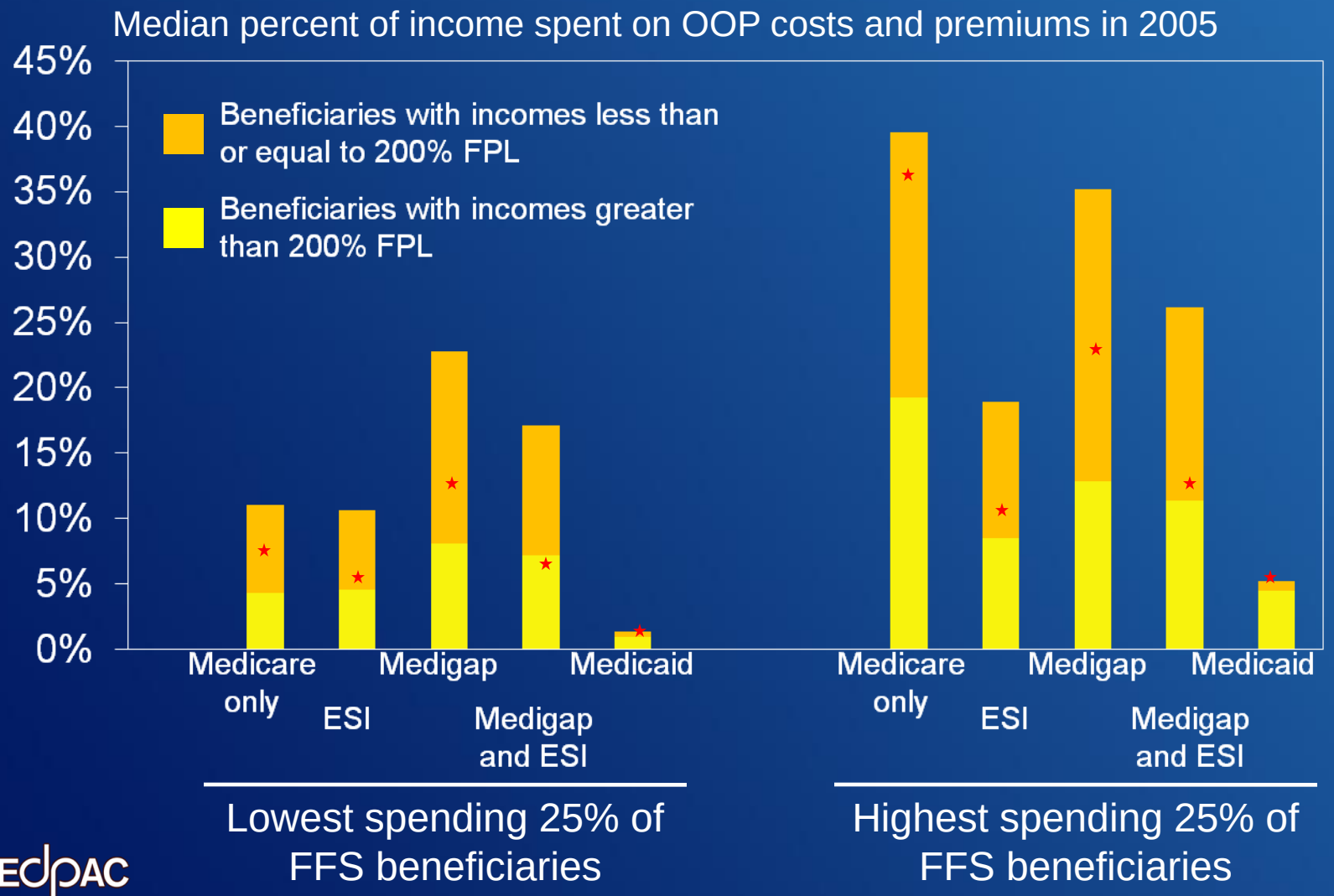
Medigap provision in PPACA

- National Association of Insurance Commissioners to revise standards for medigap plan C and plan F policies
  - Include nominal cost sharing to encourage appropriate physician services under Part B
  - Standards to be in place by Jan. 1, 2015 for newly issued policies
- No such standards applicable to retiree coverage

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

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

Wide variation in financial burden among beneficiaries



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How does cost-sharing affect service use?

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

Innovative benefit designs in the public and private sector

- Four design strategies
  - Lowering cost sharing for high-value services
  - Raising cost sharing for low-value services
  - Incentivizing enrollees to see high-performing or low-cost providers
  - Incentivizing enrollees to adopt healthier behaviors
- No interviewee relied on a single strategy

Lowering cost sharing for high-value services

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

Raising cost sharing for low-value services

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

Incentivizing enrollees to see high-performing providers

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

Incentivizing healthy behaviors

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

Integrating design innovations

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

Discussion questions: short term issues

- As a first priority, should Medicare:
  - Rationalize cost sharing?
  - Provide better financial protection to beneficiaries?
  - Set some cost sharing for all services?
- Should limits be placed on the ability of supplemental coverage to cover all cost sharing?

Discussion questions: Intermediate issues

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

Discussion questions: Long term issues

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