

CHAPTER

3

**Medicare's fee-for-service
benefit design**

Medicare's fee-for-service benefit design

Chapter summary

The Commission has been considering reform of the traditional benefit package for several years to complement our ongoing work on improving the payment system. Our aims have been to give beneficiaries better protection against high out-of-pocket (OOP) spending and to promote innovation in benefit design that will create incentives for beneficiaries to use high-value services and weigh their use of discretionary care without discouraging needed care. A further aim is to slow the growth of Medicare spending so that the program will be sustainable for future generations, although we recognize that cost-sharing changes alone are not sufficient to slow spending.

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. If not supplemented with additional coverage, the FFS benefit design exposes Medicare beneficiaries to substantial financial risk and may discourage the use of high-value care.

The lack of comprehensiveness in the FFS benefit design leads more than 90 percent of beneficiaries to take up supplemental coverage or have Medicaid, which mutes the effect of high OOP costs. Researchers agree that Medicare

In this chapter

- Shortcomings of the FFS benefit and the role of supplemental plans
- Shorter term potential improvements to FFS Medicare
- Longer term potential improvements to Medicare
- Future work

beneficiaries with supplemental coverage tend to have higher use of services and spending than those with no supplemental coverage. 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. Supplemental coverage addresses beneficiaries' concerns about the uncertainty of OOP spending under the FFS benefit, but it also dampens financial incentives to control utilization. Most of the costs of increased utilization are borne by the Medicare program.

There are short-term and long-term approaches to reforming benefits. In the short term, incremental changes to the FFS benefit and to supplemental coverage could begin changing beneficiaries' incentives. The aim of these improvements would be to reduce financial risk for beneficiaries with the highest levels of cost sharing. Potential improvements could include, for example, adding a cap to beneficiaries' OOP costs in the FFS benefit and, at the same time, requiring supplemental policies to have fixed-dollar copayments for services such as office visits and emergency room use. Such restrictions on supplemental coverage could lead to reductions in use of Medicare services sufficient to help finance the addition of an OOP cap. These strategies could be coupled with exceptions that waive cost sharing for services in certain circumstances—for example, if evidence identified them as leading to better health outcomes. The strategies could also include cost-sharing protections for low-income beneficiaries so that they would not forgo needed care. In total, these changes would be costly, unless specifically designed to be budget neutral.

However, incremental changes may not be sufficient to create a modern benefit design. For the longer term, the goal would be to design a benefit that supports innovations in provider payments and changes in health care delivery. The Medicare program will need to move toward benefit designs that give individuals incentives to use higher value care and discourage them from using lower value care.

Some payers have initiated innovative benefit designs to steer enrollees toward high-value care. We interviewed public and private payers and identified four strategies they use to achieve this goal: lowering cost sharing for high-value services, raising cost sharing for low-value services, creating financial incentives for enrollees to see high-performing or low-cost providers, and providing incentives for enrollees to adopt healthier behaviors. ■

Much of the Commission's work focuses on changing Medicare's payment systems to give providers incentives to maintain adequate access to care, improve quality, and use fewer resources. Complementary to this work is research on improving the design of Medicare's traditional fee-for-service (FFS) benefit, along with that of supplemental coverage. Reforming the FFS benefit offers an opportunity to align 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.

The current 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. If not supplemented with additional coverage, the FFS benefit design makes Medicare beneficiaries face substantial financial risk and may discourage the use of valuable care.

Neither the FFS payment system nor its benefit design is built around incentives that reward delivery and use of high-quality, high-value care. The status quo encourages growth in the volume and intensity of services and has led to care that is often not coordinated, sometimes inappropriate, and occasionally risky to patients. It has also left beneficiaries with rising Part B premiums and out-of-pocket (OOP) costs and has left taxpayers with the unsustainable burden of financing the program.

The Commission has been considering reform of the traditional benefit package. Our aim has been to give beneficiaries better protection against high OOP spending and to promote incentives for them to weigh their use of discretionary care without discouraging needed care. A further aim is to slow the growth of Medicare spending so that the program will be sustainable for future generations.

There are both short-term and long-term approaches to reforming benefits. In the short term, incremental changes in benefit design can be implemented more quickly and can provide better financial protection and give better price signals to beneficiaries seeking care. However, incremental changes are not sufficient to create a modern benefit design. A longer term goal would be to design a benefit that promotes a patient-centric Medicare program and supports innovations in provider payments and changes in health care delivery. Changes in beneficiary incentives

should mirror changes in provider payments. Ideally, these changes could encourage use of lower cost, high-quality providers.

Our analysis of the current FFS benefit package examines Medicare benefits, sources of supplemental coverage, and variation in OOP spending. We also describe programs designed to protect low-income beneficiaries from high OOP costs. We discuss recent statutory changes to benefits and supplemental coverage policies and illustrate the effects of some short-term approaches to benefit reform. Last, we examine private payers' experiences with innovative benefit designs.

Background

Today, about 75 percent of beneficiaries receive health benefits through traditional FFS Medicare.¹ FFS Medicare's benefit design is uniform, with the same Part B premium nationwide despite large regional differences in average use of services and program expenditures.² Beneficiaries can use any provider willing to accept Medicare's conditions of participation and payment rates. To cover gaps in the FFS benefit, most beneficiaries have supplemental coverage through former employers or individually purchased medigap policies, or they have additional coverage through Medicaid or other sources. Despite Medicare's lower average payment rates to providers compared with private payers' rates, the FFS program has certain desirable characteristics for providers, including little or no utilization management (American Medical Association 2009).³ Under this arrangement, there are few restrictions on the services providers and beneficiaries decide to use, and Medicare bears full insurance risk for beneficiaries' health spending.

For insured individuals outside the Medicare program, premiums act as a signal of the breadth of coverage and available providers. Premiums also reflect the relative health status and average use of services of the insured population. For example, plans with relatively tight networks of providers are expected to have lower premiums—the trade-off for less choice of providers is a lower price. In the Medicare program, however, the various premiums a beneficiary can face are not good signals of cost differences. Despite geographic differences in average use of services, FFS Medicare's Part B premium does not vary (except by income). In addition, many beneficiaries (or their former employers) pay

**TABLE
3-1****Premiums and cost-sharing requirements for Part A services in 2011**

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. \$450 per month for individuals who are not eligible for premium-free Part A and have fewer than 30 quarters of Medicare-covered employment.
Hospital stay	\$1,132 deductible for days 1–60 each benefit period. \$283 per day for days 61–90 each benefit period. \$566 per “lifetime reserve day” after day 90 each benefit period (up to 60 days over lifetime).
Skilled nursing facility stay	\$0 for the first 20 days each benefit period. \$141.50 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. 5% of the Medicare-approved amount for inpatient respite care.
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 2011b.

premiums for supplemental insurance that covers much of Medicare’s cost sharing. While premiums for medigap policies vary widely, that variation reflects the health status of a particular pool of insured individuals and each insurer’s ratings method more than breadth of coverage. Premiums for medigap policies can also be expensive because of high administrative costs, largely due to the need for medigap insurers to market directly to individuals (Moon 2006).

Beneficiaries’ use of care is strongly affected by the recommendations of medical providers. Still, the amount patients must pay for health care at the point of service can affect whether they seek care, the type of provider they see, and which treatment they receive. Ideally, the benefit design would encourage beneficiaries at the point of service to use care only when it is of high value. The challenge is to create such a design while also providing beneficiaries with clear information about the potential risks and benefits of treatment options.

Under Medicare’s FFS benefit, which has changed very little since 1965, the cost-sharing structure has considerable requirements and provides no OOP cap. For Part A services, it includes a relatively high deductible for inpatient stays (\$1,132 in 2011) and daily copayments for long stays at hospitals and skilled nursing facilities.⁴ Patients with more than one hospital stay can owe more than one hospital deductible for the year. For Part B services, the FFS benefit has a relatively low deductible (\$162 in 2011) and requires beneficiaries to pay 20 percent of allowable charges for most services, except for home health and clinical laboratory services. Increases in the deductibles and copayments under Part A and Part B are linked to average annual increases in Medicare spending for those services. There is no upper limit on how much cost sharing a beneficiary could owe under the FFS benefit. (Tables 3-1 and 3-2 show Part A and Part B premiums and cost sharing.) Analyses suggest that the actuarial value—the percent of medical spending for a

**TABLE
3-2**

Premiums and cost-sharing requirements for Part B services in 2011

Category	Amount
Premiums	<p>\$96.40 per month: Same premium as in 2009 applies if beneficiaries had the SSA withhold Part B premium payments from their Social Security check in 2009 and if income is below the following: Single beneficiaries with incomes of \$85,000 or less. Couples with incomes of \$170,000 or less.</p> <p>\$110.50 per month: Same premium as in 2010 applies if beneficiaries had the SSA withhold Part B premium payments from their Social Security check in 2010 and if income is below the following: Single beneficiaries with incomes of \$85,000 or less. Couples with incomes of \$170,000 or less.</p> <p>\$115.40 per month: All beneficiaries with incomes below the thresholds shown above and who are new to Part B for 2011 or have premiums paid by state Medicaid programs or Medicare Savings Plans.</p> <p>\$161.50 per month: Single beneficiaries with incomes between \$85,001 and \$107,000. Couples with incomes between \$170,001 and \$214,000.</p> <p>\$230.70 per month: Single beneficiaries with incomes between \$107,001 and \$160,000. Couples with incomes between \$214,001 and \$320,000.</p> <p>\$299.90 per month: Single beneficiaries with incomes between \$160,001 and \$214,000. Couples with incomes between \$320,001 and \$428,000.</p> <p>\$369.10 per month: Single beneficiaries with incomes above \$214,000. Couples with incomes above \$428,000.</p>
Deductible	The first \$162 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 22% in 2011. 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 (\$1,132 in 2011).
Mental health services	45% 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: SSA (Social Security Administration). Medicare began phasing in income-related premiums over a three-year period beginning in 2007. As of 2011, 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. In 2011, however, most beneficiaries pay the same premium as in 2009 or 2010 because of a provision in law that does not permit the Part B premium to increase by a larger dollar amount than beneficiaries' Social Security checks. CMS estimates that about 6 percent of Medicare beneficiaries pay the higher premiums. The Part B deductible increases over time by the rate of growth in per capita spending for Part B services.

Source: Centers for Medicare & Medicaid Services 2011b.

**TABLE
3-3**

Medicare cost-sharing liability in 2008

Range 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: 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.

Source: MedPAC based on data from CMS.

standard population paid by an insurer—of the traditional Medicare benefit is significantly lower than typical employer-sponsored health coverage (Peterson 2009, Yamamoto et al. 2008).

More recent changes to the FFS benefit design include greater coverage of and incentives for preventive care. The benefit now covers a “welcome to Medicare” physical within each beneficiary’s first 12 months of enrollment in Part B and annual wellness exams thereafter. It also waives the Part B cost sharing for certain preventive services, including those that are recommended by the U.S. Preventive Services Task Force with a grade A or B.

Shortcomings of the FFS benefit and the role of supplemental plans

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, Physician Payment Review Commission 1997). The FFS benefit alone does not provide true insurance—financial protection against very high levels of OOP spending. Compared with other types of coverage, Medicare’s benefit has a high inpatient deductible and a low outpatient deductible. These features lead to a small percentage of Medicare beneficiaries incurring very high levels of cost sharing (Table 3-3).

Types of supplemental coverage

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 regarding use of medical services. But about 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 behavior. Supplemental plans include medigap plans, employer-sponsored retiree plans, and Medicaid and other plans for beneficiaries with limited incomes. Most beneficiaries can also choose Medicare Advantage (MA) plans that include some supplemental benefits and variations on cost sharing (see text box, pp. 70–71).

Medigap plans

The one form of supplemental insurance available to all elderly Medicare beneficiaries (as well as to disabled Medicare beneficiaries under age 65 in most states)—medigap coverage—is popular among beneficiaries. A 2009 survey found that 88 percent of medigap policyholders are satisfied with their secondary coverage, and 77 percent believe these policies are a good value (America’s Health Insurance Plans/Blue Cross Blue Shield Association 2009). The most popular types of medigap policies, standard Plan C and Plan F, fill in nearly all of Medicare’s cost-sharing requirements, including both the Part A and Part B deductibles (Table 3-4 and Table 3-5 (p. 72)). By effectively eliminating any of 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.

Medigap policies can be expensive because they are sold to beneficiaries individually and thus tend to cover people with higher health spending and have administrative costs of 20 percent or more (Scanlon 2002).⁵ Premiums for medigap policies also vary widely, even in the same market. This variation is due in part to different approaches that states allow insurers to use for setting premium rates.⁶ But considerable variation in medigap premiums also exists in states that allow only community rating—that is, premiums cannot vary by an individual’s age, gender, or health status. For example, in 2009 in Albany, New York, premiums for a medigap Plan F policy (the most popular plan type) varied between \$1,940 and \$4,130 (Table 3-5, p. 72). Much of this variation likely reflects the average health status and utilization trends of each medigap insurer’s covered population.⁷

**TABLE
3-4**

Benefits offered under standard medigap policies in 2011

Category	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	✓	✓	✓	✓	✓	✓* (\$2,000)	✓	✓	✓	✓	✓
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 \$2,000 in 2010. 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 \$4,620 in Plan K or \$2,310 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 2011a. Additional information from the National Association of Insurance Commissioners.

Policymakers, insurers, and regulators have taken several steps to develop more affordable types of medigap policies, but so far those products have not attracted much enrollment. Medicare SELECT[®] plans have the same standard designs as other medigap policies but require beneficiaries to use a provider network in return for lower premiums.⁸ A 1997 evaluation found that SELECT plans provide a weak form of managed care in that they recruit hospitals willing to provide a discount for their networks but generally do not form physician networks (Lee et al. 1997). In 2006, insurers had 1.1 million Medicare SELECT plans in force—11 percent of all medigap policies (America's Health Insurance Plans 2008). In

addition, after 1997 insurers were allowed to sell high-deductible versions of Plan F and Plan J in return for lower premiums.⁹

The Medicare Prescription Drug, Modernization, and Improvement Act of 2003 created two other types of standard products—Plan K and Plan L—that fill in less of Medicare's cost sharing in return for lower premiums. Plan K and Plan L require policyholders to pay 50 percent and 75 percent, respectively, of cost-sharing payments other than cost sharing for extended hospital stays. Although they have lower premiums than other types of medigap policies, as of 2009, Plan K and Plan L combined made up only 0.6 percent of all medigap enrollment.

Cost sharing in Medicare Advantage plans

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive their Part A and Part B benefits through a private MA plan rather than through the traditional Medicare fee-for-service (FFS) program. While the plans must cover all Medicare benefits, they can limit the choice of providers through networks and can establish different cost-sharing requirements from those in FFS Medicare. Plans can also provide extra benefits, including lower cost sharing. On the other hand, CMS can require that plans provide certain additional benefits.

In practice, cost sharing under MA plans tends to be very different than under FFS Medicare. Few MA plans use FFS Medicare's cost-sharing structure. Only 1 percent of MA enrollees are in plans that charge the Part A deductible of \$1,132 per spell of illness. In contrast to FFS Medicare's coinsurance for physician services (Part B), almost all MA enrollees are in plans that charge flat copayments for physician services. Under FFS Medicare, there is no cost sharing for home health services, but about 5 percent of MA enrollees are in plans that charge some cost sharing for home health services.

On an actuarial basis, cost sharing is substantially lower in MA plans than in FFS Medicare, because plans can lower cost sharing through efficiency savings,

supplemental premiums, or the use of Medicare payment subsidies. (For 2011, the Commission estimates that Medicare will pay plans on average 10 percent more than the program would have spent on similar beneficiaries under FFS Medicare.) However, in some MA plans cost sharing for particular services can be higher. For example, MA plans tend to use per diem copayments for inpatient hospital care. The per diem copayments can be as high as \$400 per day but are often charged on only the first few days in the hospital. For a five-day stay in a hospital (the average Medicare hospital length of stay), the average cost sharing for MA enrollees is expected to be around \$1,025 in 2011, with 25 percent of enrollees being charged more than \$1,250 and 25 percent being charged less than \$500. The MA average cost sharing for a five-day hospital stay is typically comparable to FFS Medicare cost sharing, but FFS Medicare's \$1,132 deductible would seem high compared with MA cost sharing for a 2-day or 3-day stay and would be low compared with typical MA cost sharing for a 10-day stay.

Although MA plans usually have flat copayments for physician office visits rather than 20 percent coinsurance, plans often differentiate between primary care visits and specialty care visits. For primary care visits, copayments average about \$12.50 (with a median

(continued next page)

In June 2010, medigap insurers introduced two new types of policies—Plan M and Plan N—that do not fill in all 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 (National Association of Insurance Commissioners 2010).¹⁰ Both Plan M and Plan N are expected to have lower premiums than other medigap policies. While official data are not yet available, insurers report that Plan N is popular among new policyholders (National Association of Insurance Commissioners 2011). Its popularity is attributed to lower premiums and a relatively

simple benefit design that beneficiaries can readily understand.

The Patient Protection and Affordable Care Act of 2010 (PPACA) directs the National Association of Insurance Commissioners (NAIC) to revise standards for medigap policies Plan C and Plan F. These standard types are the only ones that cover all Medicare Part B cost sharing. The new law requests the NAIC to revise Plan C and Plan F standards to include requirements for nominal cost sharing to encourage the appropriate use of physicians' 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.

Cost sharing in Medicare Advantage plans (cont.)

of \$15.00) and can range up to \$40. Copayments for specialty care visits are higher, averaging about \$28.50 (with a median of \$30) and can be as high as \$50.

MA plans tend to follow FFS Medicare's 20 percent coinsurance structure for durable medical equipment (DME) and Part B drugs. About 95 percent of MA enrollees are in plans that charge coinsurance for DME: Nine of 10 enrollees are in plans that charge 20 percent coinsurance, and almost all enrollees face between 10 percent and 30 percent coinsurance. For Part B drugs, which include chemotherapy drugs, about four of five enrollees are in MA plans that charge 20 percent coinsurance. In previous years, some plans had coinsurance higher than 20 percent, but recently CMS limited the allowable coinsurance to 20 percent in response to complaints that higher levels were discriminatory against some of the sickest beneficiaries most likely to require Part B drugs.

While CMS has used various incentives to encourage MA plans to include an out-of-pocket (OOP) cap on beneficiary cost-sharing liability over the last several years, for 2011 CMS required that plans have a cap of no more than \$6,700 for in-network and out-of-network Medicare-covered services. Plans can have lower caps and can also have a separate lower cap on in-network cost sharing. For 2011, the average OOP cap for an

MA enrollee who obtains Medicare-covered services from providers in the plan's network is \$4,300. Half of MA enrollees have a cap of \$3,400 or less. In addition to the OOP cap, most plans enhance the Medicare-covered services by waiving the three-day hospital stay requirement that FFS Medicare applies before qualifying beneficiaries for skilled nursing facility care. Ninety-five percent of MA enrollees are in plans that waive the three-day stay requirement.

In addition to the use of cost sharing and provider networks to influence beneficiaries' use of services, plans use other utilization management techniques. Using descriptions of plan benefit packages as a crude tool to determine the extent to which plans use prior authorization and utilization review techniques, we found that 60 percent of enrollees are in plans that require the plan's medical director to approve the use of home health services.

This text box looks at common characteristics of MA plan benefit designs. However, there is variation. Some plans mimic FFS Medicare's benefit package, while others have no in-network cost sharing but charge a substantial premium. Also of note, beneficiaries in FFS Medicare may buy a supplemental policy (medigap) that covers some or all Medicare cost sharing, but MA enrollees may not be sold medigap policies. ■

Employer-sponsored retiree plans

Employer-sponsored insurance typically provides beneficiaries with broader coverage for lower premiums than medigap policies. However, employer-sponsored coverage may not fill in all cost sharing and is not available to everyone. 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 et al. 2008). Employers who 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).

Many employer plans require retirees enrolled in Medicare to pay deductibles and cost sharing just as active workers and younger retirees do. But it is unclear whether these cost-sharing arrangements apply to all retirees or primarily those who are in younger cohorts. In 2007, Actuarial Research Corporation analyzed 2005 data from the Medical Expenditure Panel Survey for the Commission. At that time, about 20 percent of Medicare beneficiaries with supplemental coverage through an employer had no OOP spending other than their premiums—their retiree plans paid for their Medicare cost sharing. In 2009, Direct Research used 2005 data from the Medicare Current Beneficiary Survey to estimate that 50 percent of FFS beneficiaries with employer-sponsored coverage paid 5 percent or less of their Part B spending OOP.

**TABLE
3-5**

Distribution of medigap policies and average premiums nationally and range of premiums for Albany, NY

National values for 2009

Plan type	Number of policyholders (in thousands)	Percent of policyholders	Average annual premium	Range of premiums in Albany, New York, February 2009*
All	9,454	100%	\$2,100	N/A
A	260	3	1,400	\$1,230-\$2,420
B	474	5	1,800	\$1,670-\$3,240
C	1,469	16	2,000	\$1,830-\$3,750
D	378	4	2,100	\$1,800-\$2,920
E, H, I, J	1,260	13	2,000	\$1,810-\$2,720
F	3,827	41	2,000	\$1,940-\$4,130
F (high deductible)	36	0	500	\$850-\$1,190
G	329	3	1,900	\$1,810-\$2,720
K	21	0	900	\$890-\$1,340
L	38	0	1,500	\$1,240-\$1,900
Waiver-state policies	590	6	2,300	N/A
Pre-1991 policies	724	8	2,700	N/A

Note: N/A (not applicable). Plans E, H, I, and J closed to further enrollment in 2010. Insurers began offering standard Plan M and Plan N in June 2010. Waiver states include Massachusetts, Minnesota, and Wisconsin. Percentages may not sum to 100 due to rounding.

*New York state uses community rating, meaning that premiums cannot vary by age, gender, or health status of the insured individual.

Source: MedPAC analysis of 2009 data from the National Association of Insurance Commissioners. Data for premiums from Albany, New York, from New York State Insurance Department website.

These estimates suggest that today a sizable portion of beneficiaries with employer-sponsored coverage have most of their Medicare cost sharing filled in by secondary insurance.

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 (Employee Benefit Research Institute 2008). As those cohorts replace older ones in Medicare, employer-sponsored supplemental coverage will play less of a role than it does today.

Supplemental benefits 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. These criteria are tied to eligibility for the Supplemental Security Income program. States have flexibility to raise the income level and disregard certain forms of income. In 2009, 24 states set Medicaid eligibility at or below these Supplemental Security Income requirements (Kaiser Family Foundation 2010). Some states provide full Medicaid benefits to additional categories of the elderly and disabled population. For example, 33 states plus the District of Columbia have a medically needy program that allows individuals with higher incomes or resources to qualify for Medicaid coverage if they have high medical expenditures (Jacobson et al. 2011).

The Congress has created a number of additional programs, called Medicare Savings Programs (MSPs) to help beneficiaries with limited incomes pay for Medicare premiums and cost sharing (Table 3-6). Medicare 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 (QMB)

**TABLE
3-6**

Federal eligibility criteria for Medicare Savings Programs

Medicare Savings Program	Income	Asset limit	Covered costs and services
Qualified Medicare beneficiary (QMB)	<100% of poverty	\$6,880 individual, \$10,020 couple	Medicare premiums and cost sharing
Specified low-income beneficiary (SLMB)	100%–120% of poverty	\$6,880 individual, \$10,020 couple	Medicare premiums
Qualifying individual (QI) block grant funded by federal government	120%–135% of poverty	\$6,880 individual, \$10,020 couple	Medicare premiums

Note: States have the flexibility to adjust countable income and assets.

Source: Jacobson et al. 2011.

program with Medicaid covering their Part B premium and cost sharing. Beneficiaries with incomes below 135 percent of the poverty level can have their Part B premium covered under either the Specified Low Income Beneficiary (SLMB) or Qualified Individual (QI) program.

About 8.8 million individuals are dually eligible for and enrolled in both Medicare and Medicaid. Most receive full Medicaid coverage, with enrollment in the programs declining as income rises (Kaiser Family Foundation 2010). Medicaid provides supplemental coverage to 62 percent of beneficiaries with incomes below 100 percent of poverty and 34 percent of beneficiaries with incomes between 100 percent and 150 percent of poverty (Jacobson et al. 2011). Those beneficiaries eligible but not enrolled in MSPs are more likely to report that they did not receive needed health care because of cost.

In addition, the Congress designed a low-income drug subsidy (LIS) to supplement the Medicare Part D drug benefit for individuals with limited incomes. Beneficiaries who meet resource limits and have incomes below 135 percent of poverty receive 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.

At present, about 10 million beneficiaries (36 percent of Part D enrollees) receive the LIS, and 6.4 million of them are dually eligible beneficiaries. Another 3.5 million qualify for the LIS either because they receive benefits

through the MSP or the Supplemental Security Income program or because the Social Security Administration determined that they were eligible after they applied directly to that agency (Medicare Payment Advisory Commission 2011).

In 2008, the Commission made three recommendations to increase beneficiary participation in MSPs (Medicare Payment Advisory Commission 2008). These recommendations included linking the resource limit for MSP eligibility to the limits set for the Part D LIS, increasing funding for the state health insurance assistance programs that counsel beneficiaries about their choices, and allowing Social Security offices to screen beneficiaries for MSP eligibility when they apply for the LIS. These recommendations were largely enacted in the Medicare Improvements for Patients and Providers Act of 2008.

The role of supplemental plans

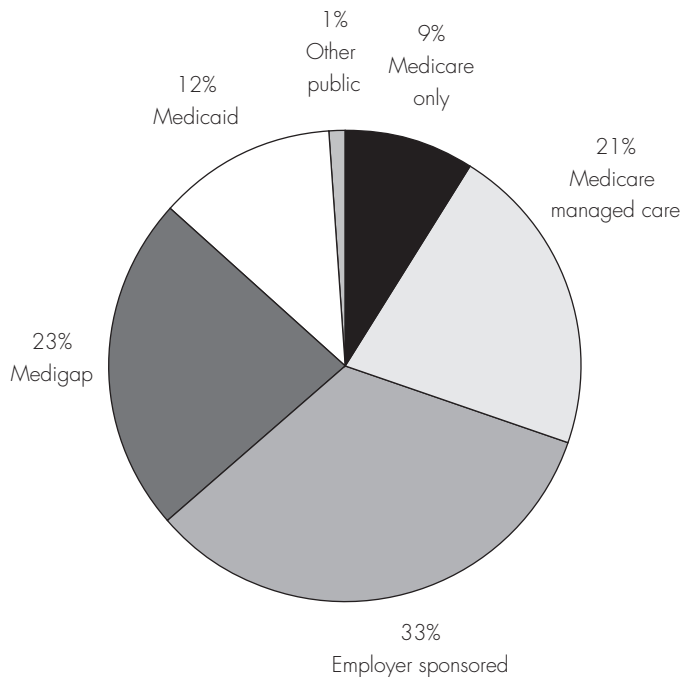
The lack of comprehensive coverage in the FFS benefit design leads more than 90 percent of beneficiaries to take up supplemental coverage (Figure 3-1, p. 74). In 2007, employer-sponsored retiree policies that wrap around the Medicare FFS benefit covered the most beneficiaries, followed by individually purchased medigap policies, private Medicare plans, and Medicaid.¹¹ Only 9 percent of beneficiaries relied solely on Medicare's benefit.

The RAND Health Insurance Experiment

There is an extensive literature about the effects of cost sharing on the use of health care services. The RAND Health Insurance Experiment (HIE) remains the gold

**FIGURE
3-1**

Most Medicare beneficiaries had supplemental coverage in 2007



Note: Excludes long-term institutionalized beneficiaries and those for whom Medicare is the secondary payer. Beneficiaries' secondary coverage is based on their monthly coverage status. Therefore, beneficiaries in one coverage category can have some months of enrollment in other coverage categories. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of preliminary 2007 Medicare Current Beneficiary Survey Cost and Use files.

standard on this subject (RAND Corporation 2006). The HIE was a large-scale randomized experiment conducted between 1971 and 1982. More than 7,750 individuals (all under age 65) participated. It concluded that:

- 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.

Additional research continues to show that lower cost sharing can lead to higher utilization and higher spending on health care. More controversial, however, is the effect of increases in cost sharing on health outcomes. Much of the literature is consistent with the notion that cost sharing can have both beneficial and detrimental effects on beneficiaries' health. (For an in-depth look at the literature see Medicare Payment Advisory Commission (2010).) The HIE found no short-term ill effects on the health of the average person.

A recent meta-analysis of the literature on cost sharing found that these results stand (Swartz 2010). However, consistent with the HIE findings, low-income individuals in poorer health may be more likely to forgo needed care as cost sharing increases. For example, 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 and drug use decreased. 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).

Researchers agree that Medicare beneficiaries with medigap or retiree health coverage tend to have higher use of services and spending than those with no supplemental coverage (Table 3-7). 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. (Insurers providing supplemental coverage make no determinations about medical necessity.) Thus, some portion of the higher spending of these beneficiaries is arguably due to an insurance effect. Studies that attribute at least a portion of higher spending to an insurance effect find a spending increase of about 25 percent, with

**TABLE
3-7**

Average cost-sharing liability and out-of-pocket spending by type of supplemental coverage in 2007

	All FFS beneficiaries	Medicare only	Employer sponsored	Medigap	Medicaid
Average per capita spending					
Medicare services	\$8,335	\$5,005	\$7,351	\$9,591	\$11,180
Medicare payment	7,139	4,268	6,168	8,127	10,111
Medicare cost-sharing liability	1,196	738	1,184	1,464	1,068
Beneficiary out of pocket	262	606	229	219	167
As percent of total spending for Medicare services					
Medicare payment	86%	85%	84%	85%	90%
Medicare cost-sharing liability	14	15	16	15	10
Beneficiary out of pocket	3	12	3	2	2
Premiums					
Health insurance	\$1,029	\$37	\$951	\$2,082	\$31
Medicare and health insurance	1,864	939	1,890	3,116	141

Note: FFS (fee-for-service). Excludes long-term institutionalized beneficiaries and those for whom Medicare is the secondary payer. Beneficiaries' secondary coverage is based on their monthly coverage status. Therefore, beneficiaries in one coverage category can have some months of enrollment in other coverage categories. Differences in spending also reflect differences in beneficiary characteristics not related to their supplemental insurance.

Source: MedPAC analysis of preliminary 2007 Medicare Current Beneficiary Survey Cost and Use files.

estimates ranging from 6 percent to 44 percent (Atherly 2001).¹² 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.

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 Medicare spends more on them (Hogan 2009). 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.

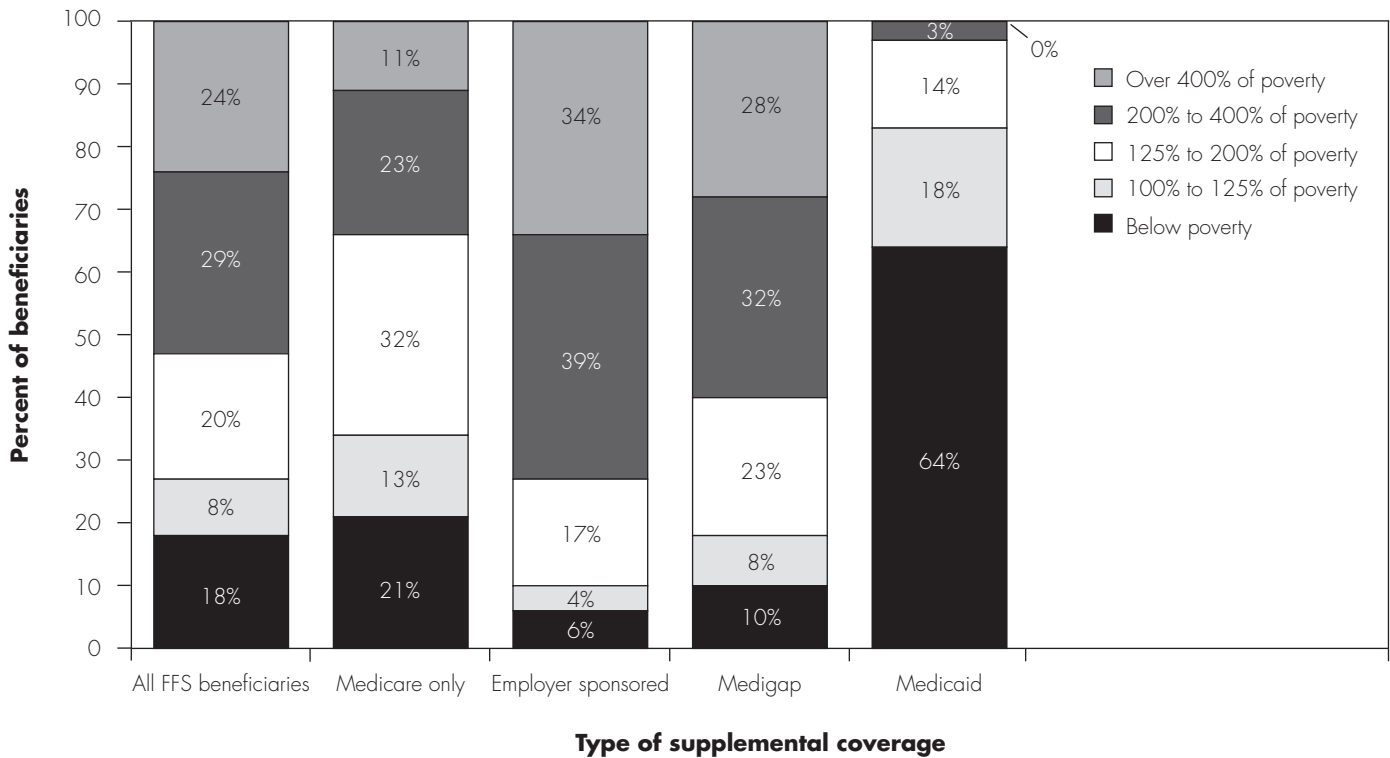
Paying little OOP seemed to be an influential factor associated with higher Medicare spending. Analyses

comparing OOP limits for beneficiaries with retiree coverage and for beneficiaries with medigap policies suggest that if supplemental coverage did not fill in as much of Medicare's cost sharing, cost sharing could be structured in ways to encourage beneficiaries to choose high-value care. For example, differential copayments between primary and specialty care could be used to encourage more of the former.

The Commission's 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 similar incomes. However, the presence of secondary insurance had a somewhat stronger effect on spending for lower income beneficiaries. This finding is consistent with other research that suggests the difference in price sensitivity to rising copayments for prescription drugs may account for some of the observed disparities in health across socioeconomic groups (Chernew and Gibson 2008).

FIGURE 3-2

Distribution of FFS beneficiaries' income by type of supplemental coverage in 2007



Note: FFS (fee-for-service). Excludes long-term institutionalized beneficiaries and those for whom Medicare is the secondary payer. Beneficiaries' secondary coverage is based on their monthly coverage status. Therefore, beneficiaries in one coverage category can have some months of enrollment in other coverage categories. Categories may not sum to 100 percent due to rounding.

Source: MedPAC analysis of preliminary 2007 Medicare Current Beneficiary Survey Cost and Use files.

Supplemental insurance and beneficiary income

The economic circumstances of beneficiaries differ significantly across categories of supplemental insurance. Among all FFS beneficiaries, in 2007, about 46 percent had incomes of 200 percent of the poverty threshold or less (Figure 3-2).¹³ On average, beneficiaries with employer-sponsored retiree coverage or medigap policies had higher incomes than individuals with no supplemental insurance or with both Medicare and Medicaid benefits.

At the median, Medicare beneficiaries spent about 16 percent of their income on premiums and other OOP health spending in 2005 (Neuman et al. 2009). However, that figure masks considerable variation across individuals. Generally, beneficiaries with higher Medicare spending pay a larger proportion of their income than those with lower Medicare spending, but the relative burden of financial liability depends on the beneficiary's type of supplemental coverage. Two groups tend to pay comparatively more than others: (1) beneficiaries with

medigap policies and (2) those with no supplemental coverage and high use of Medicare services (Medicare Payment Advisory Commission 2009).

Shorter term potential improvements to FFS Medicare

For the near term, incremental steps can be taken to begin changing beneficiaries' incentives. The aims of these measures include:

- reducing financial risk for beneficiaries who currently have very high cost sharing,
- redefining the role of supplemental coverage to avoid encouraging beneficiaries' use of lower value services, and
- encouraging beneficiaries to use high-quality, low-cost providers.

Providing beneficiaries with clear information about the potential risks and benefits of their treatment options through shared decision making with their medical providers could also be complementary to changes in benefit design.

Reducing financial risk for beneficiaries with high spending

While most individuals have at least one outpatient physician visit in a year, only about one in five has a hospital stay. Beneficiaries who have a hospitalization during a year can accumulate considerably more cost-sharing expenses than those who are not hospitalized. (Over several years, the odds of having one or more hospital stays go up considerably. For example, among beneficiaries who were in Medicare in 2004 and were alive in 2008, about half had a hospital stay at some point over that five-year period.) Although unlikely, beneficiaries with multiple hospitalizations may need to pay the inpatient deductible repeatedly, and those who require longer stays also pay sizable daily copayments. In addition, patients who are hospitalized have little control over care associated with their stay—for example, the professional services of physicians, imaging, and physical therapy—and pay 20 percent coinsurance for those services. They may also require considerable post-acute care services. Although much of Medicare beneficiaries' cost sharing is triggered by a hospitalization, most of the cost sharing they incur stems from coinsurance on their use of Part B services (Medicare Payment Advisory Commission 2009).

The Commission believes that protecting beneficiaries against the economic impact of catastrophic illness is very important. Providing a budget-neutral OOP cap on spending would reduce the financial risk for beneficiaries with high spending and may mitigate the need to purchase supplemental insurance, a significant expense for many beneficiaries.

Including an OOP cap in the FFS benefit without other design changes would generally lower spending for beneficiaries and raise spending for the government. Such a policy would benefit individuals who currently pay very high Medicare cost sharing, particularly those with no supplemental coverage, and would tend to lower supplemental premiums for many other beneficiaries. However, Medicare would begin paying for some of the costs now covered by secondary insurers. Because beneficiaries who have medigap policies pay the full premium for the supplemental benefits of everyone in their

insurance pool (including some beneficiaries with high Medicare cost sharing), all beneficiaries with medigap policies would see lower premiums, but Medicare spending would grow. An OOP cap would also lead to somewhat higher Part B premiums since these premiums are set as a percentage of Medicare's spending for Part B services.

One way to reduce Medicare's program costs under an OOP cap would be to combine the FFS deductibles for Part A and Part B services. To remain budget neutral, a combined deductible would need to be high. To illustrate, using conservative assumptions about beneficiaries' behavioral responses, Table 3-8 (p. 78) shows the combinations of the OOP cap and combined deductible under which Medicare spending would break even and the new benefit would not worsen the program's financial sustainability. (Table 3-8 assumes no changes in current coinsurance rules.) For example, if today's separate deductibles were replaced in 2011 with a combined deductible under a policy that capped OOP expenses at \$5,000, all enrollees in FFS Medicare would need to pay for the first \$1,170 of Part A or Part B services. At this amount, about 34 percent of beneficiaries would have higher OOP spending by about \$300 on average compared with current law. In contrast, about 7 percent of beneficiaries would have lower OOP spending by more than \$1,050 on average. Although only a small proportion of beneficiaries would actually have OOP spending high enough to benefit from the cap in a given year, other beneficiaries would also benefit from the reduced uncertainty of incurring very high OOP spending. Furthermore, a much higher proportion of beneficiaries would benefit from the OOP cap over time, as about half of beneficiaries have a hospital stay over a five-year period. At a lower OOP cap, the combined deductible would be higher and more beneficiaries would face higher OOP spending. If supplemental policies were permitted to fill in this combined deductible, the majority of beneficiaries would likely see little change or a net lowering of their combined OOP spending, Part B premiums, and premiums for supplemental coverage.

Redefining the role of supplemental coverage

Instead of replacing the current Part A and Part B deductibles with a combined deductible, policymakers could focus on redefining the amount of Medicare cost sharing that supplemental insurance could fill in. For example, the Congressional Budget Office (CBO) estimates that if medigap insurers were barred from paying any of the first \$550 of a policyholder's cost sharing and

**TABLE
3-8**

Level of combined FFS deductible required to hold constant Medicare program spending in 2011

Catastrophic limit on OOP spending	Combined deductible required to break even	How FFS beneficiaries' OOP spending would differ from baseline			
		Nonspenders	No appreciable change*	Higher	Lower
None — current law	\$595	5%	61%	28%	6%
\$7,000	960	5	56	33	6
\$5,000	1,170	5	54	34	7
\$4,000	1,328	5	53	35	6
\$3,000	1,635	5	52	36	7

Note: FFS (fee-for-service), OOP (out of pocket). Percents may not sum to 100 due to rounding. This analysis excludes Part D. OOP spending includes only cost-sharing amounts paid by the beneficiary—it excludes any cost sharing paid through supplemental coverage. OOP also excludes any premiums for Part A, Part B, and supplemental coverage.
*Change of \$50 or less.

Source: Actuarial Research Corporation, based on 2004–2006 Medical Expenditure Panel Survey data calibrated to 2011 spending and utilization statistics for Medicare's FFS population from the 2009 Medicare Trustees Report.

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).¹⁴ This option would apply only to medigap policies—it would not affect beneficiaries with employer-sponsored retiree coverage.

Another approach to prohibit first-dollar coverage in supplemental insurance would be to require beneficiaries to pay some 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. This approach is used by medigap Plan N and commonly by MA plans and commercial insurers.

Estimates of the effects of such copayments can vary substantially depending on the groups of services to which copayments apply. For example, MA plans often apply copayments to face-to-face visits with providers for evaluation and management services as well as X-rays and other imaging services, chiropractic care, and physical therapy. By comparison, recent guidance developed by NAIC in conjunction with CMS suggests that insurers offering medigap Plan N will use a narrow interpretation of office visits. The guidance states that Plan N will apply copayments of up to \$20 only for services under specific billing codes for evaluation and management of new and

established patients (National Association of Insurance Commissioners 2010). Such an interpretation may not achieve the degree of reduction in use of Part B services that was envisioned with changes to medigap Plan C and Plan F called for in PPACA. For Medicare FFS to adopt this approach of limiting or calibrating supplemental insurance coverage to types of services provided, other details would need to be evaluated carefully, such as the level of copayment that would apply when a beneficiary receives primary care from a medical specialist.

The copayment approach could be coupled with other changes to the FFS benefit to encourage appropriate use of services and allow a lower OOP cap. Cost sharing could be made more uniform across services and could be applied to services for which none is required today, such as laboratory tests and home health care. A separate approach involves an excise tax on insurers that offer the most complete coverage—supplemental policies that fill in most of Medicare's cost sharing. 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 because of such comprehensive coverage. Applying a tax only to supplemental policies that fill in nearly all of Medicare's cost sharing could serve several purposes. First, the tax would help to recoup some of the additional Medicare spending associated with that more complete coverage.¹⁵ Medigap insurers would pay

taxes directly to the Medicare trust funds through the same Medicare administrative contractors that process Medicare claims.¹⁶ Presumably, insurers would pass the excise tax along by raising premiums for their more complete plans. In turn, this increase would provide an incentive for beneficiaries in those plans to voluntarily consider newer medigap policies that cover less of Medicare's cost sharing.

A potential consequence of higher premiums is that some beneficiaries, rather than switching to a different supplemental plan, could choose to drop coverage altogether. If dropping all supplemental coverage led some beneficiaries to forgo necessary care, it could worsen their health outcomes and potentially result in higher Medicare spending for those beneficiaries. To encourage individuals to move into newer medigap policies or other sources of additional benefits, policymakers may want to consider reducing hurdles that prevent switching. For example, an option to change to medigap policies without first-dollar coverage that are not subject to the excise tax on a guaranteed-issue basis might limit the number of beneficiaries who choose to drop supplemental coverage.

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). The tax would, in all likelihood, 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 require paying more of Medicare's cost sharing at the point of service, that change could lead to slower growth in Medicare spending.

Encouraging beneficiaries to use high-quality, low-cost providers

Another option would be to create incentives for beneficiaries to use providers designated as high quality for specific services or procedures. Medicare FFS has had some experience using innovative methods to designate certain hospitals as providers of high-quality, low-cost services. Beneficiaries who chose these providers faced lower OOP costs. Two Medicare demonstration projects feature identification of high-quality, low-cost providers and reduced cost sharing for beneficiaries who use the designated facilities.

Coronary artery bypass graft demonstration

Using its existing demonstration authority, CMS (known as the Health Care Financing Administration at the time of the demonstration) conducted the coronary artery bypass graft (CABG) demonstration between 1991 and 1996. It examined the effect of selecting facilities based on discounted price, quality of care, and geographic dispersion to receive a bundled payment for hospital and physician services related to cardiac bypass surgery. It selected seven sites, each of which could market itself as a Medicare Participating Heart Bypass Center to increase market share.

The evaluation found that the demonstration generated considerable interest among providers, reduced the costs to Medicare and the majority of participants, and increased quality of care. It did not, however, increase market share for the majority of participating sites as many expected.

Defining the market As a first step in defining the competitive marketplace, CMS selected services surrounding two procedures that were high cost and growing in volume. CMS defined the product as all inpatient hospital and physician services that apply to the two diagnosis related groups associated with bypass surgery: with catheterization and without catheterization. Payment for hospital services included an estimated outlier amount based on each hospital's previous experience, any related readmissions, and standard Medicare hospital pass-through payments. Physician services included not only those by thoracic surgeons, cardiologists, anesthesiologists, and radiologists (all of whom were assumed to be involved in every bypass surgery) but also any other consulting physicians. For example, if a bypass patient was also depressed, the consulting psychiatrist would be paid under the bundled payment. However, the bundle excluded preadmission and postdischarge physician services, except for the standard inclusions in the surgeon's global fee.

All 734 hospitals nationwide that performed CABG surgery on Medicare patients in 1986 were eligible to participate. Participation was national, but local pressures largely motivated the competition.

The bidding process CMS invited applicants to submit their best price for the bundled payment. Hospitals calculated separate cost estimates for Part A hospital and Part B physician services, decided on a set discount rate for each, and then offered Medicare an overall global payment rate. Applicants were judged on price (50

percent), quality (25 percent), service (e.g., coverage of unrelated procedures) (10 percent), financial incentives offered to patients (e.g., reduced cost sharing), information systems, and bypass volume (5 percent each). After negotiations with CMS, seven hospitals eventually enrolled in the demonstration.

The participating institutions wanted to protect or expand their current market (Medicare Payment Advisory Commission 2003). First, they believed it was to their advantage to participate at the beginning of the program if it became the basis for selective contracting or a permanent part of the program. Second, other payers were interested in the bundled CABG payments and hospitals were concerned that failure to participate could affect their standing in the private market. Third, they worried that another hospital in the local market would be designated a Heart Bypass Center.

Results Overall, the demonstration had a positive impact by reducing providers' costs, improving quality, and reducing Medicare spending. Medicare saved about \$42.3 million on bypass patients treated in the demonstration hospitals, a savings of roughly 10 percent of the expected \$438 million spending on bypass patients, which included a 90-day postdischarge period. Eighty-six percent of the savings came from CMS-negotiated discounts, 5 percent from lower than expected spending on postdischarge care, and 9 percent from a shift in market share toward lower cost demonstration facilities. In addition, beneficiaries saved \$7.9 million in cost sharing based on the discounted Medicare charges for both hospital and physician services for a total estimated savings of \$50.3 million over 5 years.

Participating sites were largely successful in reducing their internal costs per episode. For example, several hospitals had statistically significant declines in intensive care unit and direct nursing expenses. They also achieved savings in pharmacy and laboratory costs. However, one site saw its costs per case increase.

Beneficiaries experienced improved quality and lower costs. The evaluators found that demonstration hospitals reduced inpatient mortality rates, which was notable considering their lower than average baseline mortality rates. Compared with beneficiaries at competitors' facilities, beneficiaries who received care through the demonstration sites were more satisfied with the nursing care, shorter length of stay, and reduced paperwork.

Despite these positive results, the majority of participating sites did not see as great an increase in market share or

volume as expected. Several factors may account for this finding. First, many sites did not widely advertise their participation in the demonstration. A second factor was changing local market conditions and technology, as more competing hospitals developed bypass surgery capabilities and catheterization labs. Finally, the failure to increase market share may be partly attributed to beneficiaries' and physicians' reluctance to change their site of care in response to quality information.

Acute care episode demonstration

Building on lessons learned from the CABG demonstration, in 2009 CMS began implementing the acute care episode demonstration of bundled payments for physician and hospital services treating patients who need specified orthopedic or cardiovascular procedures. The goal of the demonstration is to improve quality for FFS Medicare beneficiaries; produce savings for providers, beneficiaries, and Medicare by using market-based mechanisms; increase price and quality transparency; and encourage collaboration among providers. In this demonstration, physicians receive their full Medicare payment and can share in savings if they improve quality and achieve savings.

Five demonstration sites were chosen from applicants in Texas, Oklahoma, New Mexico, and Colorado on the basis of competitive bids. Medicare provides a single payment to cover all Part A and Part B services, including physician services, related to an inpatient stay for FFS beneficiaries. Sites can reward individual clinicians, interdisciplinary teams, and other hospital staff on the basis of measurable quality and efficiency improvements.

Participating demonstration sites can market themselves to beneficiaries and referring physicians as Value-Based Care Centers. Unlike the CABG demonstration, CMS plans to take an active role in marketing the demonstration.

Beneficiary incentives Beneficiaries who receive the designated services at one of the demonstration sites receive payment incentives if the demonstration results in program savings. Medicare shares 50 percent of the savings it gains under the demonstration with beneficiaries up to a maximum of the annual Part B premium. Hillcrest Medical Center, the first demonstration site to begin reporting results, announced that, after nine months, surgical quality has improved and patients have received checks from CMS up to \$1,157 (Coughlin 2010). Beneficiaries undergoing joint replacement have received an average payment of \$350 from Medicare.

Additional results In 2009, Hillcrest Medical Center also saw a 28 percent increase in volume for cardiology procedures and a 31 percent volume increase for orthopedic procedures. Independent evaluation will be necessary to explain the volume increases. Beneficiary surveys done at the demonstration facilities suggest that payment incentives do not drive beneficiaries' choice of providers but that independent validation of the facility as high quality has had an effect on their decision. For cardiology procedures, patients are most influenced by their physicians.

The main source of savings for Hillcrest has come from increased bargaining power for equipment and supplies from vendors. Physicians have agreed on a limited number of devices and supplies after learning the cost of various supplies. The hospital has found that the bargaining power over vendors gained through sufficient market share is a more significant source of savings than increasing the volume of patients (Hund and Joshi 2010).

Similarly, Baptist Health System in San Antonio, Texas, another demonstration site, attained \$4 million in device and supply savings over the first 18 months of the demonstration. Participating physicians—about 150 in number—shared gains of \$558,000, and 2,000 patients received an average of \$300 per beneficiary (Vesely 2011).

Medicare certification In addition to the acute care episode demonstration, Medicare has issued several national coverage determinations limiting coverage for certain services and procedures of a complex nature to facilities that meet certain criteria. These criteria require, in part, that the facilities be recognized as providers with the ability and expertise to perform the procedure and ensure patient safety. For example, a facility must be certified as Medicare approved to perform the following procedures: carotid artery stenting, ventricular assist devices for destination therapy, bariatric surgery, and lung volume reduction surgery. In these cases, Medicare certification depends on quality standards and does not have payment implications.

Other ideas to explore

The Commission will continue to explore other options that might encourage beneficiaries to seek out high-quality, low-cost providers. Pilot or demonstration programs may provide a way to try out new approaches involving supplemental coverage. NAIC is beginning to catalog states' approval of "new or innovative benefits" offered by medigap insurers. State insurance regulators have had authority to approve the addition of such

benefits to standard medigap policies for some time, but so far relatively little information has been shared. This information would allow states and insurance companies to look for best practices.

Longer term potential improvements to Medicare

For the longer term, the Medicare program needs to move toward a redesigned benefit that gives individuals incentives to use higher value care and avoid 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, PPACA established the Patient-Centered Outcomes Research Institute to identify national priorities for comparative clinical effectiveness research and to sponsor comparative-effectiveness research efforts. 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, but identifying which services are of higher or lower value can be difficult. The term "value based" is applied to strategies for reimbursing providers (value-based purchasing) and cost-sharing options designed to encourage beneficiaries to use high-value health care services or providers and to 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 health care services or away from services of low value.

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, Fendrick et al. 2001). When there is evidence that specific therapies are comparatively more effective and appropriate for certain patients, lowering their cost sharing to help increase their adherence could improve health outcomes. If greater adherence leads to fewer exacerbations of the patient's condition, this approach could also lower spending. At the same time, where evidence suggests that medical therapies are less effective, increasing

beneficiaries' cost sharing could deter use of those services. Designs of this kind would lead to overall lower spending only if it helped to reduce medical interventions when the costs outweigh the clinical benefits. However, many services do not save money, although they are cost-effective. In a previous report, we discussed the literature testing key elements of this benefit design (Medicare Payment Advisory Commission 2010). In sum, the extent to which this benefit design could reduce Medicare program spending depends 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).

Although information is limited, surveys of large employers indicate that many use or are considering using innovative benefit designs to align cost sharing with the value of services to promote the efficiency of providers and encourage employees to manage their chronic conditions. For example, in the 2007 Mercer National Survey of employer-sponsored health plans, 15 percent of large employers (500 or more employees) lowered cost sharing for prescription drugs or nondrug treatments, and about 25 percent used enrollee incentives for participation in disease management programs. In addition, 80 percent of the largest employers (10,000 or more employees) expressed interest in implementing this type of program in the next five years, and more than 50 percent were interested in implementing tiered provider networks in the future (Hargrave et al. forthcoming).

To explore the experiences of payers who implemented cost sharing and other benefit design strategies, we organized a panel on identifying high-value and low-value services and conducted interviews and site visits with these payers.

Panel on identifying high-value and low-value services

To examine ways of identifying the value of services and the implications for Medicare, we convened a panel of 11 participants, including academics, employers, benefit consultants, health plan representatives, and a consumer advocate. The panel included five physicians, a nurse, and two pharmacists. In this section, we present a summary of their discussion.¹⁷

Our panelists generally agreed that reforming the Medicare FFS benefit design to encourage the use of high-value services and discourage the use of low-value services was a good idea. They generally said that identifying most specific services as high value or low

value for individual beneficiaries was too difficult with current data and information systems. Several panelists stressed that most services provide value to some people. If the determination is too rigid, people may not get the services they need. On the other hand, if the incentive covers all use of a service that is high value for some, cost sharing may be waived for populations for whom the benefit is not proven and costs for the program will increase. In addition, they noted, a design using varied copayments targeting specific subpopulations must address both ethical and technical issues.

However, they thought that other strategies to encourage high-value, high-quality health care were feasible. These strategies include lowering cost sharing for services identified as high value (e.g., preventive care), raising cost sharing for services that can be identified as low value, providing incentives for beneficiaries to see high-quality efficient providers, and encouraging beneficiaries to adopt healthier behaviors.

Some general themes emerged from the panel discussion:

- The value of a service often depends on who gets it. Beneficiary and provider incentives must be aligned.
- Medical management must be a part of benefit design.
- Public acceptance of a benefit design based on value depends on the process used to identify the value of services.
- Beneficiaries will be more open to benefit changes if presented with choices, including choice of plans, programs, and providers.

Several panelists linked clinical effectiveness and cost-effectiveness. One panelist said that “low value is a function of mispricing.” For example, two treatments may be equally safe and effective but if one is much more expensive than the other, it becomes low value.

Most agreed that the process of identifying low-value services should be incremental, but each had different starting places. Some suggested identifying low-value services as those that can harm patients—for example, the potential for too much advanced imaging to overexpose a patient to radiation. Another panelist suggested a data-driven approach that looks first at the services that cost the program the most money and uses clinical evidence to determine their value. Another suggested starting with the Part D drug benefit, because beneficiaries are used to copayments varying depending on the tier in which

the drugs are placed, and there is more comparative effectiveness evidence for medications. Tiering could be based on value if comparative clinical effectiveness information is available.

Panelists agreed that raising or lowering copayments for a service would have more effect on utilization if the incentive created for beneficiaries is aligned with that for physicians. Attention focused on conflicting incentives in pay-for-performance programs. One physician spoke about his frustration when a health plan rates him on the percentage of his eligible patients who receive colonoscopies at the same time that it raises patient cost sharing for this procedure. Panelists also noted that Medicare supplemental policies must be aligned with 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 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 in sync 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 for them.

Another panelist suggested that ranking individual services was too difficult and politically charged. A number of panelists believed that cost sharing based on provider quality and resource use was a more practical way to achieve the goal of promoting the use of high-value care. They said the program would gain traction by tiering copayments to steer beneficiaries toward the most efficient providers. One participant talked about a plan that does both: For certain conditions, the plan uses evidence-based guidelines to define care pathways. The pathways may include referrals to specific providers who use these guidelines. Patients who choose to follow these pathways have lower copayments.

One idea that generated a lot of discussion was the introduction of what one panelist called a graded benefit. It would be a Medicare FFS benefit that would be offered to beneficiaries as an alternative to traditional Medicare. Cost sharing in this benefit design would be based on the value of services and the use of high-quality efficient providers. The option could apply to new Medicare beneficiaries.

Those who chose this option could have a separate Part B premium and opportunities for reduced cost sharing if the plan resulted in savings. Panelists agreed that beneficiaries would be more likely to accept such a benefit if they had choices. Panelists did not fully consider the many design questions raised by this approach.

Panelists also discussed whether people should be encouraged to choose the plan by rewards or face penalties if they do not. A number of panelists suggested that penalties are more effective than rewards. For example, one person noted that the literature was clear that raising copays for drugs decreases utilization but less clear that lowering copayments increases utilization at a comparable rate. Although cost can be a barrier to medication adherence, people also may skip medication because of its side effects or because they do not believe they need it, among other reasons. The result is that lowering copays leads to some increased utilization but mostly to lower costs for the patients who were already adherent. One plan provided incentives for members to fill out risk assessments and got 30 percent participation. After it put a surcharge on premiums for those who did not fill out an assessment, participation increased to more than 70 percent. A number of panelists suggested the need for a combination of rewards and penalties.

Payer experiences

Working with researchers from NORC, we interviewed more than 70 individuals, including researchers, insurers, and public and private payers. The interviews included individual phone interviews and 10 site visits. We found that differential cost sharing was employed as part of larger strategies that included creating incentives for individuals to see high-quality efficient providers and modify their health behaviors. Strategies were integrated into the benefit design and were generally not evaluated individually. Most interviewees said that the reforms had to be treated as a package. In fact, no interviewee relied on a single technique.

From our interviews, we identified four design strategies:

- lowering cost sharing for high-value services,
- raising cost sharing for low-value services,
- creating incentives for enrollees to see high-performing or low-cost providers, and
- providing incentives for enrollees to adopt healthier behaviors.

Lowering cost sharing for high-value services

Payers were most likely to lower cost sharing for preventive services and prescription drugs that treat chronic conditions. Many of the plan sponsors with whom we spoke had a long history of waiving the copayments for preventive services or creating an exemption to the deductible for specified preventive services. Some of the services most frequently targeted for variable cost sharing included preventive health or wellness services (e.g., immunizations, primary care visits) and health screenings (e.g., mammograms, Pap smears). Many spoke about it as “the right thing to do” but did not necessarily believe it would save money, even in the long term.

Another preventive care focus for some employers has been to waive cost sharing for participating in weight-management programs. The Oregon benefits boards for public employees cover the cost of participating in a weight-reduction program for those individuals who attend a set number of sessions. While the board acknowledged that evidence for the effectiveness of these programs is lacking, they determined that because many of their members were overweight or obese, it was “a pressing enough issue that we couldn’t just not do anything.” Thus far, they say that hundreds of individuals have met their weight goals.

Many of the payers interviewed have reduced or eliminated copayments for services related to care for chronic conditions that, if not well controlled, could lead to additional health complications (e.g., prescription drugs for diabetes care). These programs are structured in several different ways:

- Payers reduce or eliminate cost sharing for all drugs in a therapeutic class.
- Payers reduce cost sharing for all tiers of drugs in a therapeutic class while maintaining differences among the tiers. For example, they lower copayments in the targeted class by 100 percent for the lowest tier drugs (generally generics), 50 percent for the second tier, and 25 percent for the third tier.
- Payers reduce cost sharing for specific patient populations with conditions such as diabetes for which medication adherence has a significant effect on patient health over time.

The better a plan is at targeting the individuals who are most likely to increase their medication adherence, the greater is the likelihood the program will be cost neutral

or cost saving. However, individual targeting can be challenging to implement and raises equity concerns.

Some plan sponsors indicated that cost-sharing changes were a way to provide an incentive to enrollees to participate in activities aimed at better managing their condition and stressed the importance of pairing the reduced cost sharing with some required action on the part of the enrollees. One employer mentioned that during a brief period of time—when the plan was not providing careful oversight to ensure that beneficiaries were participating in its disease management program—the program was unable to produce cost savings for the employer. Once the disease management program was more firmly reinstated, overall medical costs began to drop again.¹⁸

At the same time, some employers are hesitant to “attach strings” to reduced cost sharing. One benefit manager was concerned that in his worker population (which includes many hourly workers, some of whom do not speak English as a primary language), the requirement to attend a program in a language they did not understand might prevent some individuals from receiving low-cost medications.

Some payers interviewed have reduced cost sharing for a wide range of services for specific populations. For example, for individuals with diabetes, some plans have developed insurance products that do not have cost sharing for a range of services, including diagnostic procedures, lab tests, medications, dietician visits, and endocrinologist visits as long as these individuals enroll in a special diabetes health plan and follow certain guidelines that are tracked on a score card.

Other payers have varied cost sharing as an incentive to use minimally invasive procedures (MIPs). Some evidence suggests that compared with open surgery, MIPs for hysterectomy, breast biopsy, and colectomy are often associated with shorter hospital stays, reduced infection rates and complications, and faster recovery time and return to work (Center for Health Value Innovation 2010). One employer introduced a lower copayment for individuals opting for MIPs for colectomy, gall bladder removal, hysterectomy, bariatric surgery, and appendectomy. They also required preauthorization for more invasive surgery for individuals who needed those procedures. They educated employees about alternative treatments in these instances. The employer reported increased use of MIPs for all the procedures except appendectomy. One barrier to this strategy mentioned by

an interviewee is the limited number of providers with experience in the field in some parts of the country.¹⁹

Raising cost sharing for low-value services

Increasing cost sharing for low-value services can protect individuals from potentially unnecessary and even harmful procedures. It has two potential cost-saving effects: It can deter the use of low-value services as patients seek lower cost options, and it also recoups more of the cost of the low-value services that are provided. Yet this approach has not commonly been implemented, and few of our interviewees had experience identifying low-value services and increasing cost sharing for them. Some plans raise cost sharing for most services and lower cost sharing for a few other services, but generally increases affect high-value and low-value services alike. Options for explicitly instituting higher cost sharing for low-value services range from adding a flat copay for selected services to charging a higher coinsurance rate.

As a form of targeted higher cost sharing, some payers interviewed use reference pricing. One plan, where comparable prescription drugs exist, covers the full cost of the lowest price option, but individuals opting for a higher cost option pay the full price difference. In another example, a company that initially waived cost sharing for colonoscopies discovered large price differences in its area and moved to a reference pricing system. The company now covers the costs of the procedure up to \$1,500 and enrollees who need a routine screening are responsible for any expenses above that amount. The company also provides its enrollees with information about which providers charge \$1,500 or less so that enrollees can make informed decisions about where they receive care. Other interviewees suggested that they were interested in adopting reference pricing in the future.

A number of initiatives are taking place in Oregon to identify and raise cost sharing for low-value services. These efforts build on the state's history incorporating value into its decisions about health coverage. Oregon began rank ordering services in 1989, with creation of the Oregon Health Plan, a state Medicaid waiver program that sought to cover more people by covering fewer services. Composed of health professionals and consumer representatives and informed by public input (surveys, focus groups, and town hall meetings), scientific evidence, and expert opinion, the Health Services Commission developed a prioritized list of services. The list consists of about 700 condition-treatment pairs rank-ordered by importance. As many services as possible are covered

within the constraints of the Medicaid budget, starting with the highest priority services.

In 2006, the Health Services Commission changed the list's ranking methodology. The new system has a population focus and has moved certain preventive services higher on the list. This new methodology serves as the basis for the state's more recent efforts to develop an essential benefits package. While the details of this plan are still in development, the concept is that a set of 20 services with a very strong evidence base would be available to enrollees at no cost. Other services would be ranked in four additional tiers, each with higher coinsurance. Actuarial modeling suggests that the plan may have the potential to produce savings of 3 percent to 5 percent initially. However, the estimate is sensitive to factors such as the initial utilization rates of enrollees. The Oregon Health Authority is presenting this proposed plan to state policymakers and soliciting feedback at public meetings.

A concurrent effort is being led by the Oregon Health Leadership Council (OHL), an organization of business leaders, health plans, and providers seeking to reduce the rate of increase of health care costs and create a simpler benefit design with three tiers of service. A middle tier—level 2—resembles most traditional plans with a deductible and coinsurance for most services. But the plan alters cost sharing for high-value and low-value services. Benefit level 1 covers prescription drugs and some lab and imaging and other ancillary services related to six chronic conditions—coronary disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, asthma, and depression—with minimal or no cost sharing. OHL originally wanted to include primary care visits in the tier without cost sharing; however, administrative barriers may not make it feasible for all insurers. For example, their billing systems may not be able to distinguish primary care visits for a specific chronic condition.

Level 3 focuses on “services that are nationally recognized as overused and driven by provider preference or supply rather than evidence-based need.” Level 3 services are subject to higher coinsurance and a separate deductible and OOP maximum. Services included in this tier are outpatient upper endoscopy; outpatient MRI, computed tomography, and positron emission tomography screening; some spine surgery and orthopedic joint procedures; percutaneous transluminal coronary angioplasty; stents; CABG surgery; electron beam computerized tomography; and non-cancer-related hysterectomy. In addition, if

individuals have an emergency room visit that does not result in an admission to the hospital or is related to one of these level 3 procedures, they face the higher cost sharing.

OHLC estimates that if insurers implement the benefit design as they have laid it out, it could result in a premium reduction of between 8 percent and 12 percent. (Plans that are already tightly managed would save less.) In those projections, the actuaries assume no net gain or loss on the level 1 services and predict most of the savings from level 3. OHLC acknowledges that the plan has received some criticism as an attempt to shift costs to consumers. OHLC counters that this approach is a more rational way to shift costs than by introducing a \$2,000 deductible for all services.

While no plan sponsor has implemented OHLC's benefit design as is, several have adapted it to meet their needs. A workgroup of the Public Employees' Benefit Board (PEBB) and Oregon Educators' Benefit Board (OEBB) recommended making several minor changes to the plan before implementing it for the 2010–2011 plan year. Enrollees in the plan face no cost sharing for 17 preventive services and can receive free tobacco-cessation and weight-management benefits. For level 3 services, individuals face a flat \$500 copayment, which is in addition to coinsurance for those services and is not included in the general deductible or OOP maximum. In reviewing the OHLC plan, the PEBB/OEBB workgroup decided to remove cardiac treatments and hysterectomy from level 3, because keeping them in a high cost-sharing tier was considered too contentious. The workgroup also recommended creating an intermediary tier with a \$100 copayment for advanced imaging and sleep studies. Representatives of the workgroup noted that in past years, less than 5 percent of their plans' membership use the services designated in the highest cost-sharing tier—roughly the same percentage of enrollees who are affected by the highest tier of their drug formulary.

Evrax Inc., which operates steel mills in Oregon and Delaware, began offering its employees a plan based on the OHLC model as of January 1, 2011. The plan includes cholesterol and blood pressure medications on the no-cost-sharing tier. While some workers have the option of staying in their current plan or selecting the value-based plan, the company is waiving the employee premium contribution for individuals who opt for the new offering. A similar plan has been rolled out to the employees of the health insurer ODS.

Insurers have found few employers who are willing to implement this OHLC benefit design. They contend that employers are interested in the concept but want to add services to the tier without cost sharing. In our discussion, an OHLC representative pointed out that to reach the goal of a 10 percent premium reduction, “we can't just add good stuff. We need to take away bad stuff. That's the value.” Another potential obstacle is the response of providers who might stand to lose some business if their services appeared on the third tier. In response, the OHLC representative noted that it had received less provider pushback than expected.

A concern that was echoed by nearly all the individuals with whom we spoke in Oregon is enrollees' perception that services on the third tier are not covered. The insurers and plan sponsors emphasize that enrollees can receive those services but are encouraged to think through the alternatives first. PEBB/OEBB explained that they view the new design structure as more about “influencing behavior and plan utilization” than about cost shifting. To facilitate decision making, plans offer shared decision making about the potential risks and benefits of some procedures and give enrollees access to decision aids where they are available.

A related criticism stated by payers interviewed is that even for services typically of low value, some individuals will benefit. Some employers expressed an interest in making exceptions for level 3 services for cases in which these services are considered medically necessary, but OHLC and insurers are reluctant to establish this precedent. They note that these services are considered covered but with a higher level of cost sharing.

ODS and Providence, who administer the plans for PEBB/OEBB, see the increased cost sharing for lower value services as a complement to prior authorization strategies they have already successfully used. An ODS representative explained that the insurer had previously used prior authorization for some expensive procedures that have less invasive alternatives. However, he explained that “prior authorization doesn't by itself change behavior. Copays are necessary.” The interviewee noted that providers often learn how to get around prior authorization requirements. In addition, a Providence representative noted that the new benefit design may be less administratively burdensome because, unlike prior authorization, the benefit design is not subject to debates between physicians and plan administrators and to appeals.

Creating incentives for enrollees to see high-performing or low-cost providers

Efforts to influence the behavior of plan enrollees can also align with initiatives such as value-based purchasing and high-quality provider networks. Purchasers and health plans can identify which physicians provide care consistent with clinical guidelines and select them for these networks, known as top tier networks. Payers can then use incentives to encourage enrollees to see providers in that high-value tier. From our interviews, we learned that plans used a variety of efforts to achieve this aim, including establishing preferred provider networks, encouraging use of the most efficient site of care, and paying for second opinions.

Provider networks Starting in 2002, Minnesota implemented a program to give state employees an incentive to see more efficient providers. Each year the state ranks its primary care clinics in order from those whose patients have the overall lowest risk-adjusted claims to those with the highest. The ordered list is then divided into four tiers, with the “lower” tiers representing the most favorable in terms of cost sharing. Patients who enroll with primary care providers in the lower tiers face lower cost sharing than those who enroll with providers in the higher tiers. The state works with providers to explain what they need to do to move into a lower cost tier, including lowering their payment rates, changing their referral patterns, and better managing patients with chronic conditions. Interviewees say the state achieved about 7 percent in savings as enrollees signed up with more efficient providers. Aetna began establishing high-performance networks by identifying specialists who were most efficient in providing care. Enrollees face reduced cost sharing for visits to those providers. Minnesota and Aetna also take into account issues of access to ensure that enrollees in various geographic areas have provider options in the high-performance tier.

One challenge facing plan administrators who are interested in establishing a tiered provider network is making sure they have adequate data to rank providers in tiers. Providers may argue that an individual insurer covers only a small fraction of the patients in their panel and therefore question the validity of the rating system. Confusion arises when a provider is considered a high performer by one insurer and not by another. Purchasers in Oregon note that statewide data-sharing initiatives might solve this problem.

For the provider tiers to have their intended effect, enrollees need to be aware of their plan’s cost-sharing

differences among providers. General Electric (GE) established a Health Coach program that allows employees to call a telephone hotline to help them decide which providers to see. The coaches provide information about quality ratings of providers, their tier ranking, and their associated cost-sharing requirements. The Health Coach also provides other assistance, including helping to make and prepare for appointments and transferring records if necessary.

Site of care In addition to providing assistance and incentives to steer patients to specifically designated, efficient primary care providers and specialists, plan sponsors implement strategies to encourage the use of primary care. On the basis of its “core strategy that everything begins with primary care,” QuadMed has lowered cost sharing for primary care visits to a \$7 copayment, making them much less expensive than specialist visits. Minnesota also encourages the use of convenience clinics to provide services such as strep tests at the lowest cost possible.

Other programs steer patients in need of complex procedures to facilities that specialize in that type of care. GE pays living and travel expenses and waives cost sharing for enrollees who go to centers of excellence for transplant surgery or for the treatment of some complicated cancers. By designating a particular facility as a center of excellence, the company is often able to negotiate discounted prices as well as see an improvement in quality and reduction in complications.

One supermarket chain sought opportunities for enrollees to receive more efficient care abroad. When the company realized the price differential between joint replacements in their area and those in other countries, it developed a benefit for enrollees to go to Singapore for the procedure, incur no cost sharing, and receive travel expenses for an accompanying spouse. The company never sent a patient to Singapore because local facilities renegotiated a much lower price to perform the procedures.

Second opinions GE has established an eSecond Opinion program through which individuals with serious health conditions are able to consult with a specialist at the Cleveland Clinic at no cost to the enrollee. The company provided several examples of cases in which the online program caught potentially serious misdiagnoses. Similarly, Hannaford Brothers, a New England supermarket chain, partnered with the Dana Farber Cancer Institute to provide oncologist-to-oncologist consultations;

the program has resulted in many instances in which diagnoses or treatment plans have changed.

Providing incentives for enrollees to adopt healthier behaviors

Some interviewees provide incentives to enrollees to engage in activities such as taking a health risk assessment, exercising, and quitting smoking. The employers with whom we spoke took various approaches to wellness programs. Roy O’Martin, a small lumber company in Louisiana, holds annual health fairs where employees can undergo biometric screenings (including measuring weight and height and testing cholesterol level, blood sugar, and prostate-specific antigen) and can review the results with an occupational health nurse. In discussion with the nurse, the employee sets goals for the coming year. Employees are not mandated to meet particular goals but choose their own. If they meet those goals, their portion of their health insurance premium is waived.

Hannaford Brothers phased in its wellness incentives. In the first year, enrollees had to complete a health risk appraisal and abstain from smoking to receive a \$20 per week healthy behavior credit. In year two, enrollees had to accept a call from a nurse case manager if something in the risk appraisal triggered the need for outreach. Starting in the third year, individuals contacted by a case manager needed to negotiate and meet goals related to the risk factor. In addition, all employees need to receive preventive care recommended by guidelines. The program has been well received by primary care providers who noted that increased accountability has prompted patients to talk to providers about their preventive care needs.

While the programs described above emphasize health risk assessments, not all employers with whom we spoke were convinced of their value. One employer explained the company does not see much return from having employees fill out health risk assessments. Another wondered how actionable the information derived from these assessments would be. Most employers and insurers who value health risk assessments believe they must be combined with other outreach activities. One interviewee put it bluntly: “anything that’s not integrated is probably a waste of time.” For example, Cigna uses the data to engage high-risk individuals in disease management efforts.

In addition to health screenings and risk assessments, some employers create incentives for individuals to stop smoking. At GE, employees who smoke and who do not agree to try to quit are required to pay a premium

surcharge. Next year, employees who currently smoke will have to stop smoking for at least 90 days to avoid the surcharge. QuadMed also charges \$11 per week more in premiums for individuals who do not sign up to be tobacco free and receive recommended screenings.

Impact of benefit design changes

Although some interviewees reported successful results from their benefit design initiatives, limited research is available to evaluate these programs. In some cases, the programs are too new to be able to assess results. Several of our interviewees noted that even if a strategy is effective, how that translates into costs or savings may vary from one organization to another. Under a cost-sharing program, for example, a company that had a high baseline adherence rate for statins would find itself paying the full cost of statin prescriptions, which employees would take regardless of incentives, and would see fewer returns in preventing additional heart attacks than a company with a lower baseline adherence rate. Of course, the rationale for lowering cost sharing for high-value services does not rest solely on the notion that employers should save money. Wage offsets and risk alleviation could justify lower copays for high-value services even if few employees changed behavior. Nevertheless, companies with low baseline adherence rates could achieve better results with a cost-sharing incentive program, as it would have further to go to change enrollee behavior and prevent additional heart attacks.

The Commission will consider these and other policy options. We need to assess the relevance of these strategies to Medicare. All the strategies would entail choosing among design options with both technical and policy implications.

Future work

In the coming year, the Commission will continue looking at ways to improve the Medicare FFS benefit design. One issue is particularly important. Providing a budget-neutral OOP cap on spending would protect beneficiaries against the economic impact of catastrophic illness. Ideally, it could mitigate the need for individuals to purchase supplemental insurance, a significant expense for many beneficiaries.

To add an OOP cap to Medicare, we must examine the program’s cost-sharing structure. Commissioners agree

that rationalizing cost sharing is an important goal but one that raises complex issues. We will analyze different options and assess their distributional impacts.

The Commission continues to be interested in some of the innovative benefit designs being tested in the private sector. In particular, we will examine ways to provide incentives for beneficiaries to use high-quality, efficient providers. Defining such providers and providing beneficiaries with sufficient educational resources to make informed decisions is a necessity of such an approach.

Thus, improving the Medicare benefit design is an important endeavor that will enhance price signals in the Medicare program and support payment and other health care reforms. An improved benefit package can reduce beneficiary risk, help control program costs, and create incentives to increase the efficiency of the Medicare program. ■

Endnotes

- 1 The other quarter of Medicare beneficiaries are enrolled in private plans, primarily Medicare Advantage (MA) plans. MA plans can vary the benefit structure, within limits, as long as the actuarial value of the benefit is at least as high as the traditional FFS Medicare benefit. For more information on the MA program see our March 2011 report (Medicare Payment Advisory Commission 2011).
- 2 Higher income beneficiaries pay a higher income-related Part B premium.
- 3 For example, the American Medical Association's 2009 National Health Insurer Report Card shows that Medicare performed similar to or better than private insurers on several claims-processing measures, such as indicators for timeliness, transparency, and accuracy of claims processing (American Medical Association 2009). The report card noted that, although Medicare had higher rates of denied claims (4 percent) than several of the private insurers, Medicare does not require preauthorization for services, as do many private insurers.
- 4 In 2007, the Part A deductible was \$992 and the Part B deductible was an additional \$131. By comparison, in 2007, a typical large employer used a combined deductible for inpatient and outpatient care of \$500 per individual (\$1,000 per family) for in-network care (Yamamoto et al. 2008). (For out-of-network providers, it was \$1,000 per individual (\$2,000 per family).) For people younger than age 65 who are not enrolled in Medicare, deductibles can be much higher than Medicare's if they purchase insurance in the individual market—that is, without the benefit of a large risk pool like major employers and Medicare have. In a 2009 survey, the median respondent who purchased a single, individual policy with a preferred provider organization or an HMO with a point-of-service option faced a deductible between \$2,000 and \$2,500 (America's Health Insurance Plans 2009).
- 5 By comparison, a 2006 survey of Blue Cross Blue Shield plans that covered their own insured business as well as plans run for self-insured employer groups found that administrative costs were typically about 12 percent of premiums (Merlis 2009).
- 6 Wide ranges in premiums suggest that the market for supplemental coverage is not very efficient. Different ratings methods are one reason for the wide range, and they include the following:
 - *Community rating*—all beneficiaries are charged the same rate for a given plan.
 - *Issue age rating*—all beneficiaries in a plan are charged a set rate based on how old they are when they first purchase the plan.
 - *Attained age rating*—all beneficiaries of a given age are charged the same within a plan.
 - *Individual medical underwriting*—the process that an insurance company uses to decide, based on the applicant's medical history, whether to accept the application for insurance. Except in guaranteed issue situations, beneficiaries in poorer health may be refused coverage entirely and may have fewer choices of plans available to them (sometimes only higher priced options), and preexisting condition exclusions may apply.
- 7 While beneficiaries may be confused by the array of premium choices and lose confidence that they can select the plan that is best for them, there is a safeguard against plans providing poor value. Medigap plans must return a minimum level of benefits relative to their premiums, with a medical loss ratio of not less than 65 percent; that is, each medigap plan must pay out in medical benefits at least 65 percent of the premiums collected from the policyholders. Group policies, which are sold through employers, unions, and other groups and tend to have lower administrative costs, must have a minimum loss ratio of 75 percent. The National Association of Insurance Commissioners reports that for 2008, the average medigap loss ratio was 80 percent (81 percent for group policies and 79 percent for individual policies).
- 8 Medicare SELECT provider networks are usually just for inpatient care but in some cases include specific physicians. When a policyholder does not use a network provider for nonemergency care, she must pay some or all of Medicare's cost sharing.
- 9 Under the terms of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, insurers cannot issue new Plan J policies because they would compete with Part D by including prescription drugs in their covered benefits. In 2009, enrollees paid the first \$2,000 in Medicare cost sharing under the high deductible of Plan F.
- 10 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 2010).

- 11 Some employers offer retiree coverage through MA plans. As of April 2010, about 18 percent of enrollment in MA plans was through employer groups.
- 12 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).
- 13 In 2007, the poverty threshold was \$10,210 for single people and about \$13,690 for married couples.
- 14 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 assumes some ramp up of the policy in 2013, we present their steady-state estimates for 2014.
- 15 It is similar in nature to the approach used in Part D, in which beneficiaries who enroll in plans with enhanced benefits must pay premiums that incorporate an assumption about their higher use of services stemming from having supplemental benefits.
- 16 Insurers are also facing new taxes under the new health reform law. Specifically, the law calls for a general fee on health insurance providers and places an excise tax on high-cost employer-sponsored health coverage.
- 17 The Commission did not conduct an independent analysis to evaluate panelists' conclusions.
- 18 Note that all discussions of costs in this section are based on interviewees' comments and not on any independent analysis.
- 19 Savings with this strategy could be offset by an increase in volume for the procedures. We have no data on whether such a volume offset occurred in this instance.

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