THE FUTURE OF MEDICARE

Understanding the Medicare Population and Consumer Affordability

MAY 6, 2022

ALLIANCE FOR HEALTH POLICY | 30 YEARS

UPCOMING EVENT

MAY 20,2022 | 10:30 – 11:00 am ET

Session #3: Policy Options to Improve Medicare Sustainability

This session will help attendees consider the implications of policy options to promote Medicare sustainability. Panelists will explore trends in Medicare spending; introduce key concepts related to Medicare financing and solvency; and explore the implications of policy options to promote Medicare sustainability.

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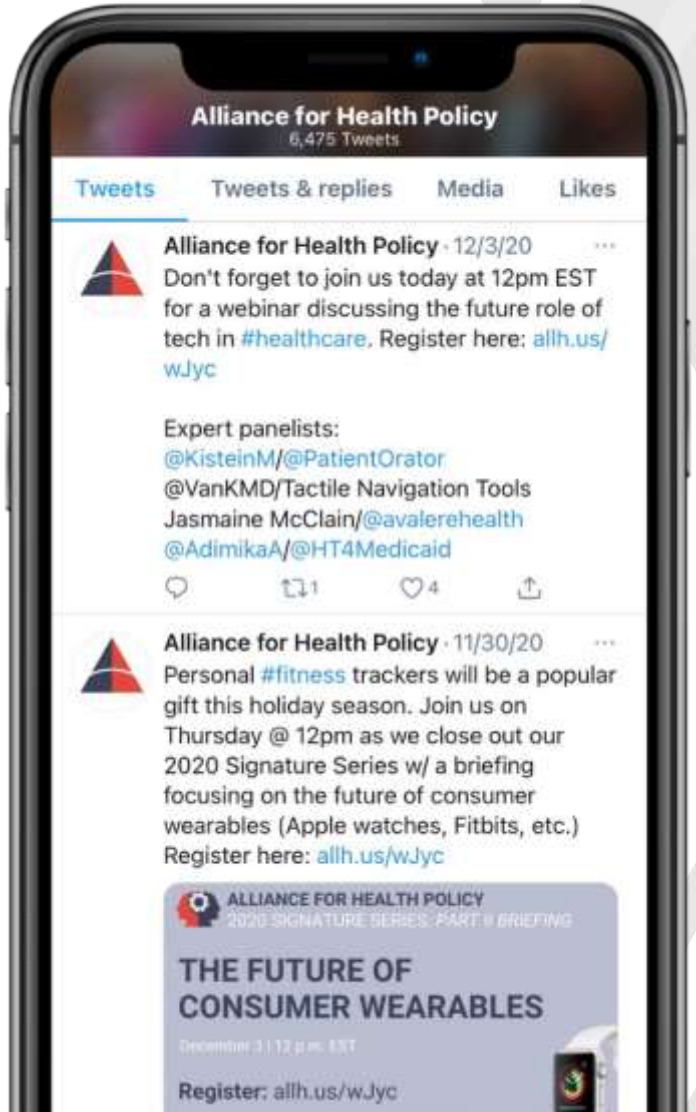

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Brandon Wilson, Dr.P.H., MHA

Director, Center for Consumer Engagement in Health Innovation

Community Catalyst

30 YEARS

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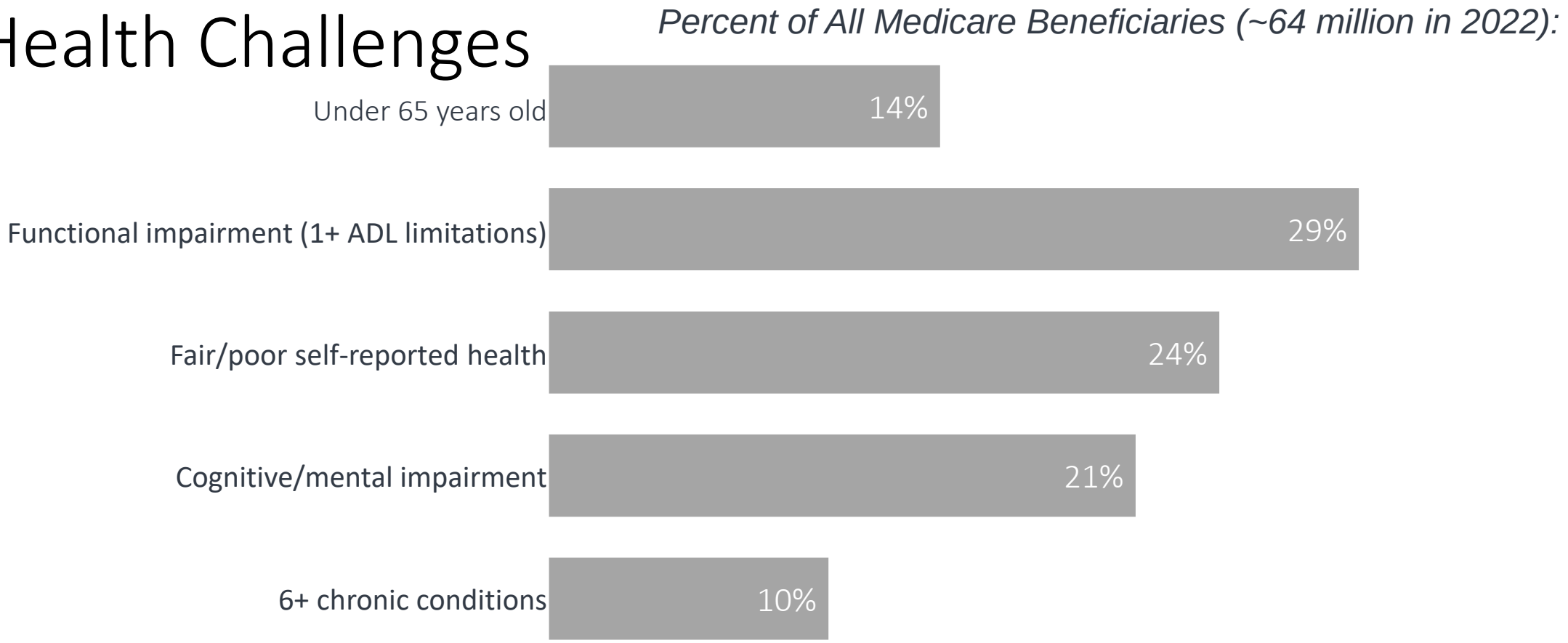
30 YEARS

Understanding the Medicare Population and Consumer Affordability

Tricia Neuman, Sc.D.
Senior Vice President and Executive Director, Program on Medicare Policy

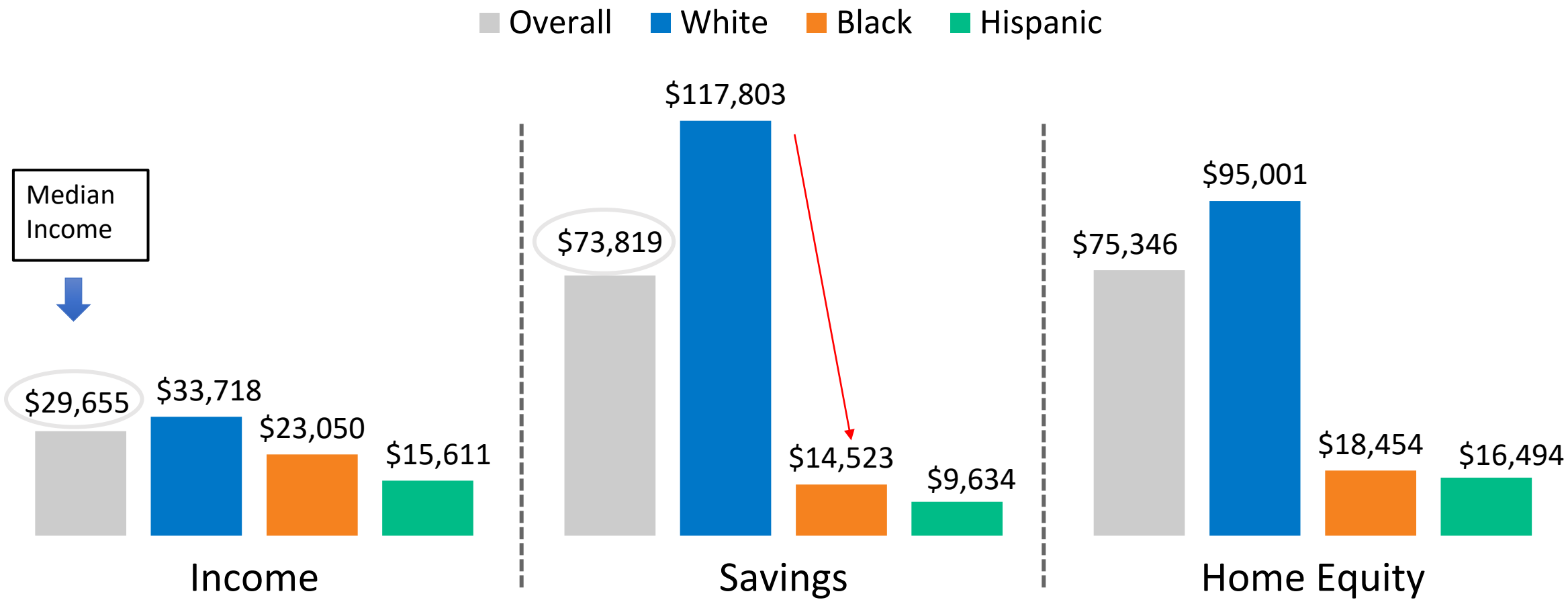
For the Alliance for Health Reform

Many on Medicare Enjoy Good Health, But a Significant Share Have Functional, Cognitive & Other Health Challenges



NOTE: ADL is activity of daily living.
SOURCE: KFF, “Medicare Beneficiaries’ Financial Security Before the Coronavirus Pandemic,” April 2020; “Racial and Ethnic Health Inequities and Medicare,” February 2021.

Half of All Medicare Beneficiaries Lived on Incomes of $29,655 or Less and Had Savings of $73,819 or Less Per Person in 2019



SOURCE: KFF, "Medicare Beneficiaries' Financial Security Before the Coronavirus Pandemic," April 2020.

What Benefits Are Covered by Medicare?

- Part A covers inpatient hospital care, skilled nursing facility care, hospice care, and some home health services

- Part B covers physician services, outpatient hospital care, preventive services, some home health, diagnostic procedures, and durable medical equipment (e.g., wheelchairs)
- Part C (Medicare Advantage) provides Medicare-covered benefits through private plans that contract with Medicare, such as HMOs and PPOs

- Part D covers prescription drugs provided by private plans that contract with Medicare, including stand-alone prescription drug plans and Medicare Advantage plans

Medicare's Cost-Sharing Requirements and Benefit Gaps Contribute to Relatively High Out-of-Pocket Costs

No out-of-pocket cap on cost-sharing for benefits covered under Medicare Parts A and B*

Long-term services and supports – very limited coverage

Average annual cost of semi-private room in nursing home, 2021: $108,000

No out-of-pocket cap on cost-sharing for Part D prescription drugs

Dental services not generally covered

Average out-of-pocket spending among people using dental services, 2018: $874

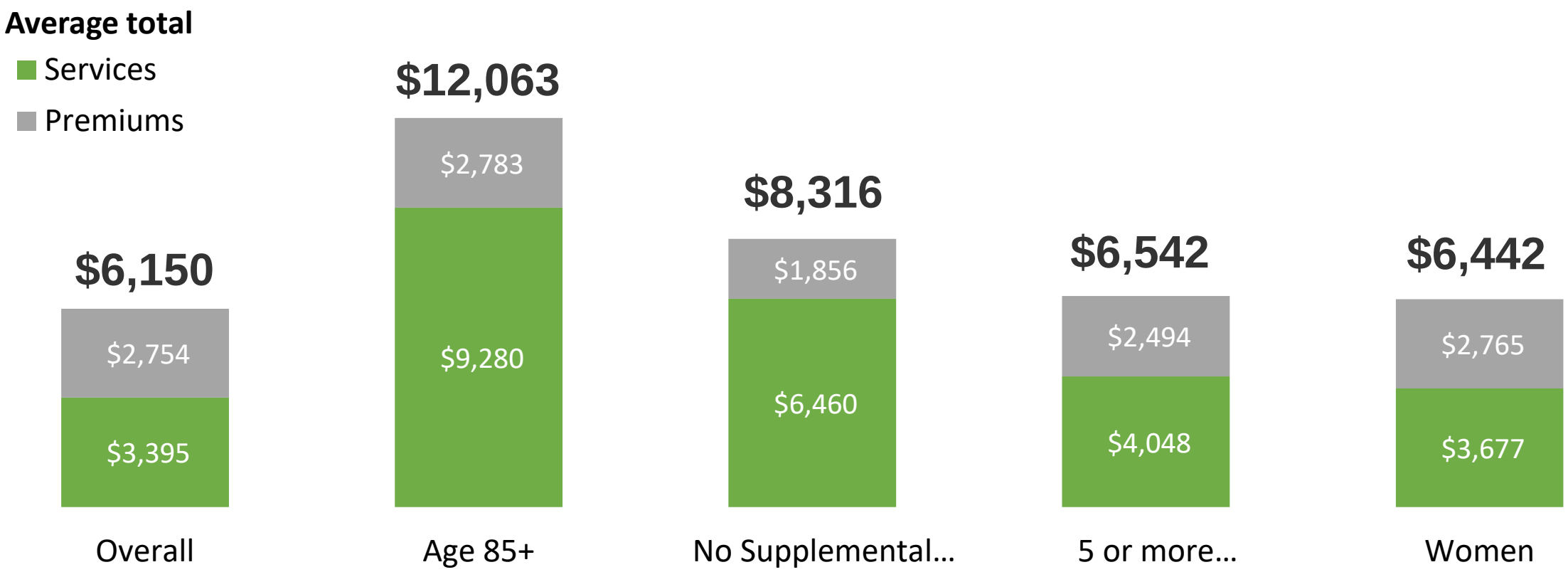
Limited premium and cost-sharing assistance for low-income Medicare beneficiaries (Subject to asset test)

Hearing aids and routine eye exams and eyeglasses – not covered

Average out-of-pocket spending, users of hearing ($914) or vision ($230) in 2018

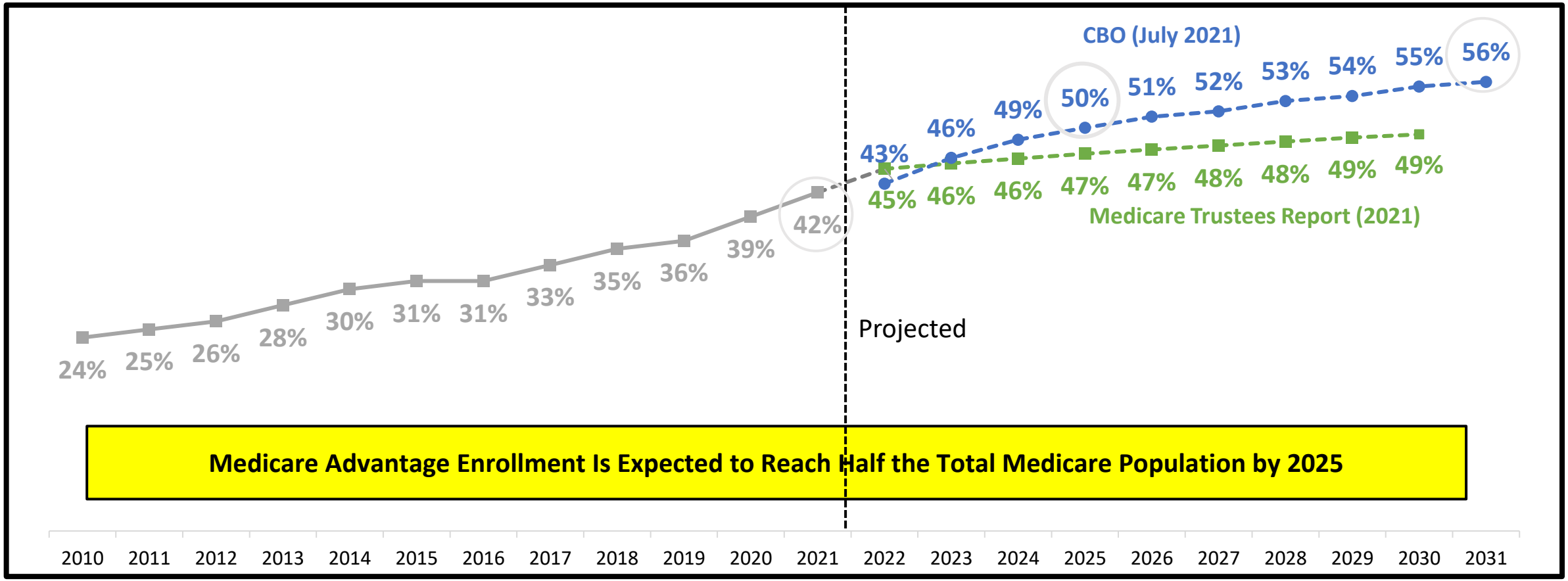
NOTE: *Except in Medicare Advantage
SOURCE: KFF, "Dental, Hearing, and Vision Costs and Coverage Among Medicare Beneficiaries in Traditional Medicare and Medicare Advantage," September 2021.

The Average Traditional Medicare Beneficiary Spent $6,150 Out-of- Pocket for Health Care in 2018; Some Spent Much More



SOURCE: KFF analysis of the CMS Medicare Current Beneficiary Survey, 2018.

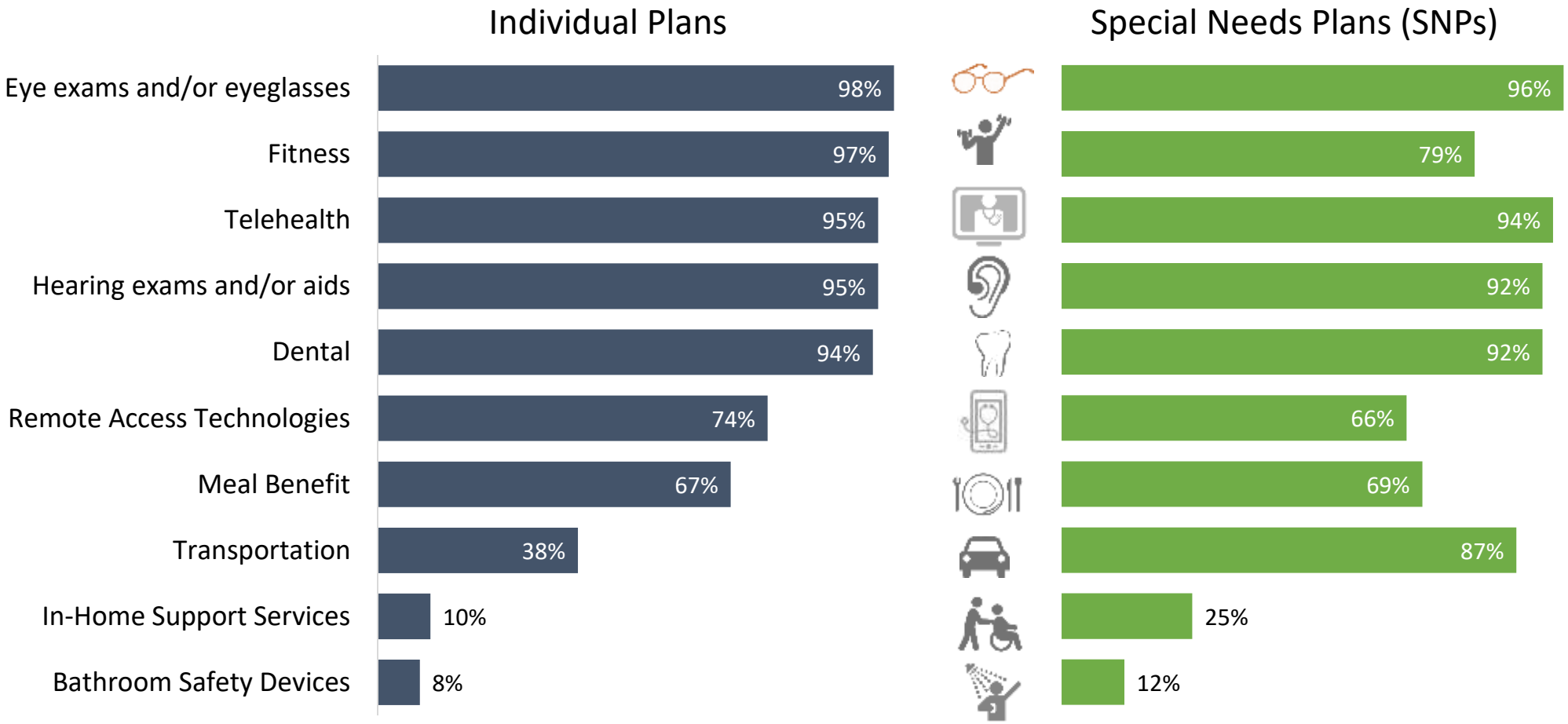
A Rising Share of Medicare Beneficiaries Are Enrolled in Medicare Advantage Plans Offered by Private Insurers



NOTE: This analysis uses beneficiaries with Medicare Part A as the total Medicare population. The share of Medicare beneficiaries in Medicare Advantage would be higher if the Medicare population was limited to beneficiaries with both Part A and B.

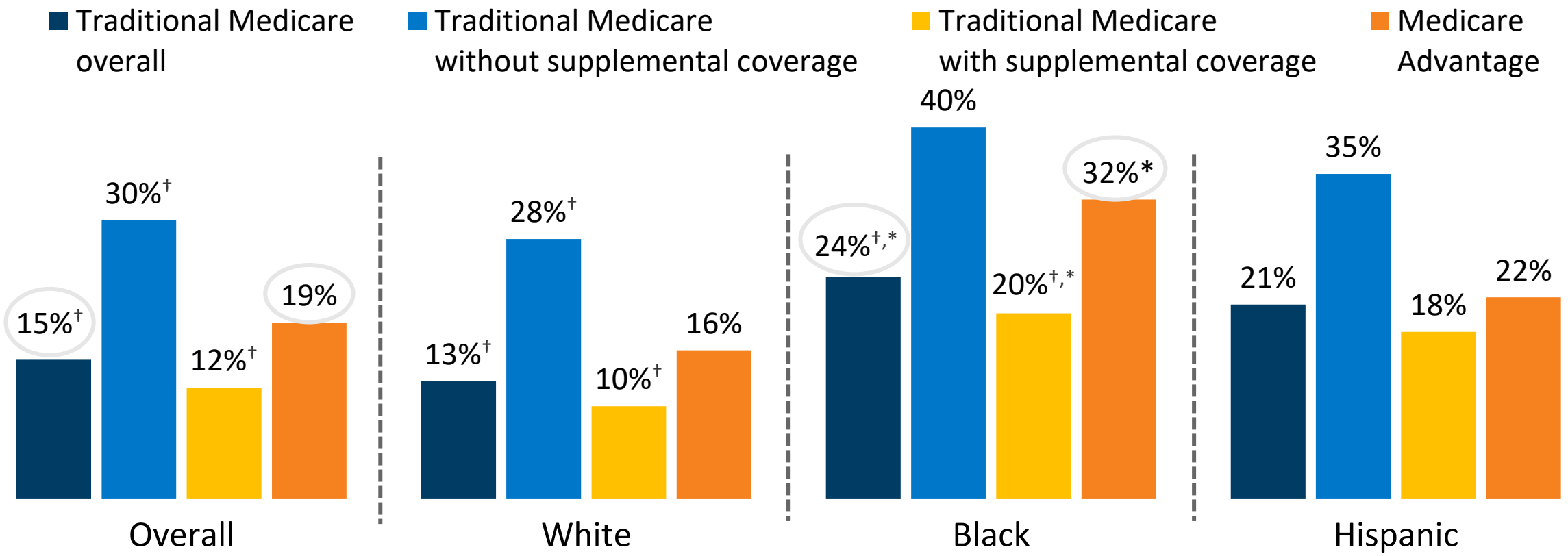
SOURCE: KFF, "Medicare Advantage in 2021: Enrollment Update and Key Trends," June 2021; Projections for 2022 to 2031 are from the Congressional Budget Office (CBO) Medicare Baseline for July 2021, and for 2022 to 2030 from the 2021 Annual Report of the Boards of Trustees.

Most Medicare Advantage Plans Offer Benefits Not Covered Under Traditional Medicare in 2022



SOURCE: KFF, “Medicare Advantage 2022 Spotlight: First Look,” November 2021.

A Smaller Share of Beneficiaries in Traditional Medicare Than in Medicare Advantage Report Cost-Related Problems, Mainly Due to Supplemental Coverage



NOTE: † denotes statistically significant difference from beneficiaries in Medicare Advantage of the same racial/ethnic group in both bivariate and multivariate analyses. *denotes statistically significant difference from White beneficiaries within the same coverage group in both bivariate and multivariate analyses. Data on other racial/ethnic groups is not available for other specific groups beyond those shown due to small sample size. SOURCE: KFF, "Cost-Related Problems Are Less Common Among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage," June 2021

Increases in Medicare Spending Have Led to Higher Medicare Premiums and Deductibles for Ben

SOURCE: KFF, "The Facts About Medicare Spending," April 2022

https://www.kff.org/interactive/medicare-spending/

There's Much More on Medicare at KFF.org/Medicare

- ✓ An Overview of Medicare
- ✓ Medicare Advantage 2022 Spotlight: First Look
- ✓ Help with Medicare Premium and Cost-Sharing Assistance Varies by State
- ✓ Dental, Hearing, and Vision Costs and Coverage Among Medicare Beneficiaries in Traditional Medicare and Medicare Advantage
- ✓ Medicare Beneficiaries' Financial Security Before the Coronavirus Pandemic
- ✓ Cost-Related Problems Are Less Common Among Beneficiaries in Traditional Medicare Than in Medicare Advantage, Mainly Due to Supplemental Coverage
- ✓ Millions of Medicare Part D Enrollees Have Had Out-of-Pocket Drug Spending Above the Catastrophic Threshold Over Time
- ✓ The Facts About Medicare Spending – a data visualization

For more information, contact trician@kff.org or @Tricia_Neuman or visit kff.org/medicare

Loren Saulsberry, Ph.D.

Assistant Professor

The University of Chicago Department of Public Health Sciences

THE UNIVERSITY OF CHICAGO
Biological Sciences Division

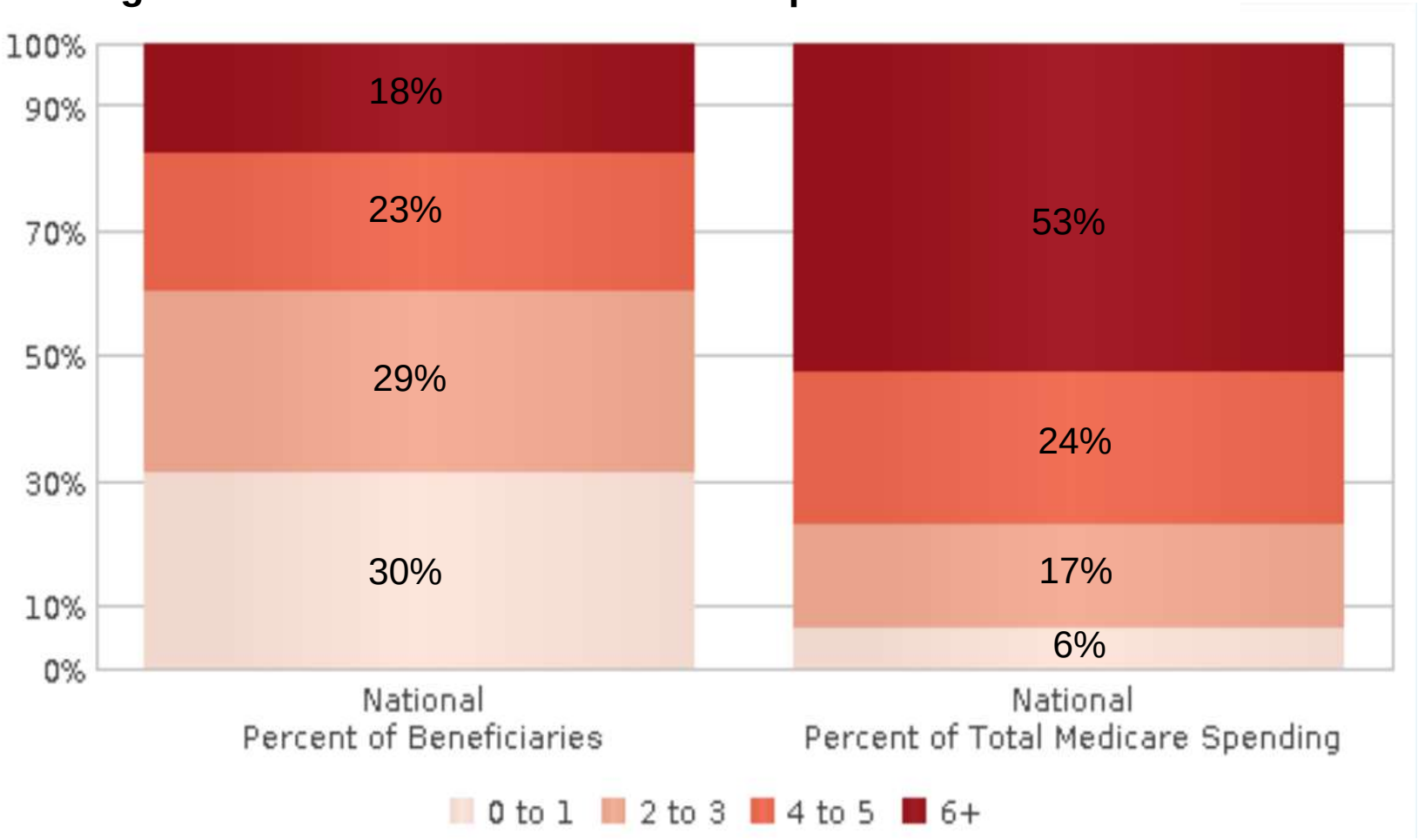
Disparities in the Medicare Population and Implications for Beneficiaries with Chronic Conditions

Loren Saulsberry, Ph.D.
Department of Public Health Sciences
The University of Chicago

6 May 2022

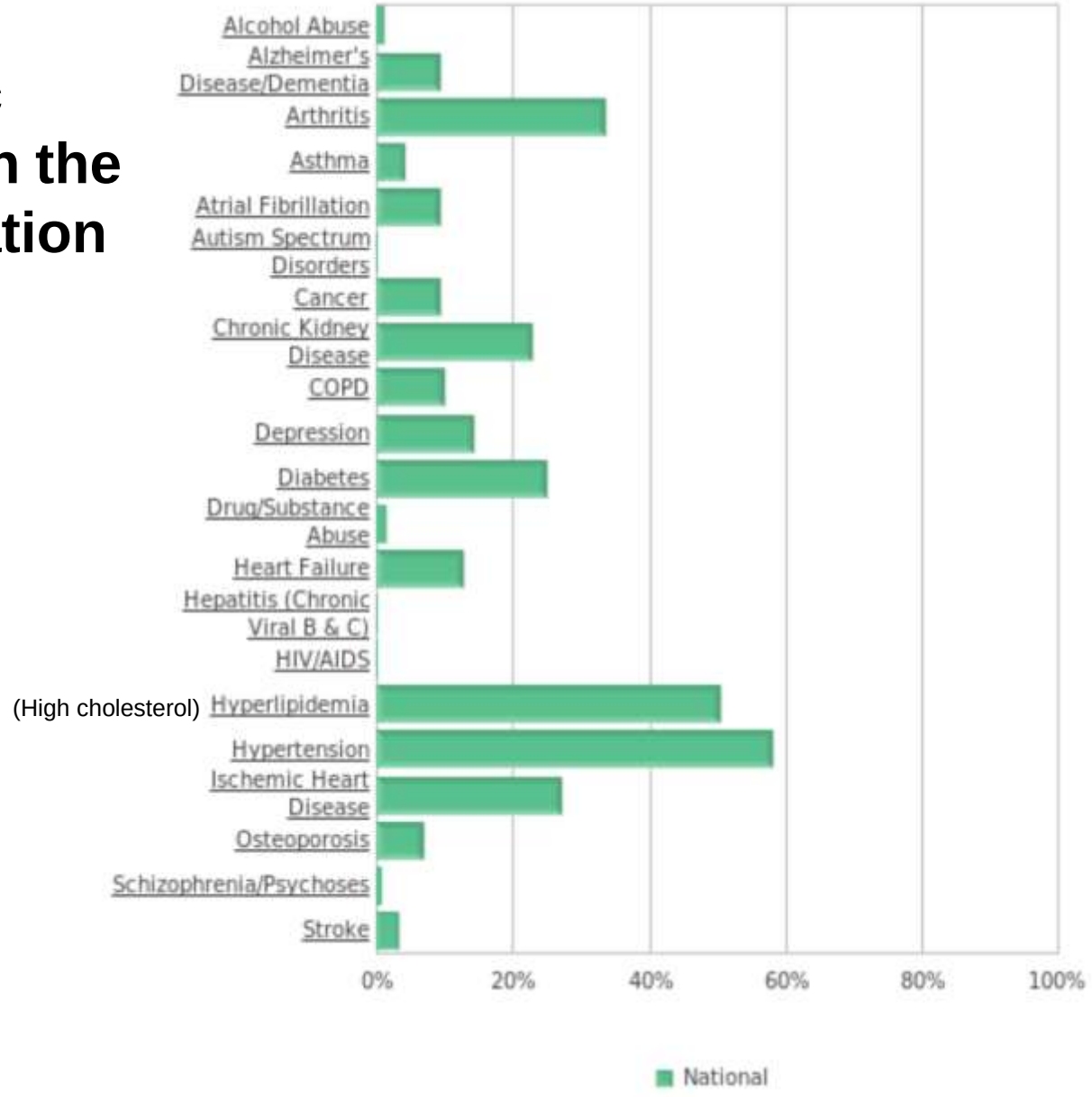
The majority (70%) of Medicare beneficiaries over 65 years have 2+ chronic conditions.

Spending for these beneficiaries with multiple chronic conditions make up the largest shares of national Medicare expenditures.



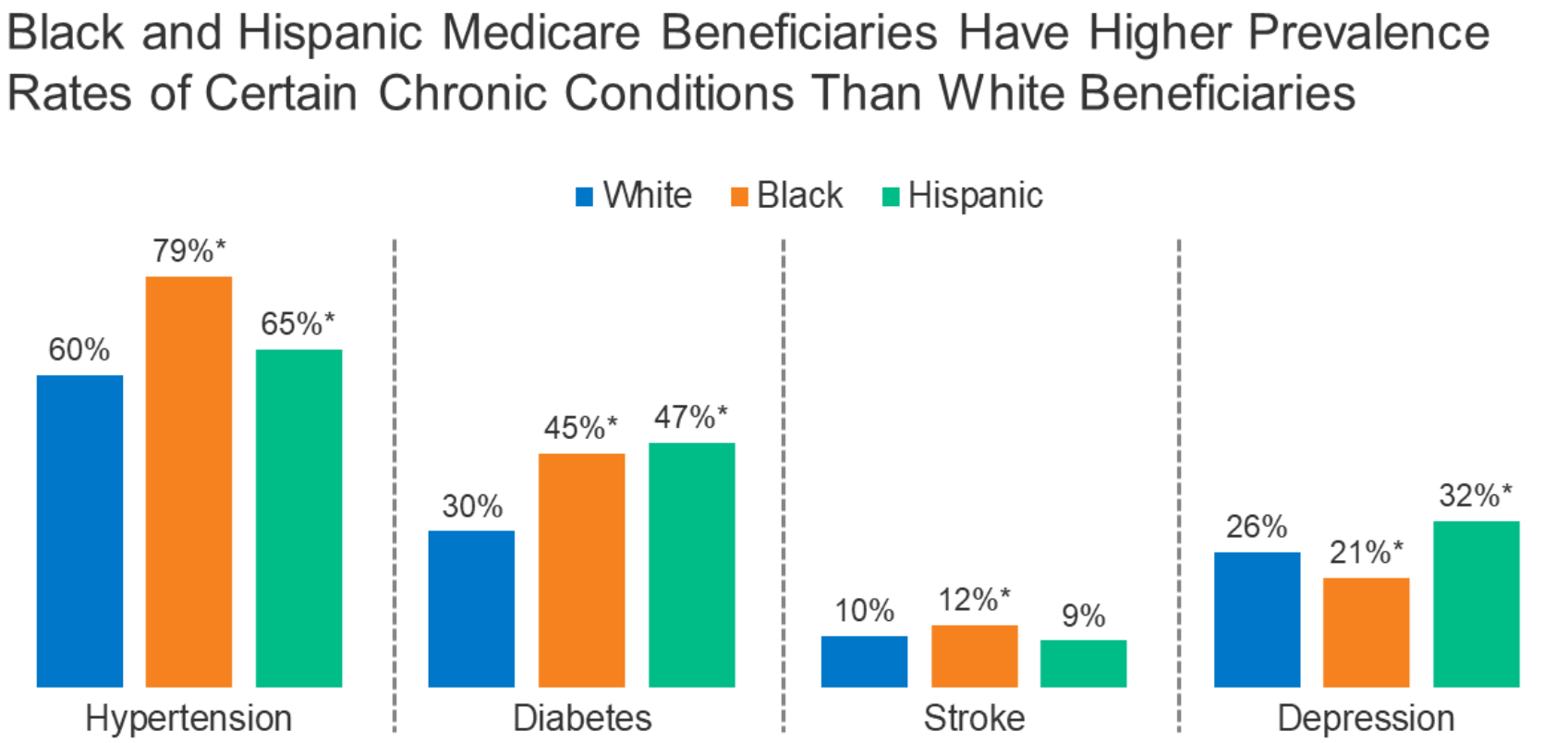
Centers for Medicare and Medicaid Services (CMS).State: Medicare Chronic Conditions Dashboard, 2018.

Types of chronic conditions within the Medicare population (over 65 years)



Centers for Medicare and Medicaid Services (CMS).State: Medicare Chronic Conditions Dashboard, 2018.

Chronic disease burden is not distributed evenly across the Medicare population.



NOTE: *denotes statistically significant difference at the 95% confidence level from Whites. Data on other racial/ethnic groups not shown and is not available for other specific groups beyond those shown due to small sample size. Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic.

SOURCE: KFF analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary Survey, 2018 Survey File.

KFF

Background—Disparities in the Medicare population

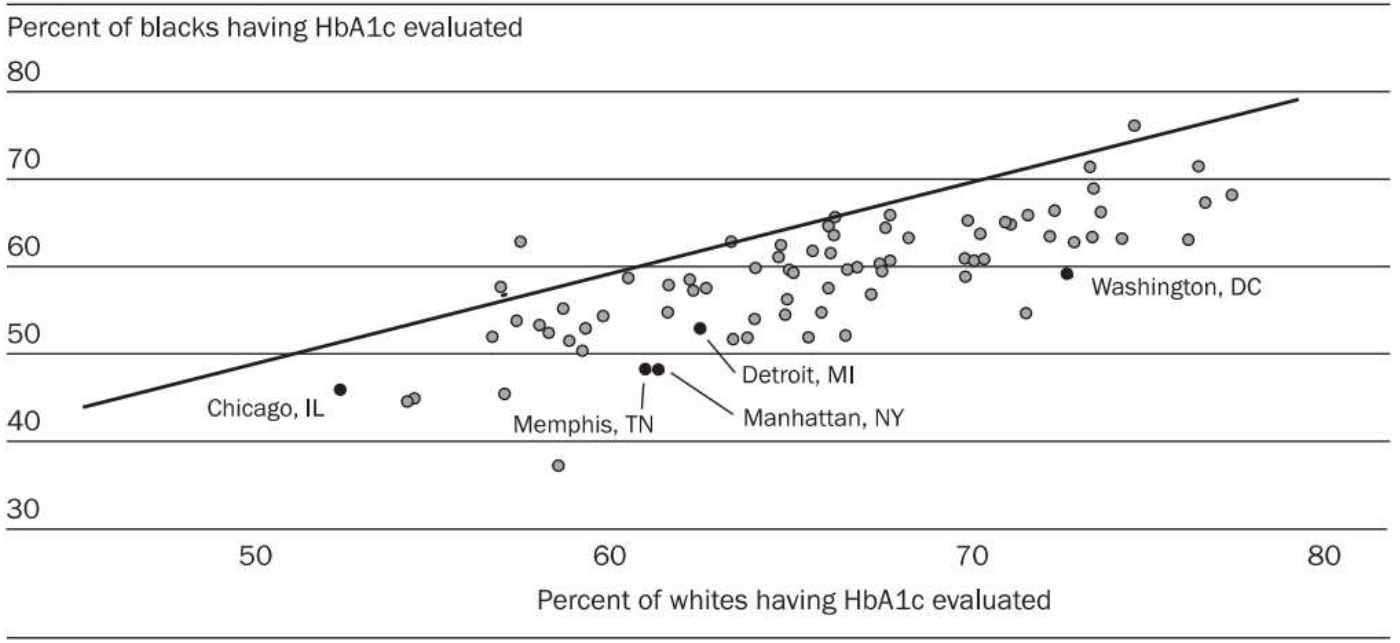
Despite long-standing knowledge of racial and ethnic health care disparities (Smedley et al. *Institute of Medicine.* 2003), **inequities in the U.S. health system persist** (Mahajan et al. *JAMA*. 2021)

- Use (e.g., types of health services received)
- Costs (e.g., insurance expenditures, patient out-of-pocket expenses)
- Geography

Disparities in the use of services within the Medicare population

EXHIBIT 2

Black–White Differences In HbA1c Evaluation For Diabetics In 79 Hospital Referral Regions (HRRs), Medicare Population, 1998–2001



SOURCE: Authors' analysis of Medicare claims data, 1998–2001.
NOTES: Sample is Medicare enrollees in the seventy-nine HRRs with the largest black populations (representing 80 percent of the U.S. elderly black population). Data represent the percentage of diabetics having hemoglobin A1c (HbA1c) evaluated at least once each year, by race, adjusted for age and sex.

Baicker et al. *Health Affairs.* 2004.

Disparities in the costs of services within the Medicare population

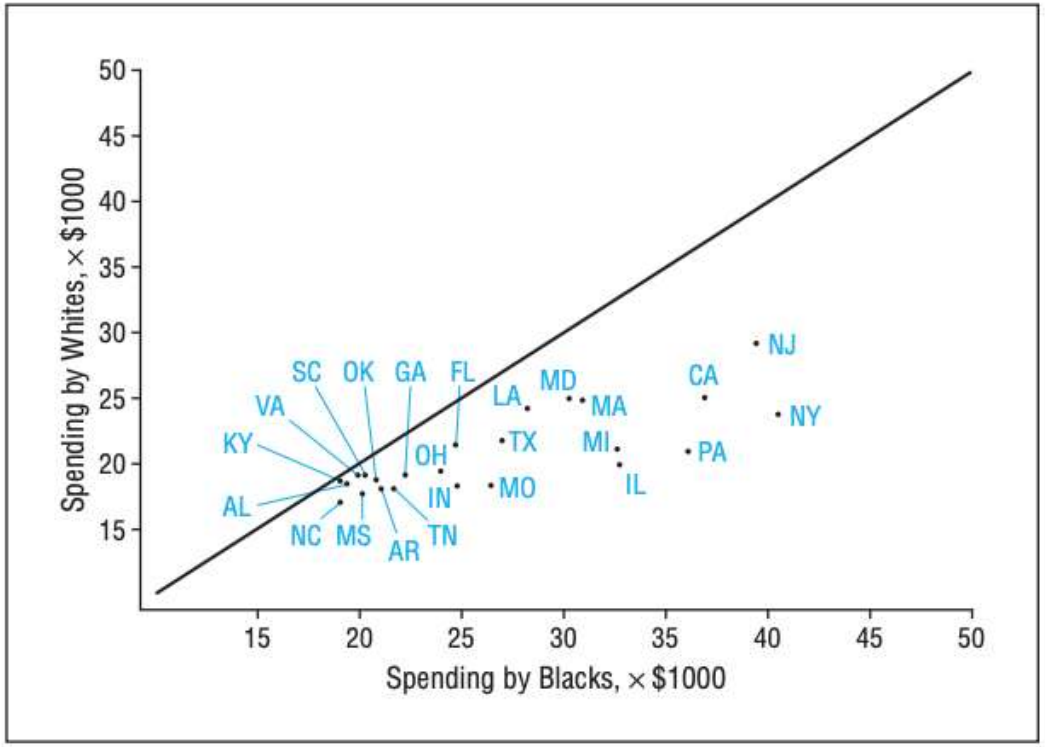
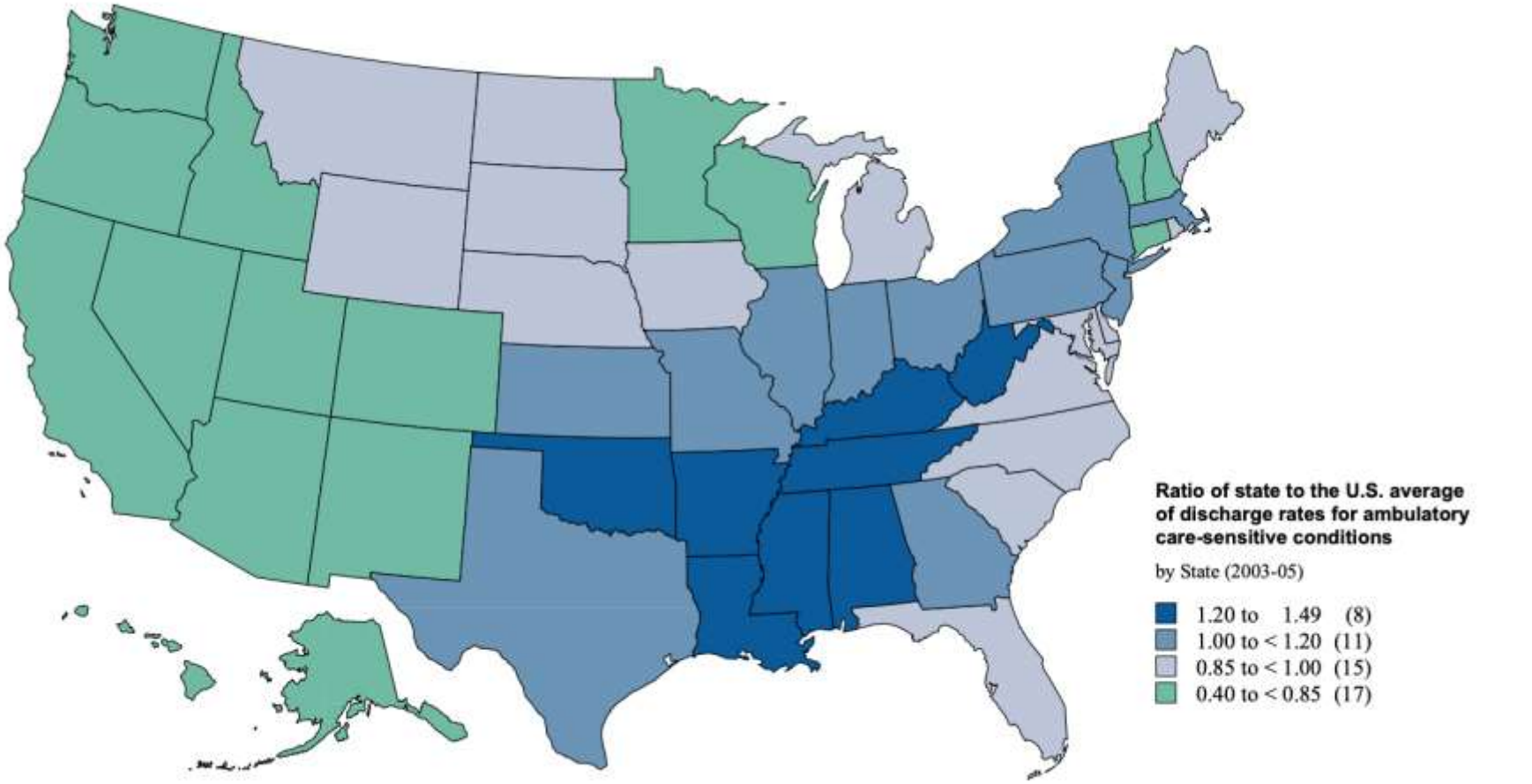


Figure 1. Comparison of black and white average Medicare expenditures 6 months before death, by state. Only the 24 states with at least 400 sample sizes for each racial cohort are plotted.

Hanchate et al. *Arch Intern Med.* 2009.

Disparities across geographic region within the Medicare population



Map 5. Hospitalization for ambulatory care-sensitive conditions, by state (2003-05)

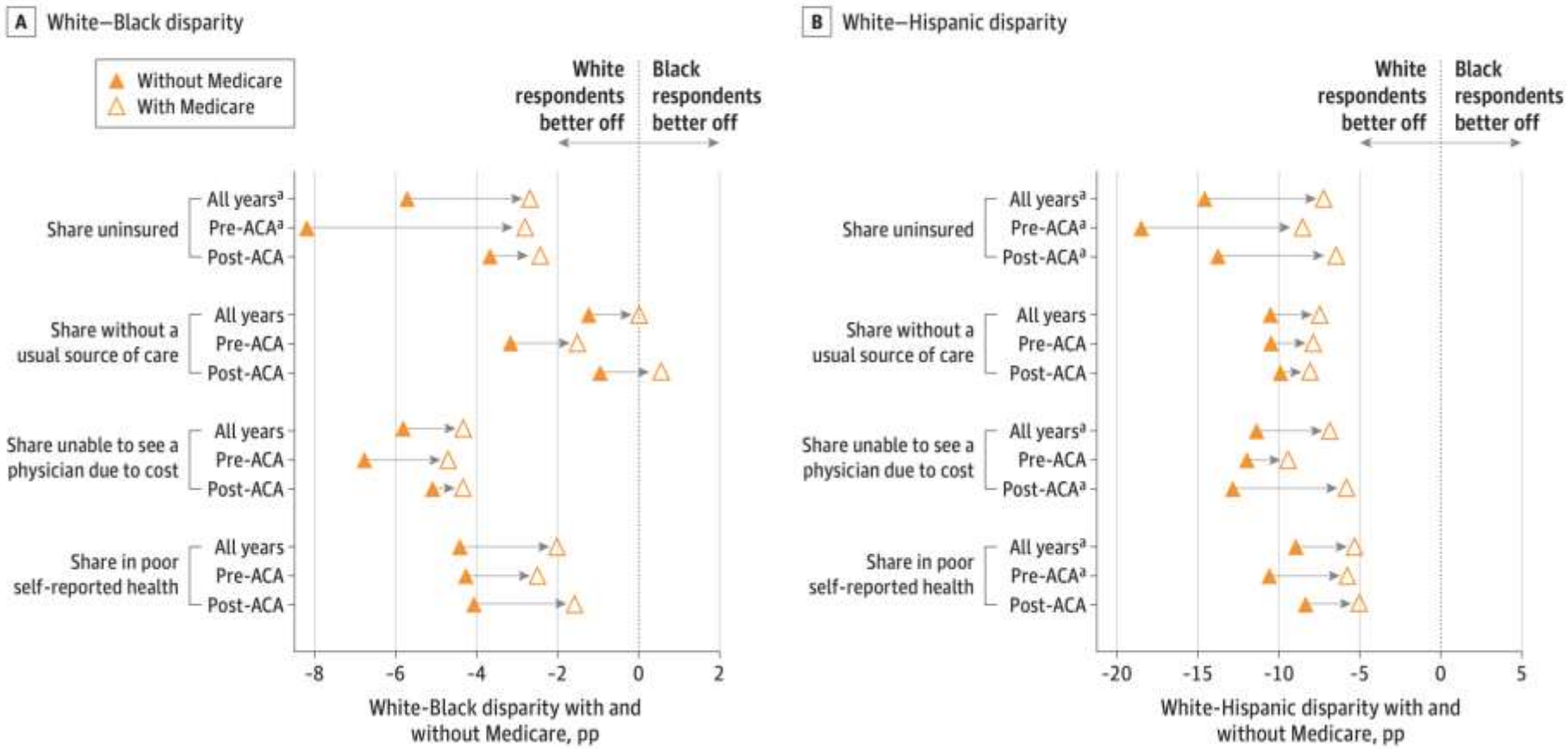
Fisher et al. Robert Wood Johnson Foundation. 2008.

Increased attention to leveraging the Medicare program to advance health equity:

- Seshamani and Jacobs. *JAMA*. 2022
- Landers, Vladeck, and Cole. *Health Affairs Blog.* March 23, 2020.

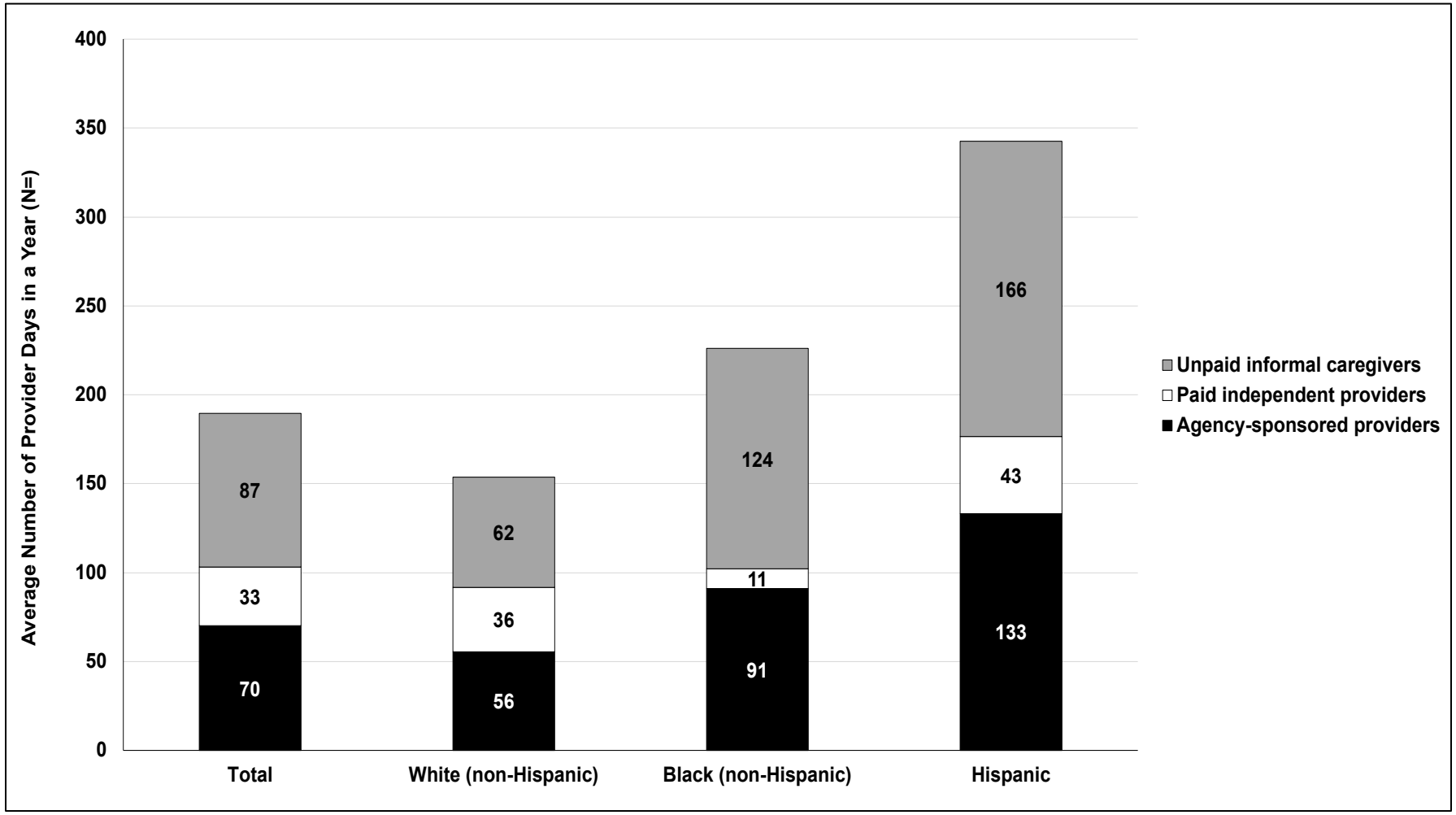
Evidence that Medicare coverage can shrink some of the racial/ethnic disparity gaps

Figure 3. Changes in Racial and Ethnic Disparities in Coverage, Access, and Health Around the Medicare Eligibility Age Pre-ACA vs Post-ACA



Wallace et al. *JAMA Intern Med.* 2021.

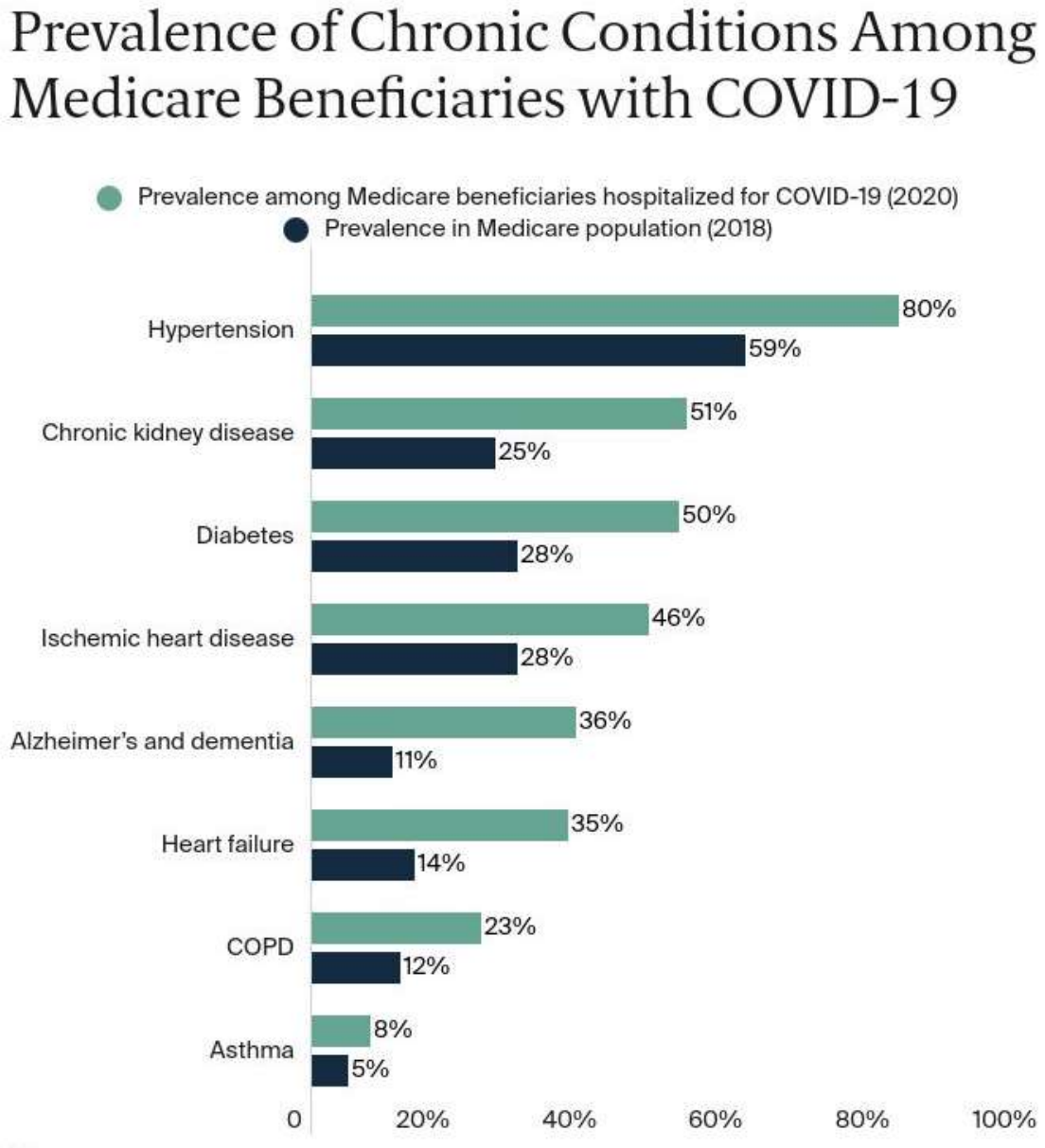
Black (non-Hispanic) and Hispanic beneficiaries with chronic conditions who used home health services relied more heavily on unpaid informal caregivers and agency-sponsored providers.



Saulsberry et al. “Improving Health Equity for Older Adults and Complex Patient Populations.” The Commonwealth Fund. 2022.

Analysis of Medical Expenditure Panel Survey (MEPS), 2009-2019. Study population includes Medicare fee-for-service beneficiaries ages 65-74. Unpaid informal caregivers: including care delivered by unpaid informal caregivers. Paid independent providers: including care delivered by self-employed persons. Agency-sponsored providers: including care delivered by agencies/hospitals/nursing homes.

COVID-19 placed the challenges and disparities experienced by Medicare beneficiaries with chronic conditions in stark relief



Kristen E. Riley et al. The Commonwealth Fund. 2021.

Considerations for Future Policy Directions

- Context (and interpretation)

- Measurement (methods and metrics)
  - Appropriate?
  - “what gets measured gets improved”

- Geography (location)

- Existing infrastructure vs. Building anew

Key Resources—Disparities in the Medicare Population

Centers for Medicare and Medicaid Services (CMS). Mapping Medicare Disparities. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities

Fisher, Elliott S., David C. Goodman, and Amitabh Chandra. "Disparities in Health and Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project." Robert Wood Johnson Foundation, June 2008.

Fiscella K, Sanders MR. Racial and Ethnic Disparities in the Quality of Health Care. *Annu Rev Public Health*. 2016;37:375-394. doi:10.1146/annurev-publhealth-032315-021439

Waidmann TA. Estimating the Cost of Racial and Ethnic Health Disparities. The Urban Institute. September 2009. https://www.urban.org/research/publication/estimating-cost-racial-and-ethnic-health-disparities

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30 YEARS

Navigating complex coverage for low-income Medicare beneficiaries

Challenges for beneficiaries and opportunities for policy reform

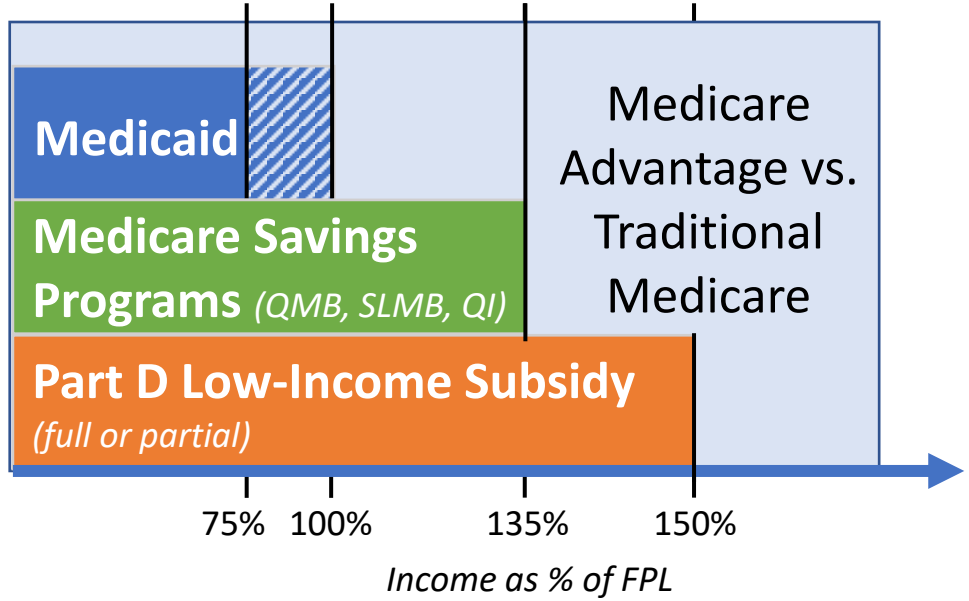
Alliance for Health Policy
May 6, 2022

Eric T. Roberts, Ph.D.
University of Pittsburgh

Coverage for low-income Medicare beneficiaries

- Low-income Medicare beneficiaries navigate a fragmented and often confusing set of coverage sources and financial assistance programs
- These include:
  1) **Traditional Medicare** and **Medicare Advantage**
  2) **Medicaid,** which supplements Medicare and covers Medicare's out-of-pocket costs
  3) **Medicare Savings Programs (MSPs)** and **Part D Low-Income Subsidy (LIS),** which help with Medicare's out-of-pocket costs

Coverage and financial assistance programs for low-income Medicare beneficiaries



Note: Individuals must also meet asset tests to qualify for Medicaid, the Medicare Savings Programs, and the Low-Income Subsidy.

Coverage for low-income Medicare beneficiaries

- Patchwork of coverage sources and programs poses challenges:
  1) Requires individuals to navigate multiple programs with different eligibility rules and benefits (Medicaid, MSPs, and LIS)
     - Complex rules can make it difficult for individuals to enroll in financial assistance programs for which they qualify
  2) Restrictive eligibility rules leave many individuals with low-to-moderate incomes ineligible for assistance
     - Eligibility for Medicaid, the MSPs, and LIS phases down abruptly above income thresholds, leading to “coverage cliffs”
     - These coverage cliffs increase out-of-pocket costs and reduce care among near-poor individuals

Coverage for low-income Medicare beneficiaries

- Patchwork of coverage sources and programs poses challenges:
  3) Separate administration of Medicare and Medicaid may lead to suboptimal coordination of benefits and care for individuals enrolled in both programs (dual-eligibles)

  4) Alongside this patchwork of programs, beneficiaries must simultaneously navigate Medicare coverage options
     - Complex trade-offs between Traditional Medicare (TM) & Medicare Advantage (MA)—e.g., breadth of provider networks, cost sharing, coverage of supplemental benefits
     - How individuals weigh these trade-offs may be affected by whether they receive Medicaid or other financial assistance

Today's webinar

- Review Medicaid and the financial assistance programs available to low-income Medicare beneficiaries (what is covered, who is eligible, who enrolls)
- Discuss 3 interrelated areas of concern:
  1) Low take-up of financial assistance programs among those who are eligible
  2) Coverage cliffs among the near-poor
  3) Challenge of getting Medicare and Medicaid to work well together for dual-eligibles (challenge of integration)
- Discuss opportunities for policy reforms to enhance financial protection and improve care for low-income Medicare beneficiaries

Medicaid and financial assistance programs

What is covered, who is eligible, and who enrolls

Medicaid and financial assistance programs

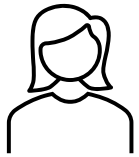
		Medicare Savings Programs (MSP)			Part D Low-Income Subsidy (LIS)	
	Medicaid	**Qualified Medicare Beneficiary (QMB) program**	**Specified Low-Income Medicare Beneficiary (SLMB) program**	**Qualifying Individual (QI) program**	**Full LIS**	**Partial LIS**
What is covered	• Pays for Medicare Part A/B premiums and cost sharing • Covers long-term care • Covers dental, vision, and hearing care (depending on state)	• Pays for Medicare Part A/B premiums and cost sharing	• Pays the Part B premium	• Pays the Part B premium	• Pays the Part D premium • $0 deductible • Nominal drug copayments, with annual OOP limit	• Partial Part D premium subsidy • Low deductible • Reduced co-insurance/co-pays
Income eligibility limits	≤75%-100% of FPL, varying by state	≤100% of FPL except in 4 states	≤120% of FPL except in 4 states	≤135% of FPL except in 4 states	≤135% of FPL	≤150% of FPL
Asset eligibility limits (2022)	≤$2,000 individuals, ≤$3,000 couples (varies in some states)	≤$7,970 individuals, ≤$11,960 couples (varies in some states)			≤$7,970 individuals, ≤$11,960 couples	≤$13,290 individuals, ≤$26,520 couples
Administration	← Medicaid →				Social Security Administration	

Medicaid and financial assistance programs

- 3 vignettes to illustrate this complexity:

Ms. Garcia, age 65 and living in Pennsylvania. Income: $13,000/year (95% of poverty level), and assets of $1,900.

- *Eligible for Medicaid; eligible for automatic LIS enrollment.*



Ms. Butler, age 65 and living in Connecticut. Income: $13,000/year (95% of poverty level), and assets of $1,900.

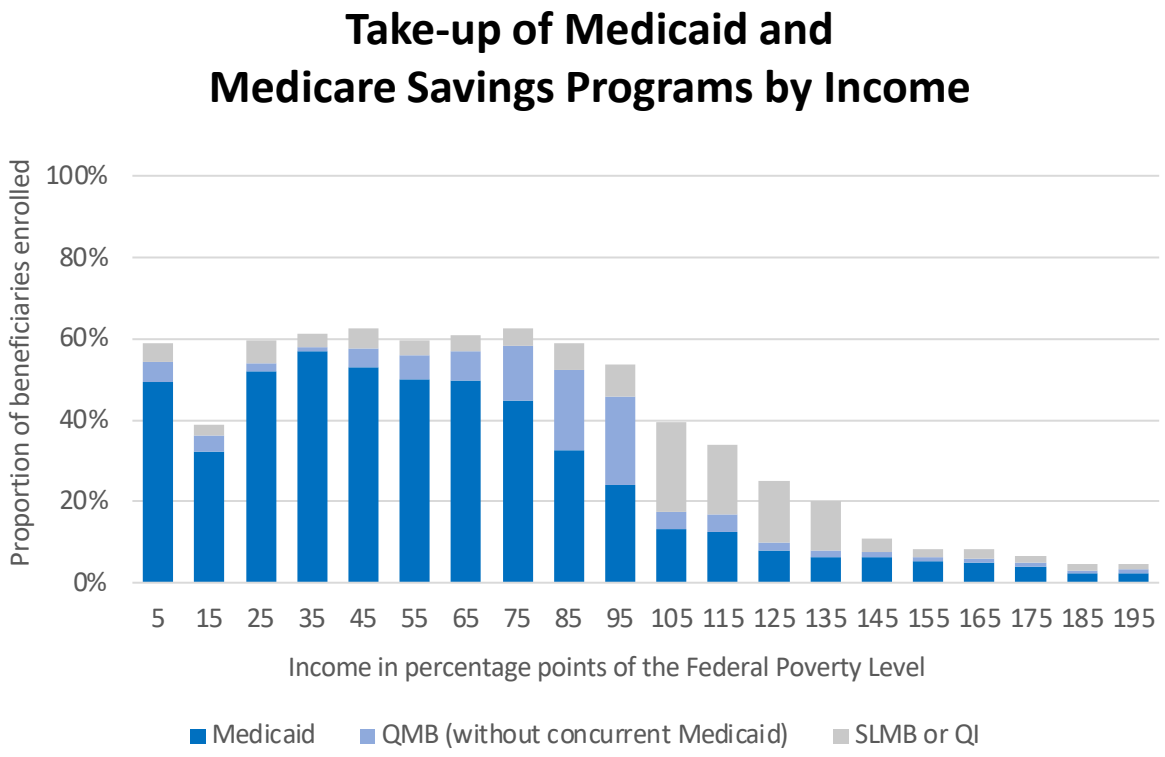
- *Ineligible for Medicaid based on Connecticut criteria.*
- *Eligible for QMB; eligible for automatic LIS enrollment.*

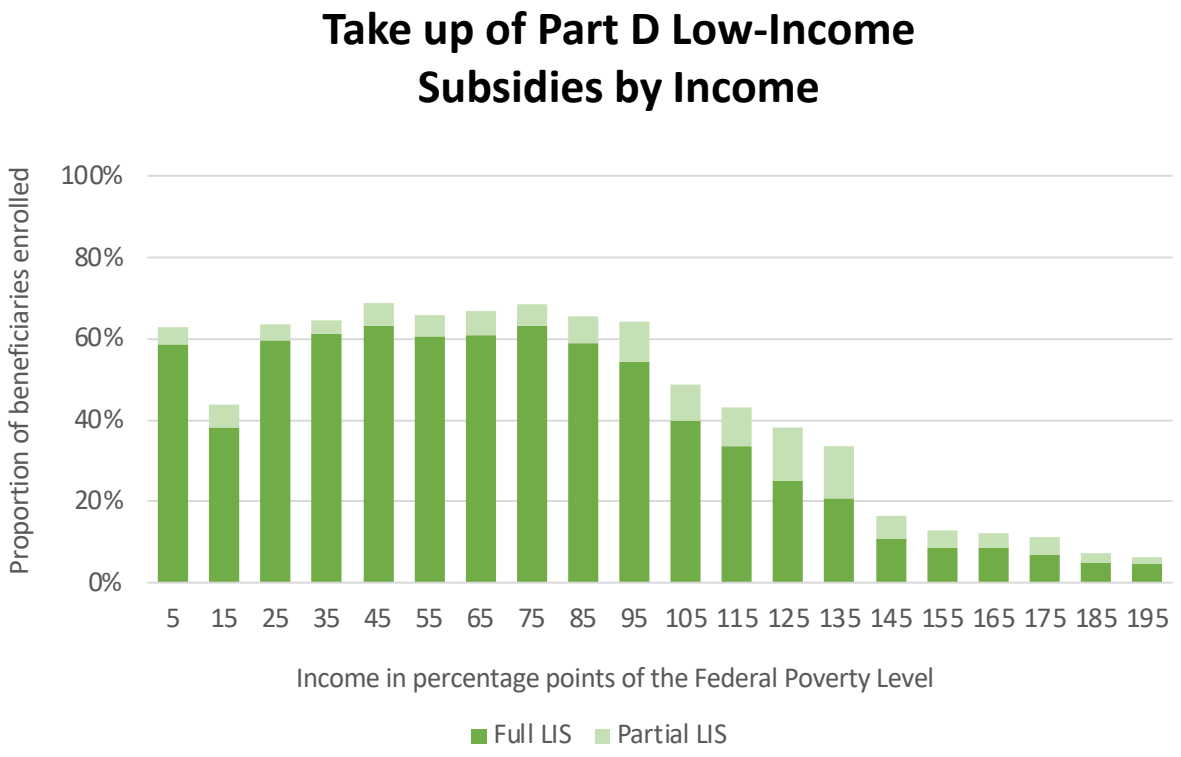
Mr. Smith, age 70 and living in California. Income: $14,000/year (136% of poverty level), and assets of $12,000

- *Ineligible for Medicaid or the MSPs.*
- *Eligible for Partial LIS, but Mr. Smith must file an application with the Social Security Administration (ineligible for automatic LIS enrollment).*

Policy issues and challenges

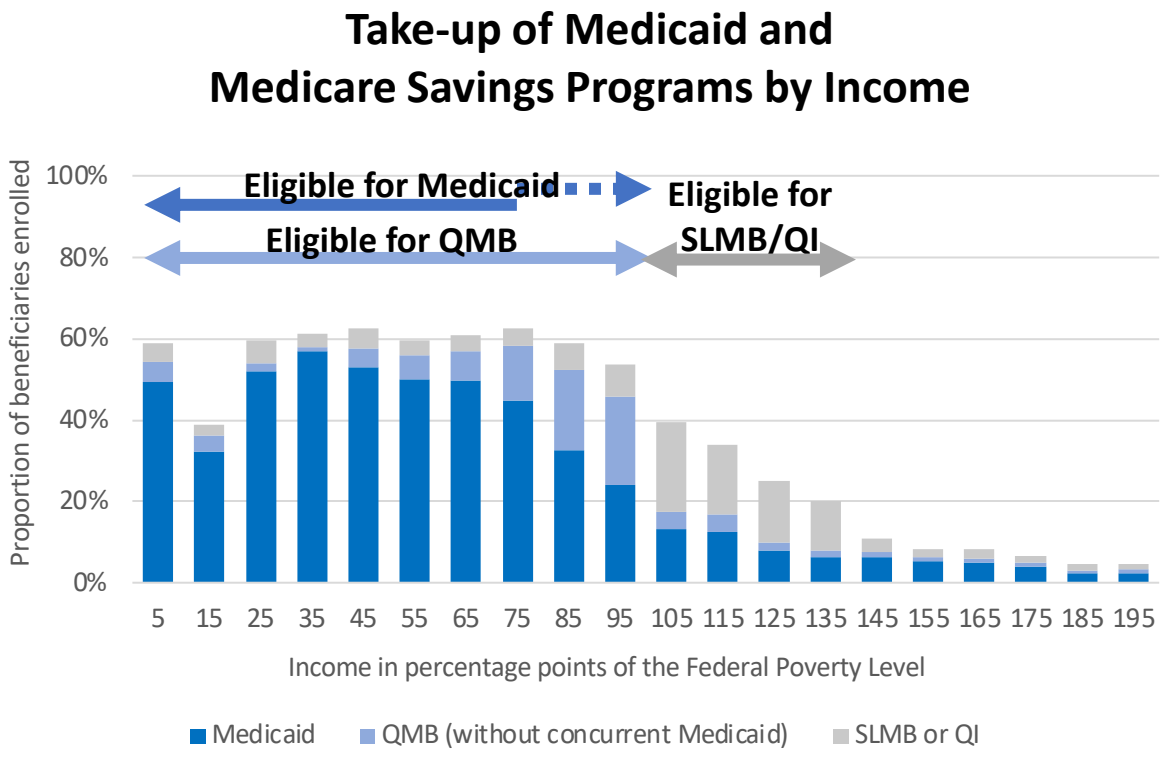
Issue #1—Low Take-Up of Financial Assistance

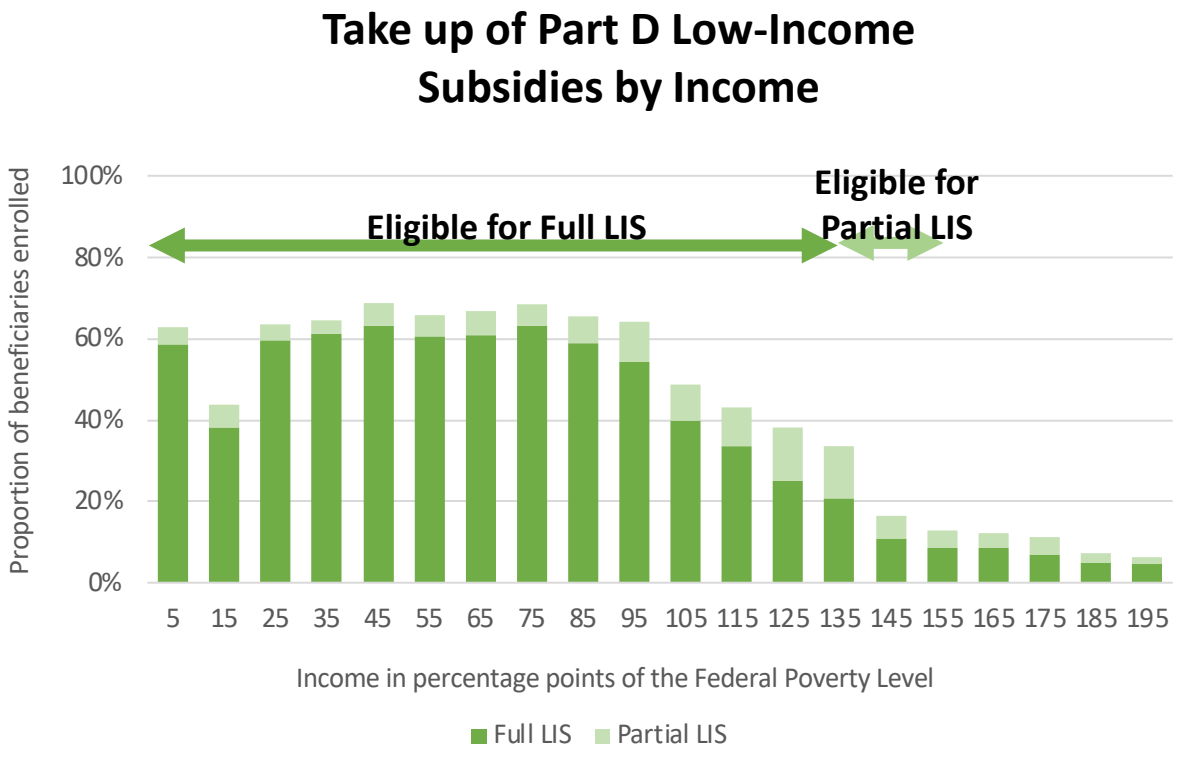




Note: Authors' analyses from waves 9-13 of the Health and Retirement Study.

Issue #1—Low Take-Up of Financial Assistance



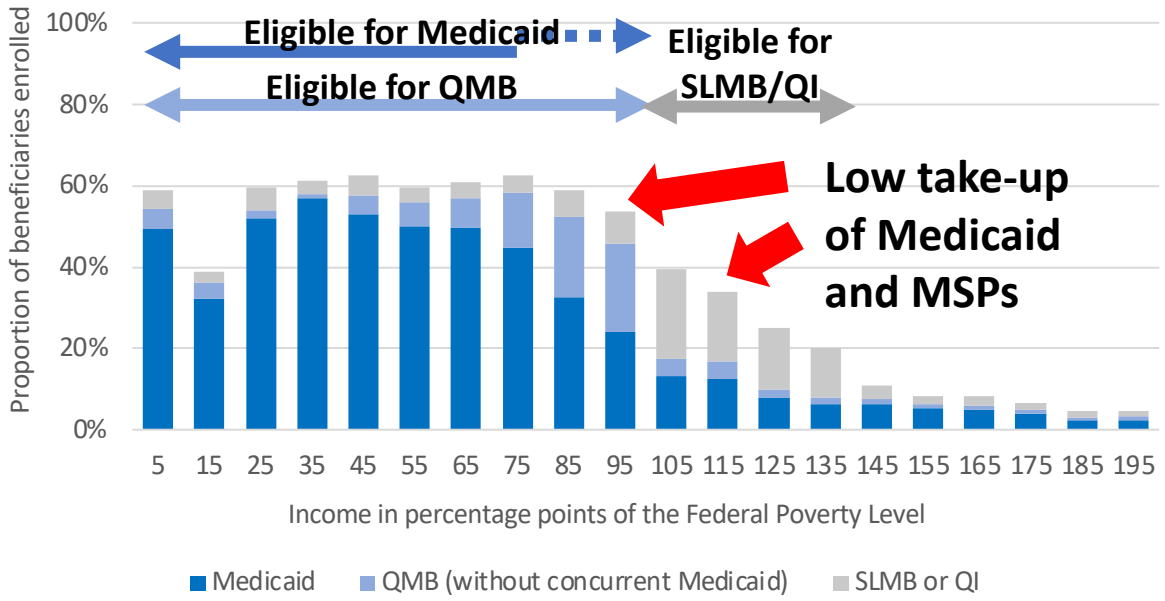


Note: Authors' analyses from waves 9-13 of the Health and Retirement Study.

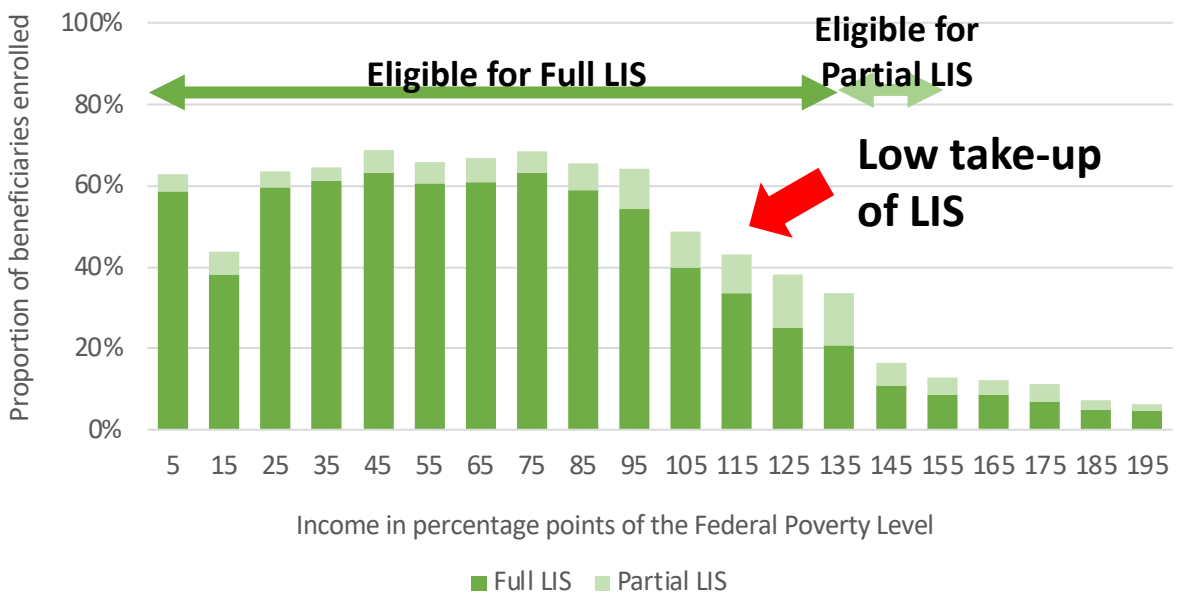
Who receives Medicaid & financial assistance

And what problems does this reveal?

Take-up of Medicaid and Medicare Savings Programs by Income



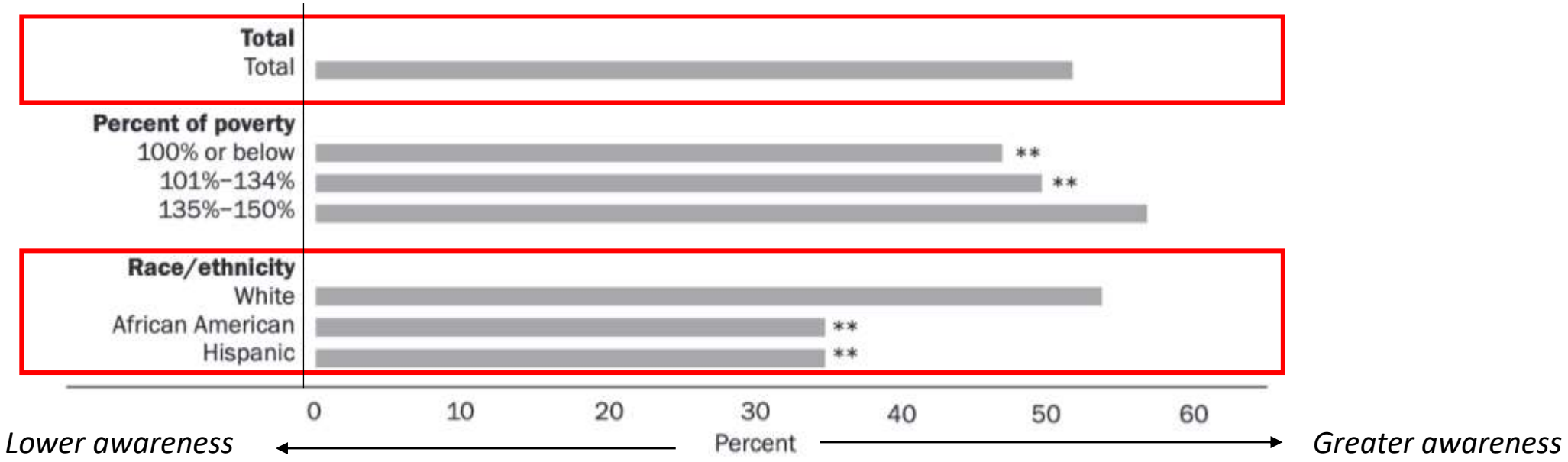
Take up of Part D Low-Income Subsidies by Income



Note: Authors' analyses from waves 9-13 of the Health and Retirement Study.

Issue #1—Low Take-Up of Financial Assistance

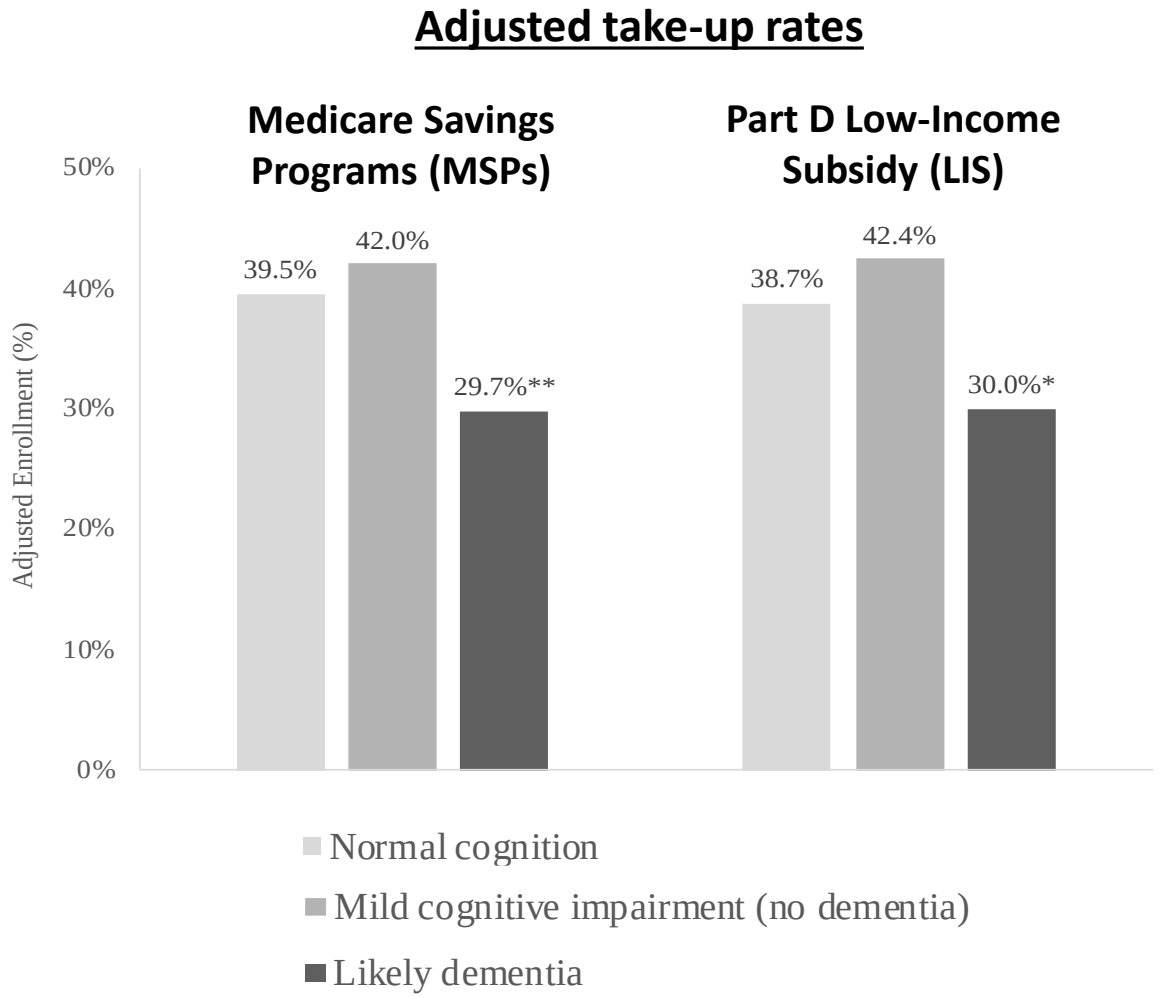
- Awareness of the LIS is low among individuals who are eligible but do not receive it



Sources: Haber SG, et al. Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs. 2003.
Neuman P, et al. Medicare prescription drug benefit progress report: findings from a 2006 national survey of seniors. Health Afffairs (Millwood). 2007;26(5):w630-w643.

Issue #1—Low Take-Up of Financial Assistance

- Low-income individuals with severe cognitive impairment are less likely to enroll in the MSPs and LIS
- Related work has shown that individuals with severe cognitive impairment are less likely to be aware of the LIS

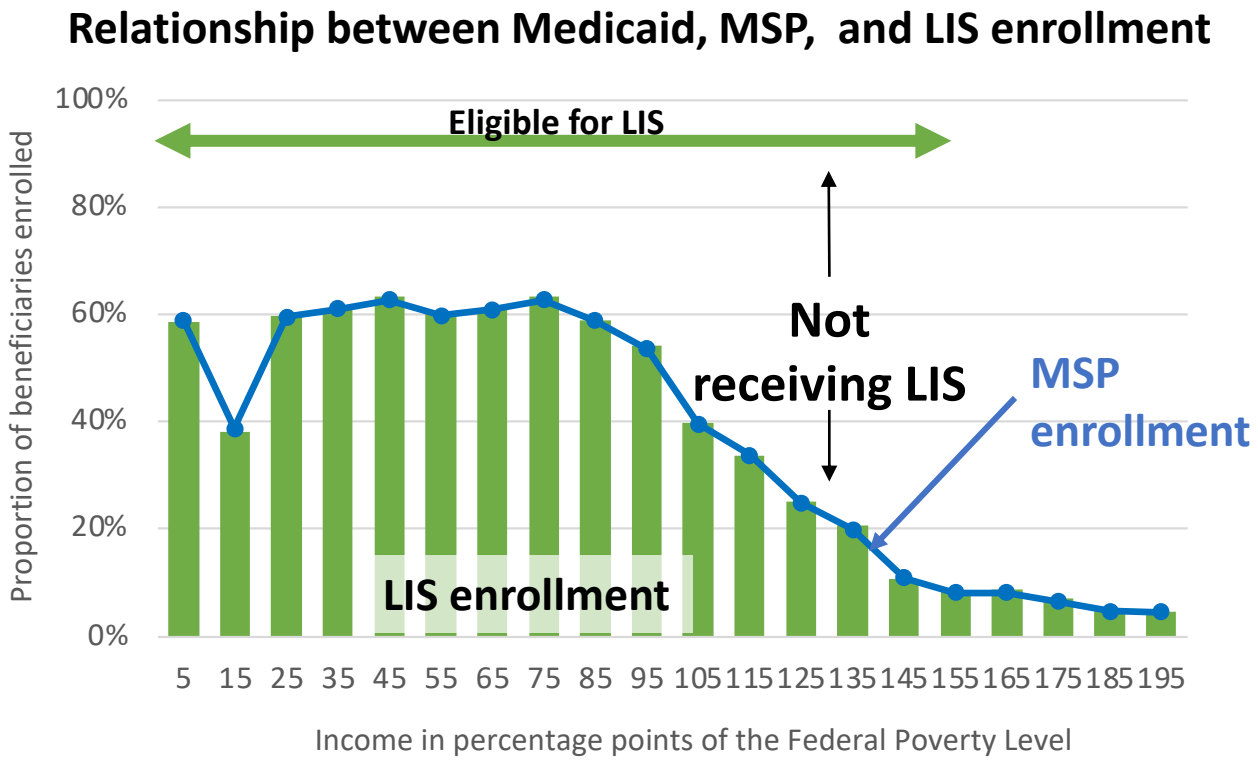


Statistically different from enrollment among individuals with normal cognition: *P<0.05, ** P<0.01.

Source: Roberts ET, McGarry BE, Glynn A. Cognition and Take-up of the Medicare Savings Programs. JAMA Intern Med. 2020;180(11):1529-1531.

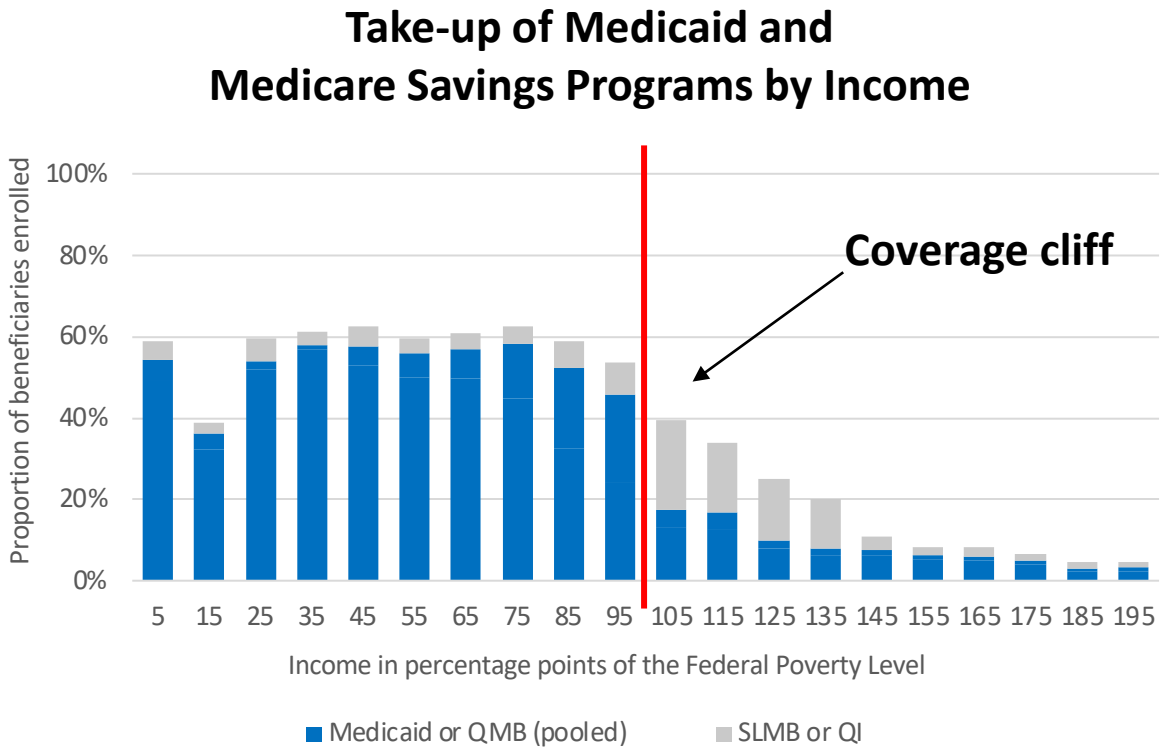
Issue #1—Low Take-Up of Financial Assistance

- Most Medicare beneficiaries who have the LIS receive this benefit automatically with Medicaid/the MSPs
  - Without auto-enrollment, fewer low-income beneficiaries get the LIS



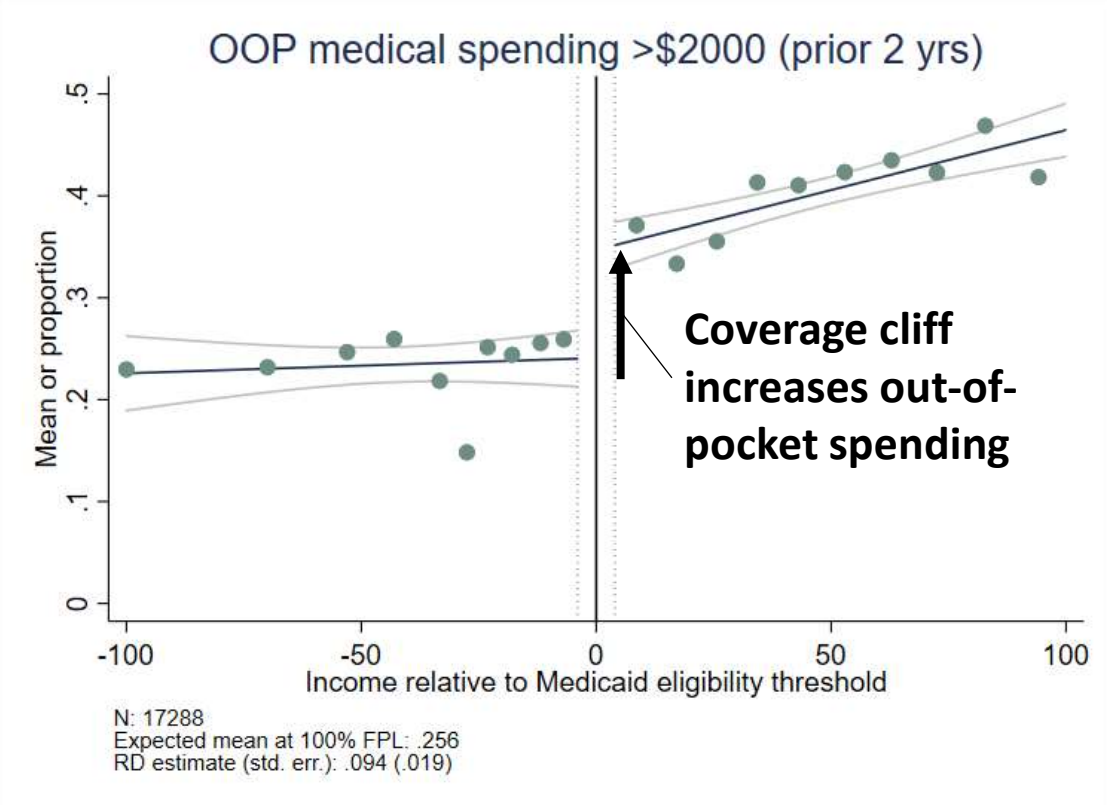
Issue #2—Coverage Cliffs

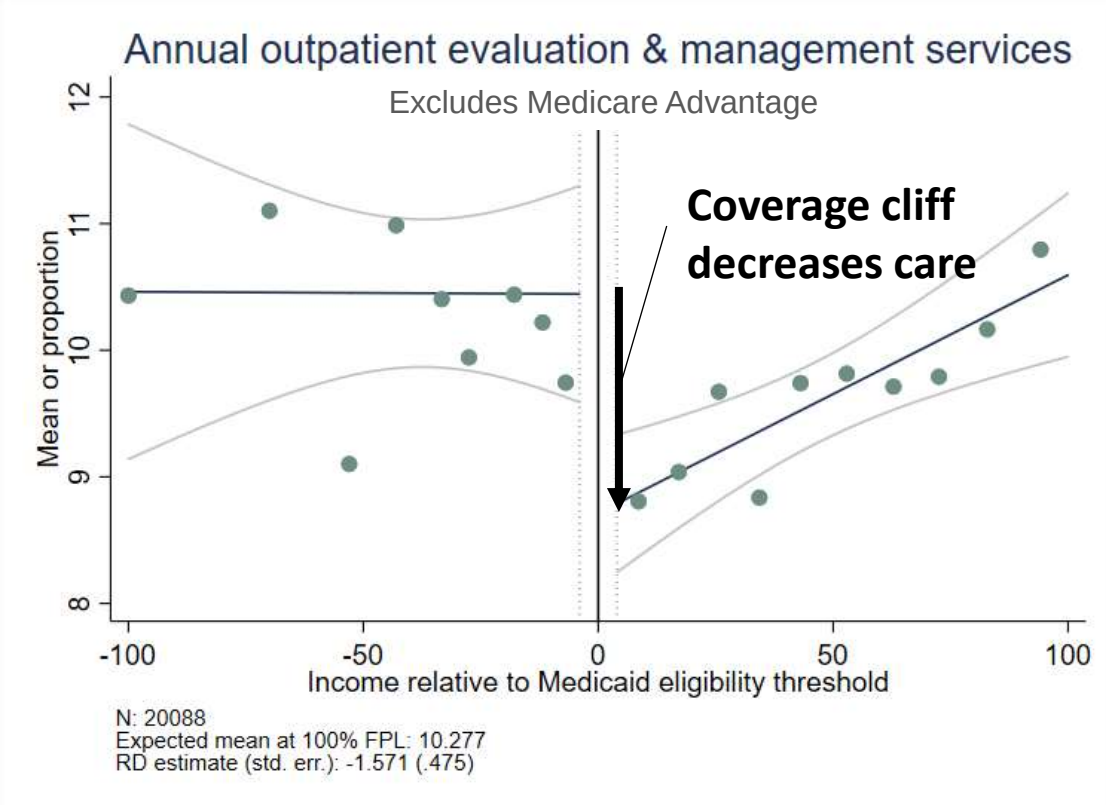
- Beneficiaries with incomes >100% of FPL are ineligible for help with Parts A and B cost sharing
- This abrupt drop-off in assistance—a "coverage cliff"—has large impacts on out-of-pocket spending and use of care



Note: Authors' analyses from waves 9-13 of the Health and Retirement Study.

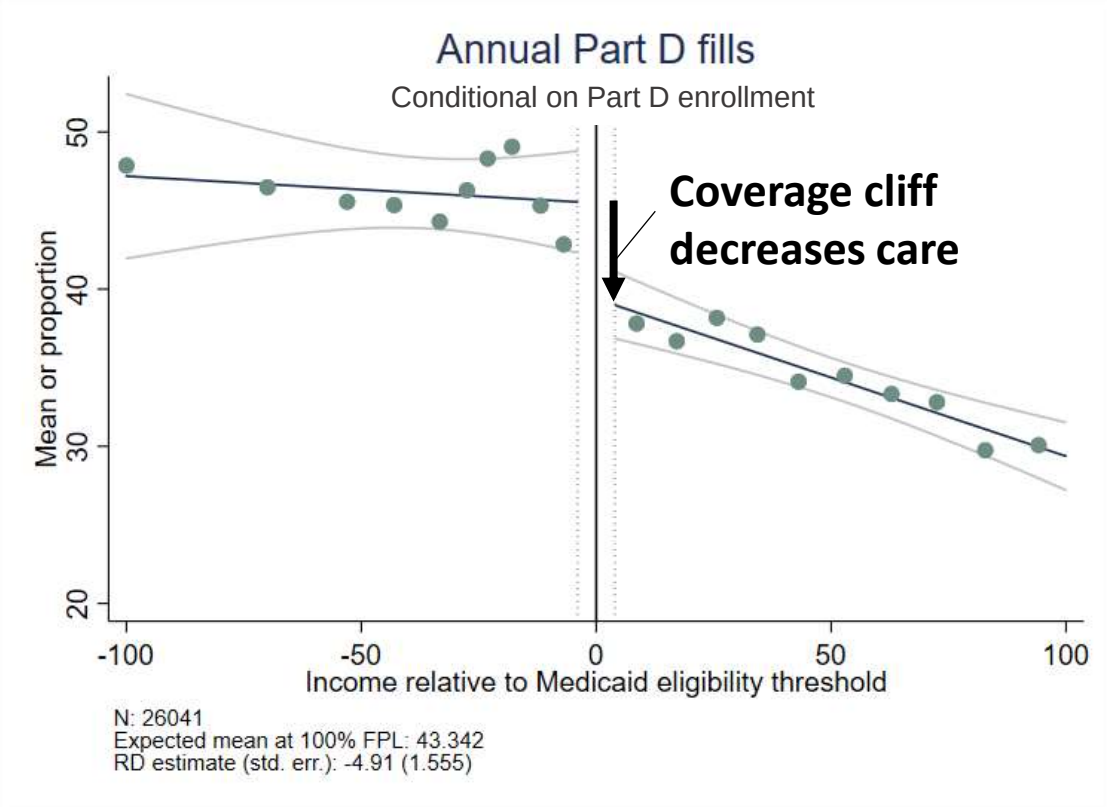
Issue #2—Coverage Cliffs

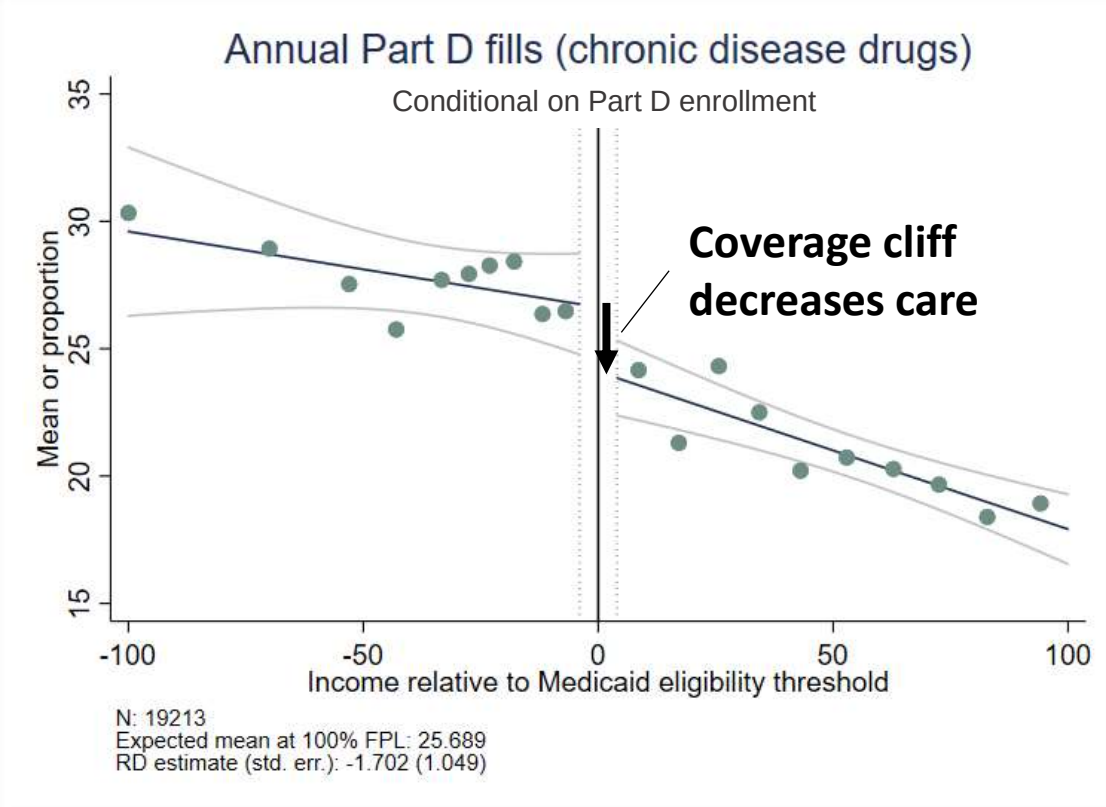




Source: Roberts ET et al. Medicaid Coverage 'Cliff' Increases Expenses And Decreases Care For Near-Poor Medicare Beneficiaries. Health Aff (Millwood). 2021;40(4):552-561.

Issue #2—Coverage Cliffs





Source: Roberts ET et al. Medicaid Coverage 'Cliff' Increases Expenses And Decreases Care For Near-Poor Medicare Beneficiaries. Health Aff (Millwood). 2021;40(4):552-561.

Issue #3—Integrating Medicare and Medicaid

- 12 million individuals are dually enrolled in Medicare and Medicaid
  - 9 million “full” duals who receive full Medicaid
  - 3 million “partial” duals who are enrolled in one of the Medicare Savings Programs (limited Medicaid benefits)
- Concerns about care fragmentation when patients receive coverage from two separate payers
  - **These concerns are especially salient among “full” duals …**

Issue #3—Integrating Medicare and Medicaid

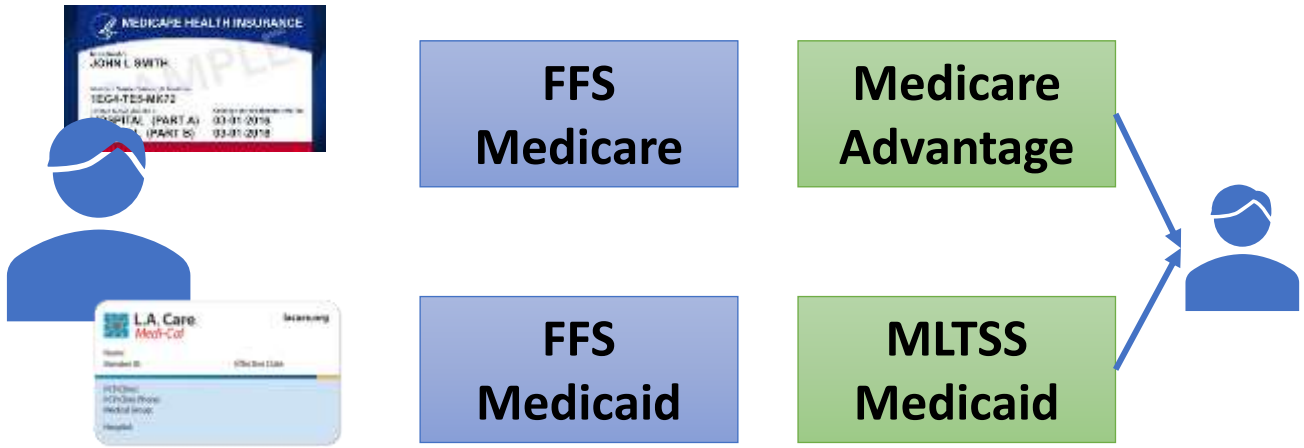
- Full duals are medically complex and incur high health care costs
  - 18% live in long-term nursing care facilities (vs. 3% of partial duals)
  - 30% have ≥3 functional limitations (vs. 12% of partial duals)
  - Account for 26% of Medicare spending and 29% of Medicaid spending

Issue #3—Integrating Medicare and Medicaid

- For full duals, Medicare and Medicaid pay for distinct services
  - Medicare is primary payer for inpatient/outpatient care and prescription drugs
  - Medicaid pays for long-term services and supports (LTSS): nursing home care and home and community-based services
  - Medicaid may also pay for dental, vision, hearing, and medical transportation (varies by state)
- Coverage of different services through bifurcated programs limits opportunities to integrate care
- **What would more integrated coverage look like?**

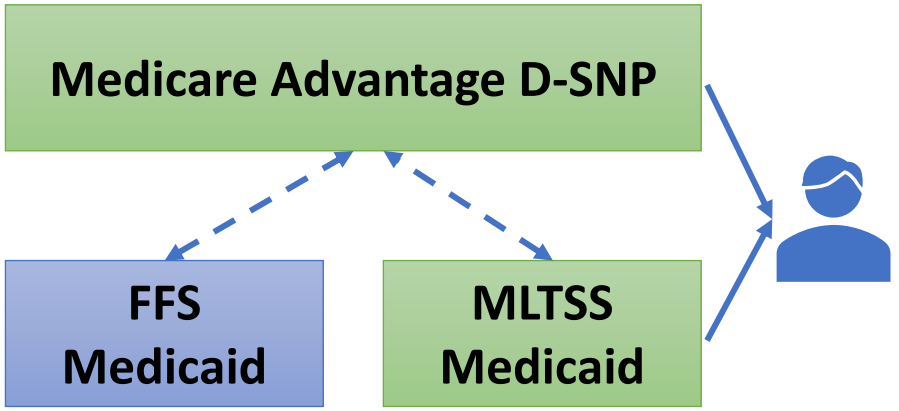
Issue #3—Integrating Medicare and Medicaid

Scenario A: Least Integrated



- Separate administration and financing of Medicare & Medicaid
- Limited opportunities for integration
- **~6 million full duals**

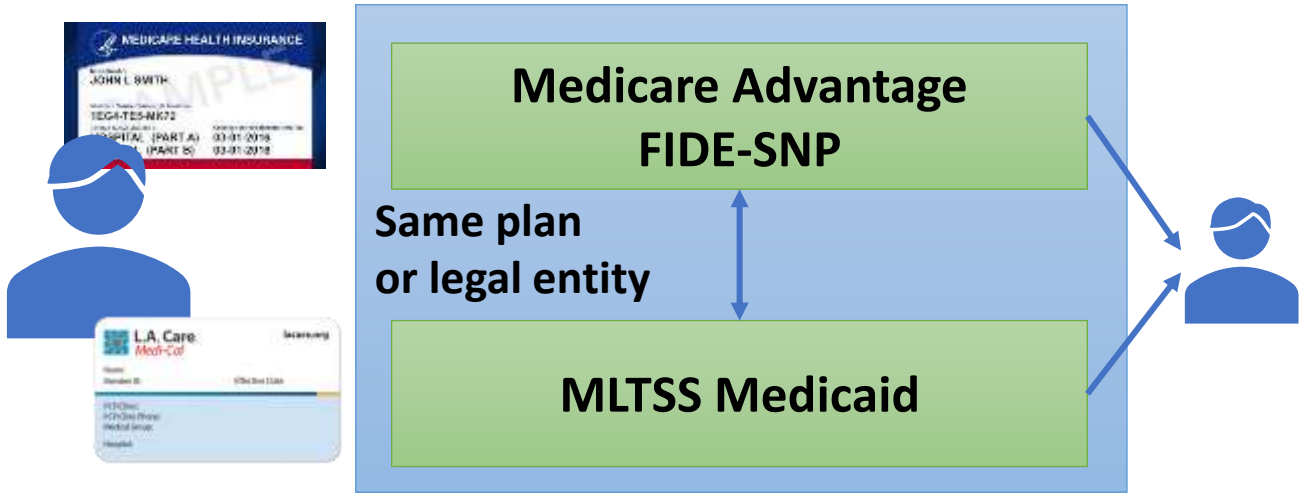
Scenario B: Limited Integration



- Dual-Eligible Special Needs Plan (D-SNP)
- D-SNP required to have a Medicaid contract that defines the plan's care coordination responsibilities
- Few other mechanisms for integrating care
- **~2.2 million full duals**

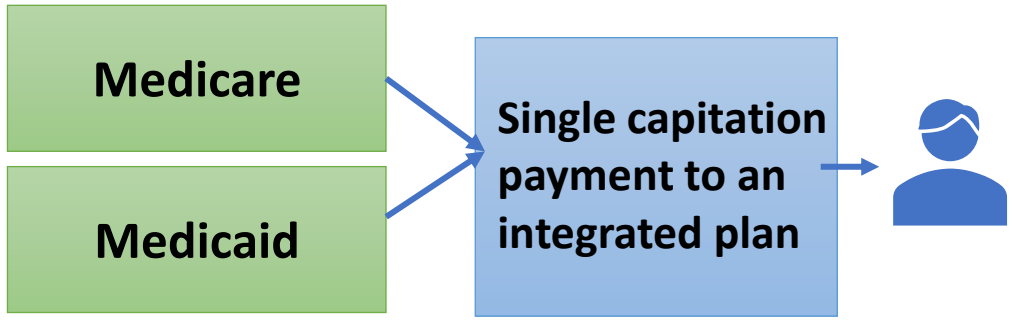
Issue #3—Integrating Medicare and Medicaid

Scenario C: More Integrated



- Fully-Integrated Dual-Eligible SNP (FIDE-SNP)
- Plan is financially at risk for substantially all Medicare & Medicaid services, including LTSS
- **~ 300,000 full duals**

Scenario D: Most Integrated



- Medicare-Medicaid Plans
- Program of All Inclusive Care for the Elderly (PACE)
- **~ 450,000 full duals**

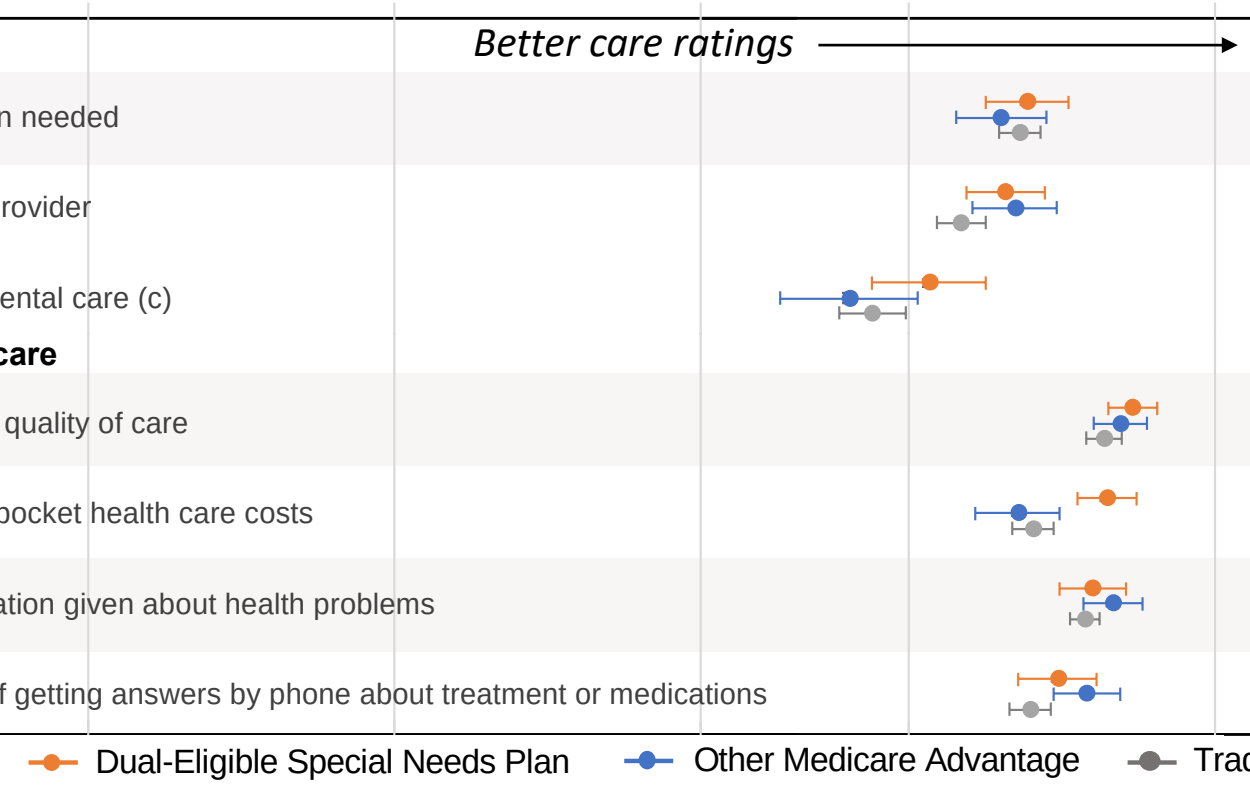
Issue #3—Integrating Medicare and Medicaid

- Growth in integrated coverage will likely come from D-SNPs, FIDE-SNPs, and an “intermediate” class of SNPs (HIDE-SNPs)
- Growth in integrated plans will also occur as more states implement Medicaid MLTSS programs
- CMS recently strengthened integration standards across all classes of SNPs (particularly FIDE-SNPs)

Issue #3—Integrating Medicare and Medicaid

- D-SNPs generally do not outperform other Medicare Advantage plans in access or satisfaction with care among duals

Outcome	Overall mean among dual-eligibles, % [a]	Adjusted difference between: D-SNPs and Traditional Medicare [b]	Adjusted difference between: D-SNPs and Medicare Advantage [b]
Access to care			
Able to get care when needed	87.3	0.5	1.7
Has a primary care provider	83.6	2.9*	-0.6
Able to get needed dental care (c)	78.3	3.7*	5.2*
Satisfaction with care			
Satisfied with overall quality of care	92.9	1.9*	0.9
Satisfied with out-of-pocket health care costs	88.7	4.8***	5.8***
Satisfied with information given about health problems	91.8	0.5	-1.3
Satisfied with ease of getting answers by phone about treatment or medications	88.3	1.8	-1.9



Source: Roberts ET and Mellor JM. Differences in care between Special Needs Plans and other Medicare coverage for dual-eligibles: implications for quality and equity. (Under review)

Issue #3—Integrating Medicare and Medicaid

- Key research on integrated D-SNPs (including FIDE-SNPs):

Study	Setting/state	Main findings
Keohane et al (2021)	D-SNPs aligned with MLTSS plans in Tennessee (2011-17)	↑ **Aligned D-SNP penetration associated with:** ↓ hospitalizations ↓ nursing home use *Among beneficiaries age ≥65 years*
Anderson et al. (2018)	Duals enrolled in a Minnesota FIDE-SNP (2010-12)	**FIDE-SNP enrollment associated with:** ↓ hospitalizations — (no difference) nursing home use ↑ PCP visits ↑ HCBS use *vs. enrollment FFS Medicare & separate Medicaid managed care plans*
Kim et al. (2017)	Duals enrolled in aligned Medicare Advantage and Medicaid managed care plans in Oregon (2011-14)	**Enrollment in aligned plans associated with:** ↑ improvements over time in preventive service use (diabetes and cholesterol screenings) ↑ PCP visits over time ↓ ED visits over time

Conclusions

Conclusions

- Coverage for low-income Medicare beneficiaries is complex and fragmented
- Several programs exist to supplement Medicare and reduce out-of-pocket costs for low-income Medicare beneficiaries
  - But the programs are under-utilized, in part because they are difficult to navigate
  - Due to restrictive eligibility rules, not all beneficiaries who need help get it
- Medicare and Medicaid remain poorly integrated for dual-eligibles
- Early evidence suggests some benefits of fully integrated models (FIDE-SNPs), but the evidence base is limited

Considerations for policy

- Simplify and harmonize eligibility criteria across MSPs and LIS
- Taper assistance for near-poor individuals to mitigate coverage “cliffs”
- Make broader use of auto-enrollment to streamline take-up (*ex parte* enrollment and renewals)

Considerations for policy (and research)

- Need to identify and replicate attributes of successful integrated plans
  - Further evidence is needed on the relative performance of FIDE-SNPs, HIDE-SNPs, and D-SNPs to identify successful models
  - Need to understand what high-performing plans do well to provide higher-quality, more efficient care

Thank you

Please reach out!

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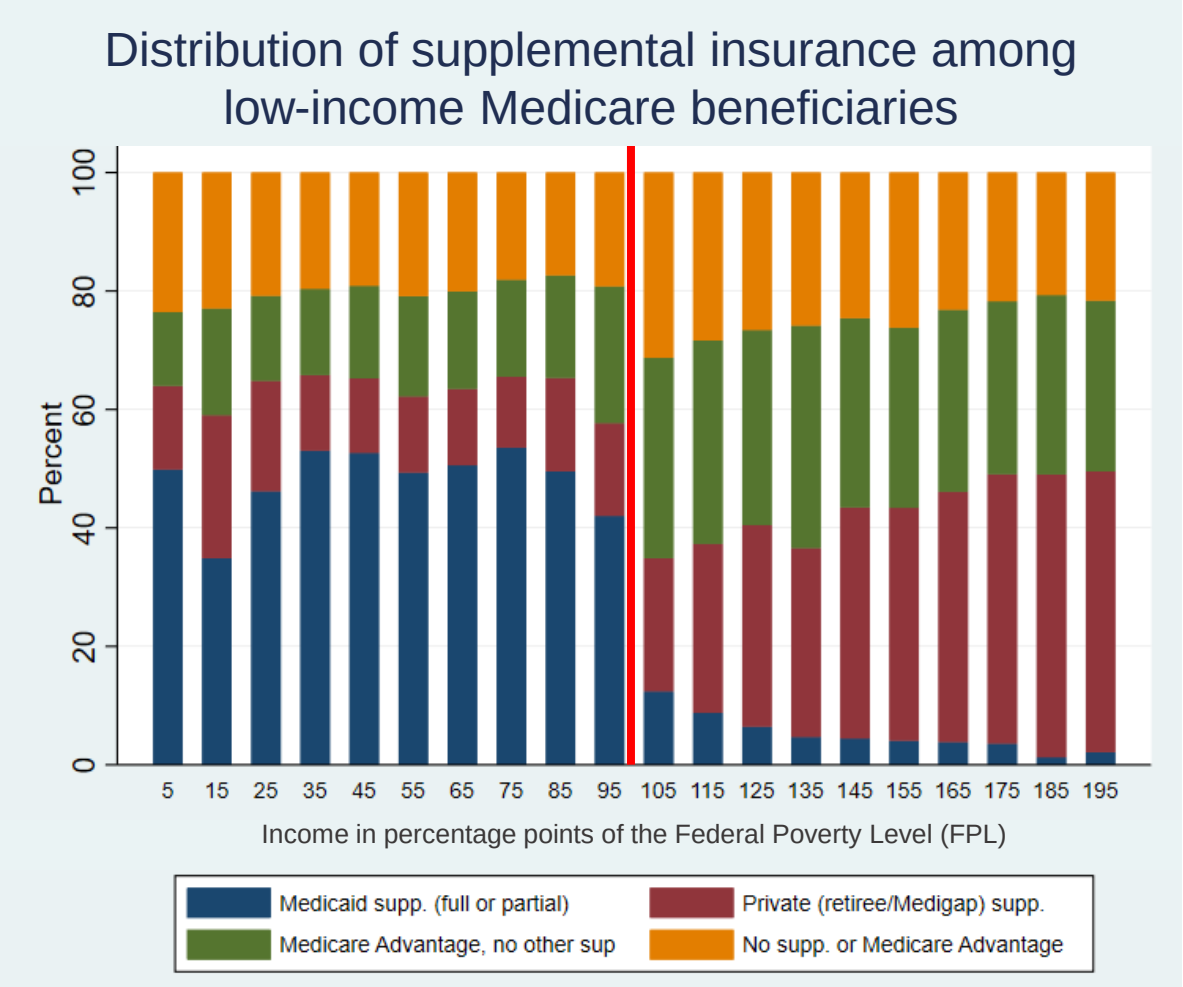
Appendix

Medicaid coverage cliff

- Combined phase-downs of full Medicaid and QMB (partial Medicaid) lead to **Medicaid coverage cliff** immediately above 100% of FPL
  - Both full Medicaid and the QMB program cover Medicare's out-of-pocket costs



Source: Authors' analyses of the Health and Retirement Study (waves 9-13) linked to Medicare enrollment data.

@Lef_Copeland | @MedicareRights

Lindsey Copeland, J.D.

Director of Federal Policy

Medicare Rights Center

30 YEARS

Understanding the Medicare Population and Consumer Affordability

May 6, 2022

Medicare Enrollment

- Nearly 30% of all calls to the Medicare Rights Center's national helpline relate to enrollment.
- Most people are automatically enrolled in Medicare because they are receiving Social Security benefits—but a growing number are not.
- These individuals must actively enroll, navigating complex rules and systems.

In 2016, only 60% of Medicare-eligible 65-year-olds were taking Social Security, compared to 92% who were in 2002

Enrollment Considerations

1. **Job-based insurance:** Insurance offered by an employer or union for current employees. If you are covered by your or your spouse's (or in some cases, your family member's) job-based insurance, it may work with Medicare to cover your health care costs. Job-based insurance may also allow you to delay Medicare enrollment. Job-based insurance either pays primary or secondary to Medicare, depending on the size of the employer.
2. **Retiree insurance:** Insurance plans that employers may provide to former employees who have retired. Retiree insurance always pays secondary to Medicare.
3. **Federal Employee Health Benefits (FEHB):** Insurance for current and former government employees and their family members. FEHB is either primary or secondary, depending on whether or not you are enrolled in Part B.
4. **TRICARE:** Insurance provided by the federal government to active duty and retired military personnel and their family members. There are many different TRICARE programs. TRICARE for Life for retirees pays secondary to Medicare.
5. **Veterans Affairs (VA) benefits:** Insurance provided by the federal government to veterans. Benefits include pensions, educational stipends, and health care, among others. VA benefits do not coordinate with Medicare.

2022 MSP eligibility standards*

Qualified Medicare Beneficiary (QMB)
Gross monthly income limits: 100% Federal Poverty Level, or FPL, + $20**

Most states:	$1,153 – Individual	$1,546 – Couple
Asset limits:	$8,400 – Individual	$12,600 – Couple

Specified Low-income Medicare Beneficiary (SLMB)
Gross monthly income limits: 120% FPL + $20

Most states:	$1,379 – Individual	$1,851 – Couple
Asset limits:	$8,400 – Individual	$12,600 – Couple

Qualifying Individual (QI)
Gross monthly income limits: 135% FPL + $20

Most states:	$1,549 – Individual	$2,080 – Couple
Asset limits:	$8,400 – Individual	$12,600 – Couple

First-time Enrollment Periods

Initial Enrollment Period

Part B Special Enrollment Period

General Enrollment Period

Type of Insurance	Conditions	Primary	Secondary
65+ with job-based insurance	Fewer than 20 employees	Medicare	Employer
	20+ employees	Employer	Medicare
Disabled job-based insurance	Fewer than 100 employees	Medicare	Employer
	100+ employees	Employer	Medicare
Liability insurance	Liability-related claims	Liability	Medicare
	Unrelated medical claims	Medicare	Not applicable[1]
Retiree insurance	Not eligible for Medicare	Retiree	Not applicable
	Eligible for Medicare	Medicare	Retiree
Veterans Administration (VA) benefits	Claim from VA facility	VA benefits	Not applicable[2]
	Claim from non-VA facility	Medicare	Not applicable
COBRA	Had COBRA before enrolling in Medicare	Medicare	Not applicable[3]
	Had Medicare before becoming eligible for COBRA	Medicare	COBRA
Medicaid	Eligible for Medicare	Medicare	Medicaid (payer of last resort)

[1] Liability insurance only pays on liability-related medical claims.

Lack of Medicare Eligibility Notification

- Only older adults who already receive or have applied for Social Security benefits before turning 65 are notified by the federal government when they first become eligible for Medicare.
  - **Those not automatically enrolled in Medicare are not informed about enrollment rules and policies.**

- Historically, the eligibility age for both Medicare and Social Security was 65. This made the linkage between the programs' beneficiary notification systems less problematic than it is now that the ages are no longer aligned.
  - **Today, Medicare-eligible individuals who do not begin taking Social Security until they reach the age for full retirement benefits (currently 66) receive nothing from the federal government about their initial Medicare eligibility at age 65.**

Consequences of Enrollment Mistakes

Lifetime Late Enrollment Penalty: Failure to enroll in Part B when first eligible may result in a 10% premium penalty for each 12-month period of delayed enrollment, for as long as the beneficiary has coverage. In 2020, an estimated 776,200 people were paying a Part B LEP. The average amount increased their monthly premium by nearly 30%.

High Out-of-pocket Costs: A beneficiary's other coverage, if any, may not pay for their care and/or may recoup payments it paid when Medicare should have.

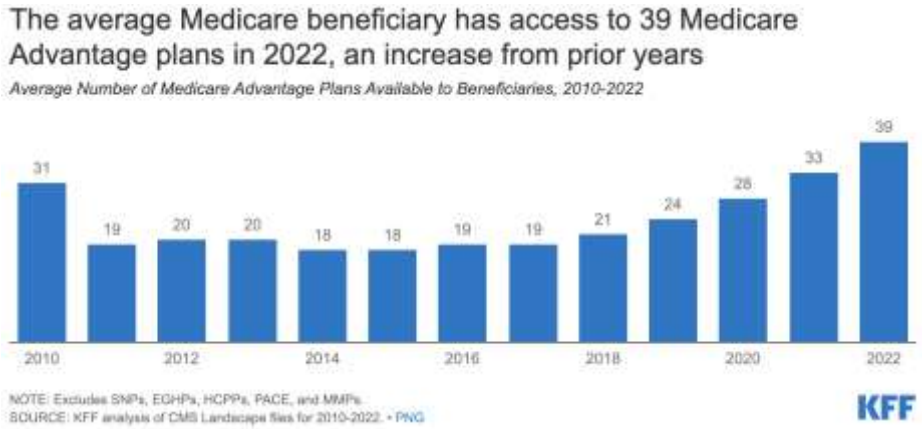
Gaps in Coverage: A beneficiary may have to wait until the next GEP to enroll in Part B, which will delay their Medicare coverage.

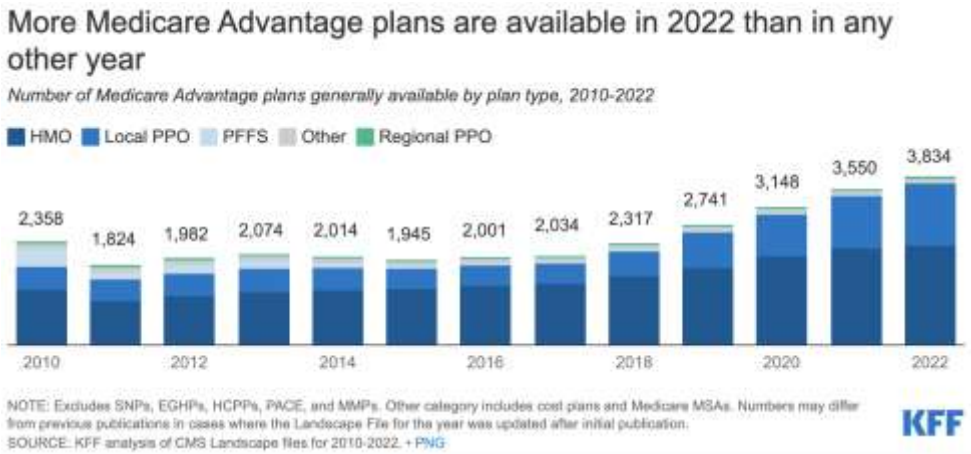
Limited Relief Opportunities: Equitable relief and enrollment in a Medicare Savings Program (MSP) may help some, but these avenues are very limited.

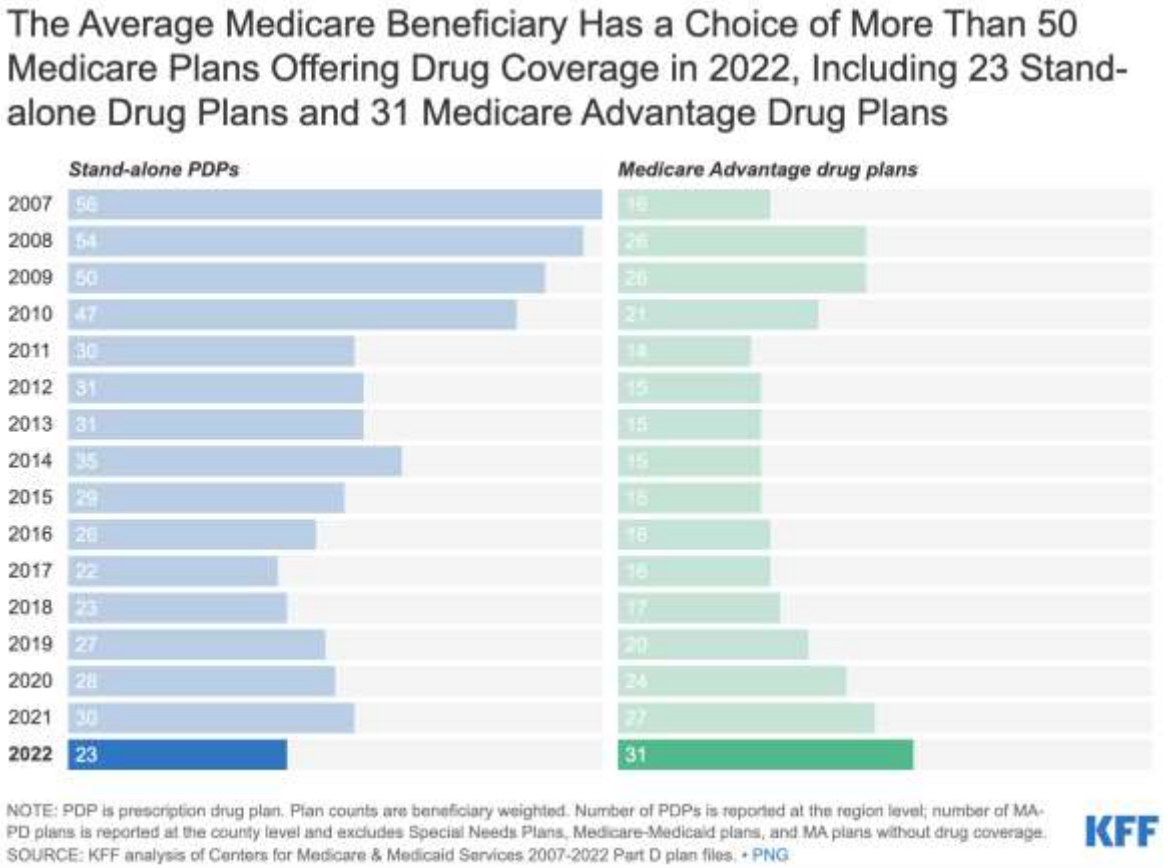
Opportunities to Modernize Enrollment

- **Pass the Beneficiary Enrollment Notice and Eligibility Simplification (BENES) 2.0 Act**
  - The bipartisan BENES 2.0 Act (S. 3675) would direct the federal government to notify people approaching Medicare eligibility about how and when to enroll.
- **Implement the BENES Act**
  - Beginning in 2023, the BENES Act will eliminate lengthy waits for coverage post-enrollment. It also aligns administrative SEP authority across the program. Comments are due June 27.
- **Expand Access to Relief**
  - Through needed and existing flexibilities, apply equitable relief more broadly; establish SEPs, as needed; and impose limits on the Part B LEP amount and/or duration.

MA and Part D Plan Choice

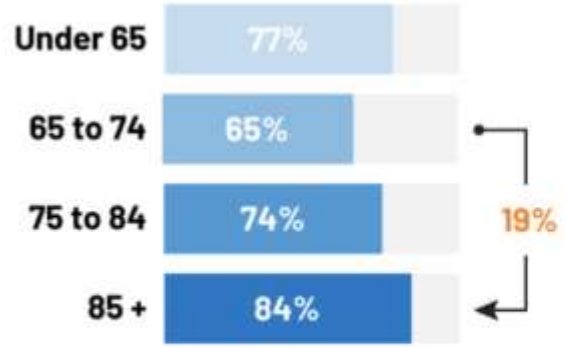


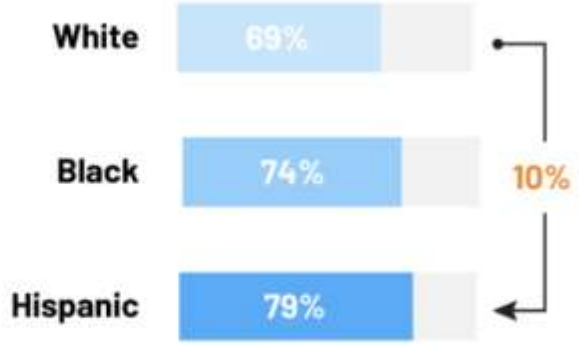




7 in 10 Medicare Beneficiaries Didn't Compare Plans During a Recent Open Enrollment Period

Certain groups of Medicare beneficiaries were more likely not to compare plans





NOTE: Estimates represent share of Medicare beneficiaries who did not compare their Medicare insurance plan with other plans available during the 2018 open enrollment period.
SOURCE: KFF analysis of CMS Medicare Current Beneficiary Survey, 2019 Survey File

KFF

Opportunities to Reduce Complexity

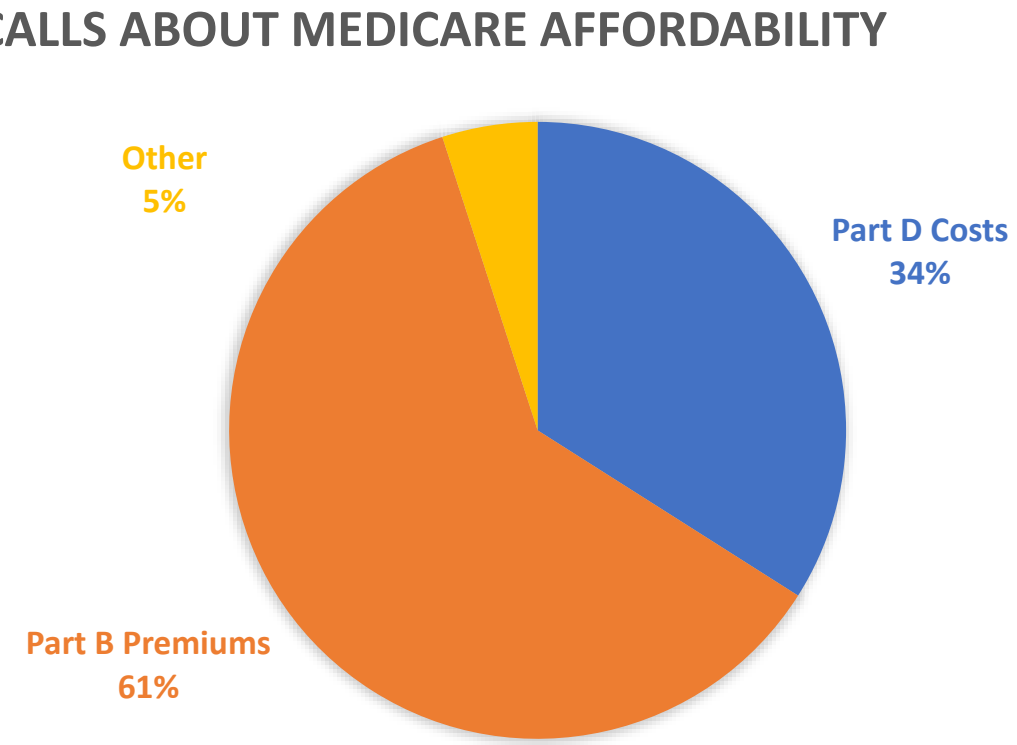
- **Make Plans Easier to Understand and Compare**
  - Consolidate plan choices and standardize options to better facilitate informed decision-making.
- **Improve Consumer Tools**
  - Continuously review and refine Medicare Plan Finder and other instruments; ensure consumer-facing materials are clear, accurate, and available in multiple languages.
- **Strengthen Plan Guardrails and Beneficiary Protections**
  - Deter inappropriate denials, streamline appeals processes, and reinstate marketing guidelines and network adequacy rules.

People with Medicare Struggle to Afford Health Care and Prescription Drugs

Nearly

25%

of all MRC Helpline calls are related to health care and Rx drug affordability



Opportunities to Improve Affordability

- **Limit Beneficiary Costs**
  - Original Medicare and Part D have no out-of-pocket (OOP) maximums. While MA plans do have a cap, it is too high.
- **Address Cost Drivers**
  - To best lower costs for beneficiaries and the system, such caps should be coupled with changes that target the underlying causes of health care and Rx drug unaffordability.
- **Ease Access to Low-Income Assistance Programs**
  - Increase MSP and LIS eligibility by eliminating asset limits, raising income thresholds, and streamlining burdensome application processes.
- **Strengthen Coverage**
  - Add comprehensive oral, vision, and hearing coverage to Medicare Part B.
- **Increase Medicaid HCBS Funding**
  - Expand access to HCBS services, as well as to workforce and caregiver supports.
- **Improve Access to SNF Care**
  - Eliminate the three-day hospital stay requirement for Skilled Nursing Facility (SNF) coverage.

TAKE OUR SURVEY

Please fill out the evaluation survey you will receive immediately after this presentation, or via email this afternoon!

www.allhealthpolicy.org

UPCOMING EVENT

MAY 20,2022 | 10:30 – 11:00 am ET

Session #3: Policy Options to Improve Medicare Sustainability

This session will help attendees consider the implications of policy options to promote Medicare sustainability. Panelists will explore trends in Medicare spending; introduce key concepts related to Medicare financing and solvency; and explore the implications of policy options to promote Medicare sustainability.

Visit: all.us/Medicare22

THANK YOU FOR ATTENDING!

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