Restructuring Medicare Cost Sharing:
Options and Implications

Alliance for Health Reform
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Exhibit 1

Recent proposals include three main approaches to changing Medicare cost sharing

1) **Revise the cost-sharing features of traditional Medicare**
   - Simplify deductibles and cost sharing
   - Add an out-of-pocket spending maximum

2) **Restrict and/or discourage supplemental coverage (Medigap and/or employer-sponsored retiree plans)**
   - Prohibit "first-dollar" Medigap coverage
   - Supplemental coverage premium surcharge

3) **Restructure Medicare cost sharing AND prohibit/restrict supplemental coverage**

Exhibit 2

Two examples of restructured Medicare cost sharing

➢ CBO (March 2011)

- Unified $550 Part A and B deductible
- 20% coinsurance on all Medicare services
- $5,500 out-of-pocket (OOP) spending maximum

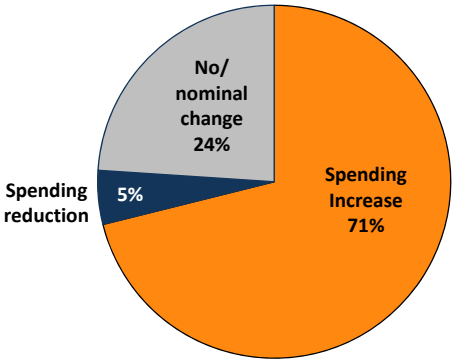
➢ MedPAC (June 2012)

- Unified Part A and B deductible
- Copayments that vary by service and provider; e.g., $20 for primary care visit; $40 for specialist visit; $750 copay per hospital admission
- Out-of-pocket spending maximum
- Gives HHS Secretary authority to make "value-based" changes to the benefit design

Exhibit 3

Under the CBO design, a small share of Medicare beneficiaries would pay less than under current law; most would face higher costs

CBO Design: $550 deductible, 20% coinsurance for all services, $5,500 out-of-pocket maximum in 2013



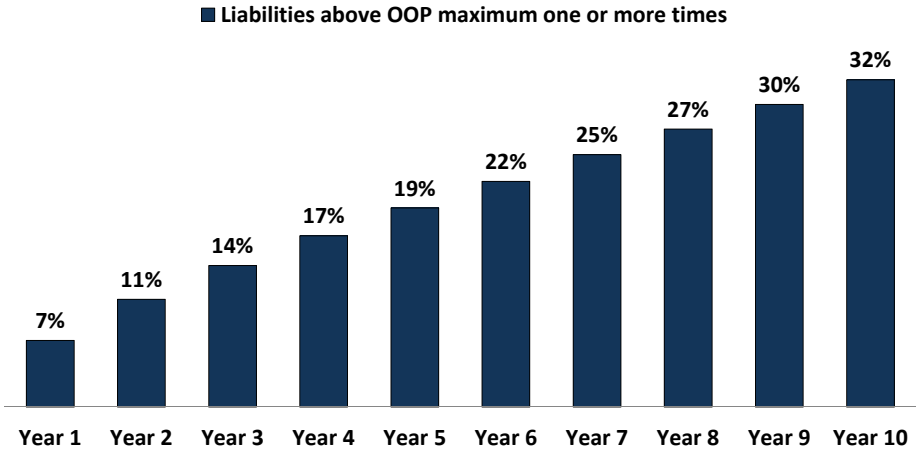
Traditional Medicare beneficiaries, 2013: 40.8 million

- **About 2 million beneficiaries (5%) would see savings ($1,570 on average)**
- **About 29 million beneficiaries (71%) would see costs increase ($180 on average)**
  - For those using physician services but no inpatient care, the deductible would more than triple compared to current law ($147 to $550)

NOTES: Out-of-pocket costs includes premiums and cost-sharing requirements. No/nominal change group includes beneficiaries with changes in spending no more than ±$25.
SOURCE: Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending," November 2011.

Exhibit 4

A small share would reach a $5,000 OOP maximum in any given year, but a larger share would reach the limit over a longer period of time

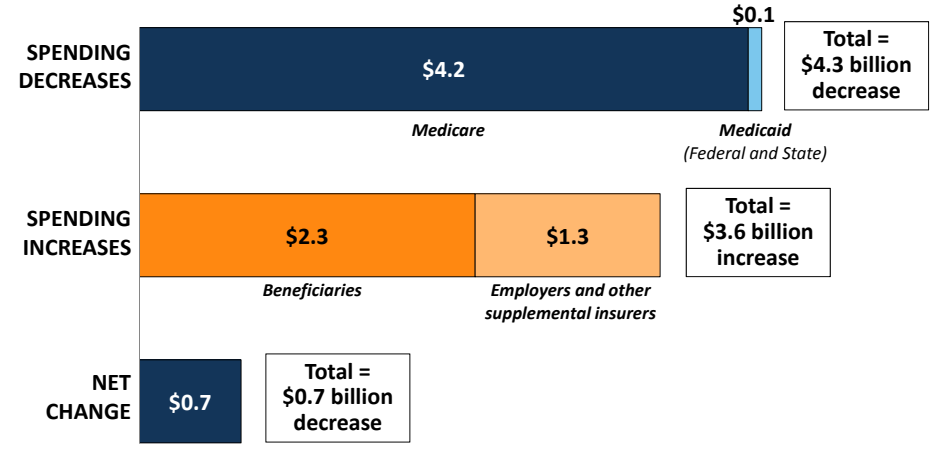


NOTES: Cohort includes beneficiaries who died during the 10-year period. Analysis assumed current cost-sharing requirements and no changes in supplemental coverage. The $5,000 maximum is expressed in 2009 dollars and indexed for projected growth in average spending per traditional Medicare beneficiary.
SOURCE: Actuarial Research Corporation analysis for MedPAC and the Kaiser Family Foundation, June 2013.

Exhibit 5

Under the CBO design, Medicare spending would decrease, but costs would be shifted onto beneficiaries and other payers

CBO Design: $550 deductible, 20% coinsurance for all services, $5,500 out-of-pocket maximum in 2013



NOTES: Other supplemental insurers includes Veterans' Administration, Indian Health Service and other federal sources; other state and local sources; worker's compensation; and other unclassified sources.
SOURCE: Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending," November 2011.

Exhibit 6

Approaches to prohibiting and/or discouraging supplemental coverage

➢ CBO (March 2011)

- Prohibits "first-dollar" Medigap coverage: Medigap policies not allowed to cover first $550 in cost sharing for Part A/B services and limited to covering half of the next $4,950, but would cover any remaining cost-sharing liability

➢ MedPAC (June 2012)

- Imposes an additional charge on the premiums of supplemental insurance policies – both Medigap and employer-sponsored retiree plans

➢ President's FY2014 Budget

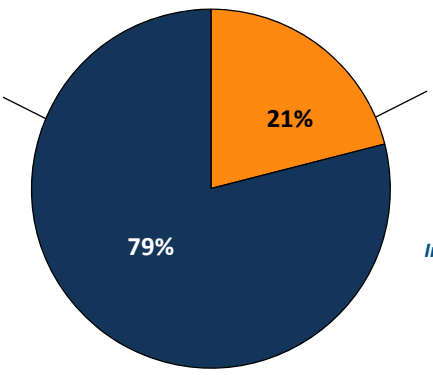
- Imposes a Part B premium surcharge for new Medicare beneficiaries with "first-dollar" or "near-first dollar" Medigap coverage, beginning in 2017

Exhibit 7

Prohibiting first-dollar Medigap coverage would reduce costs for many Medigap enrollees, but one in five expected to pay more

Plans not allowed to cover first $550 in cost sharing for Part A/B services and limited to covering half of the next $4,950, but would cover any remaining obligations

Share of Medigap policyholders expected to see costs decline (due to lower Medigap premiums)



Share of Medigap policyholders expected to see costs rise (because cost sharing increases would be greater than expected premium reductions)

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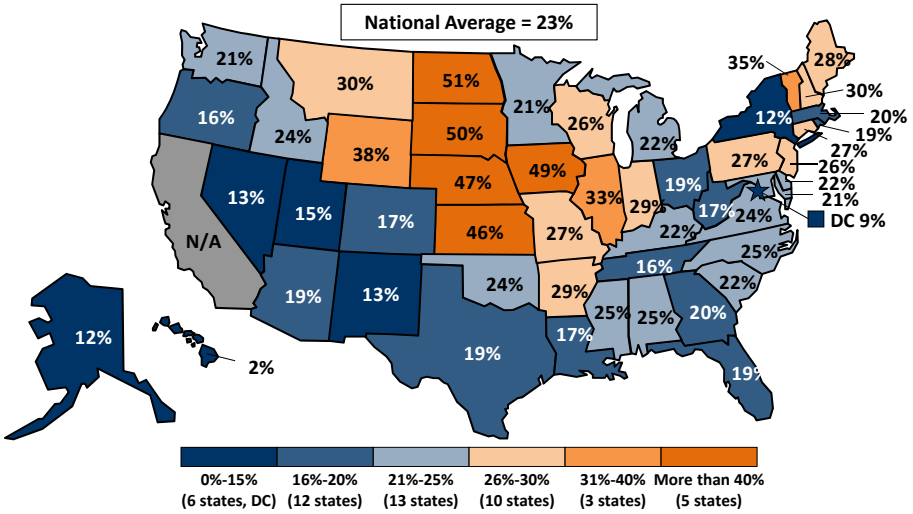
Includes a disproportionate share of those in relatively poor health and those with modest incomes

SOURCE: Kaiser Family Foundation, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," July 2011.

Exhibit 8

Medigap restrictions would have different geographic implications

Percent of Medicare Beneficiaries with Medigap by State, All Plans, 2010



NOTES: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis includes standardized plans A-N, policies existing prior to federal standardization, plans in Massachusetts, Minnesota, and Wisconsin that are not part of the federal standardization program, and plans that identified as Medicare Select; excludes plans where number of covered lives was less than 20. Number of Medigap policyholders as of December 31, 2010, as reported in the NAIC data.
SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2010 National Association of Insurance Commissioners (NAIC) Medicare Supplement data. Kaiser Family foundation and Mathematica Policy Research analysis of CMS State/County Market Penetration Files.

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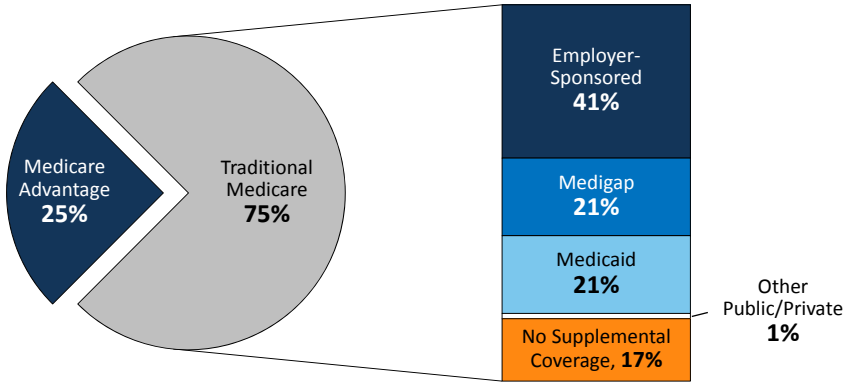
Exhibit 9

A surcharge on Medigap and retiree coverage could affect 6 out of 10 beneficiaries in traditional Medicare



Total Number of Beneficiaries, 2009:
47.2 Million

Beneficiaries with Traditional Medicare, 2009:
35.4 Million

NOTES: Numbers do not sum due to rounding. Some Medicare beneficiaries have more than once source of coverage during the year; for example, 2% of all Medicare beneficiaries had both Medicare Advantage and Medigap in 2009. Supplemental Coverage was assigned in the following order: 1) Medicare Advantage, 2) Medicaid, 3) Employer, 4) Medigap, 5) Other public/private coverage, 6) No supplemental coverage; individuals with more than one source of coverage were assigned to the category that appears highest in the ordering.
SOURCE: Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary 2009 Cost and Use file.

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Exhibit 10

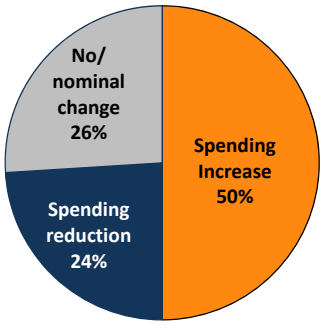
Most recent proposals combine restructured cost sharing with changes to supplemental coverage

- **CBO (March 2011)**
  - Combines restructured cost sharing with a prohibition on first-dollar Medigap coverage
- **MedPAC (June 2012)**
  - Combines restructured cost sharing with a premium surcharge on supplemental coverage (both Medigap and employer-sponsored retiree plans)
- **New(er) features**
  - "Value-based" cost sharing
  - Income-related cost-sharing amounts (e.g., higher out-of-pocket maximum for higher-income beneficiaries)
  - Enhanced financial protections for low-income beneficiaries

Exhibit 11

Under the CBO design, about a quarter of beneficiaries would spend less, but half would spend more

Medicare: $550 deductible, 20% coinsurance for all services, $5,500 out-of-pocket maximum
Medigap: Plans prohibited from covering the deductible and more than half of the 20% coinsurance



Traditional Medicare beneficiaries, 2013: 40.8 million

- **Nearly a quarter expected to see costs decline**
  - More than under restructured cost sharing alone, due in part to drop in Medigap and Part B premiums
- **Half of beneficiaries expected to see cost increases, including an estimated six million beneficiaries who would see costs increase by $250 or more**
  - Fewer than under restructured cost sharing alone, but Medigap restrictions would expose them to more cost sharing

NOTES: Out-of-pocket costs includes premiums and cost-sharing requirements. No/nominal change group includes beneficiaries with changes in spending no more than ±$25.
SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.

Exhibit 12

Key Takeaways

- Not all Medicare cost-sharing restructuring/supplemental coverage proposals are alike; effects would vary depending on design details
- If designed to achieve Medicare savings, cost-sharing restructuring proposals would create winners and losers among Medicare beneficiaries in any given year
  - **Restructured cost sharing:**
    - Most beneficiaries would pay more with a unified deductible and uniform coinsurance than they would under current law
    - A small share would benefit from the out-of-pocket spending maximum in any given year; a larger share over a multiple-year period
  - **Supplemental coverage restrictions:**
    - Achieves Medicare savings by increasing enrollees' exposure to Medicare cost-sharing obligations and/or by collecting premium surcharges
- Increased exposure to cost sharing may lead to reduced use of both necessary and unnecessary care – producing efficiency gains from the latter, but potential health complications and additional costs from the former
- Attention is needed to avoid shifting excessive costs onto beneficiaries with modest incomes