MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, March 21, 2002
10:10 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
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JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Total spending and sources of payment for beneficiaries' health care
-- Dan Zabinski, Chantal Worzala, Ariel Winter

MR. WINTER: I will be talking about total spending and sources of payment for beneficiaries' health care, and then Dan will be talking about out-of-pocket spending by beneficiaries and their financial liability.

Spending on beneficiaries' health care, including long-term care, is estimated to be about $450 billion in 2002, or over $11,000 per beneficiary. This estimate was developed by us in conjunction with Actuarial Research Corporation.

A couple of important points to make about this spending, spending by Medicare is estimated to be about 60 percent of the total. This leaves a significant portion of spending that is covered by other payers.

Total resources spent on health care could be viewed as a budget constraint in redesigning benefits. That is, existing Medicare and non-Medicare spending may be adequate to finance a comprehensive benefit package. Total resources could be spent more efficiently. In other words, we could provide better benefits at the same or lower cost.

This slide and the next one present preliminary estimates of total spending, excluding long-term care, and how that spending is distributed by payer and type of service. While Medicare accounts for the majority of spending, almost $270 billion, other payers are responsible for a significant portion, almost $190 billion.

Private supplemental, which includes Medigap, employer-sponsored insurance, and Medicare+Choice benefits paid for by additional beneficiary premiums accounts for about 15 percent of the total. Beneficiary out-of-pocket spending accounts for about 18 percent of the total. And the remainder, about 7 percent, is accounted for by government supplemental, which includes Medicaid acute care spending, and VA and DOD spending.

The spending figures for each payer include both payments for services and administrative costs. If administrative costs were shown separately, they would account for about 5 percent of total spending. One-third of this amount would come from Medicare and two-thirds comes from all supplemental. As we discussed earlier, administrative costs are much lower for Medicare than for supplemental insurance, particularly private supplemental.

Here we show spending by type of service, excluding long-term care and administrative costs. Spending on Medicare covered services is about three-quarters of total spending, about $330 billion. This includes both Medicare payments and cost-sharing that is paid for by beneficiaries and supplemental coverage. Medicare payments are about 80 percent of this spending.

Spending on non-covered services is about one-quarter of total spending, or about $100 billion. Most of this spending, almost $90 billion, is on prescription drugs not covered by

Medicare. The other non-covered services category includes vision, dental, and some equipment.

The last point I'd like to make is that total resources could be reallocated to purchase better benefits at the same or lower cost.

A couple of main sources of inefficiency in the current system are supplemental coverage which, as we've discussed earlier, has high administrative costs.

DR. REISCHAUER: Could you hold that until Alice comes back?

MR. WINTER: I want to get it out before some comes back.

It also provides first dollar coverage, which leads to higher total Medicare spending.

Another source of inefficiency is the existence of duplicate sources of coverage among beneficiaries, such as Medicare+Choice and Medigap, which we also discussed in the previous presentation.

I can either take questions now or we can move on to Dan's presentation on out-of-pocket spending. Any questions? Okay, so we'll move on to Dan.

DR. ZABINSKI: Just one comment, Murray, I like these new microphones. I don't know if you had a hand in it.

Ariel discussed national level spending and I'm going to move down to the beneficiary level and focus on their out-of-pocket spending on health care. First, I'll discuss sources of beneficiaries' out-of-pocket spending.

In this diagram, we illustrate total spending on beneficiaries' health care use broken into sources of payment. The very top rectangle is the portion of total spending paid by Medicare. The remaining four rectangles comprise the portion of total spending that is not paid by Medicare.

As you can see, I've divided the portion not paid by Medicare into two broad parts, cost-sharing on services covered by Medicare and the cost of non-covered services. The diagram indicates that part of cost-sharing and part of non-covered services are paid out-of-pocket by beneficiaries. In addition, part of cost-sharing and part of covered services are paid by supplemental insurance, which includes private sector coverage such as Medigap and employer-sponsored insurance, as well as public sector coverage such as Medicaid.

However, beneficiaries often have an out-of-pocket expense associated with private sector supplemental insurance because they typically pay at least part of the premium.

In addition to these sources of out-of-pocket spending, most beneficiaries pay out-of-pocket for the Part B premium. So if you combine all of the sources of out-of-pocket spending, we have that a beneficiaries' total out-of-pocket spending is the sum of their out-of-pocket spending on cost-sharing, non-covered services, private sector supplemental insurance premiums, and the Part B premium.

In the following slides, we're going to analyze out-of-pocket spending for a sample that's drawn from the Medicare Current Beneficiary Survey that includes non-institutionalized

beneficiaries who participated in fee-for-service Medicare in 1998.

Beneficiaries' total out-of-pocket spending is a concern to many and one likely reason is that may beneficiaries have income that are below or at least close to poverty, as indicated on this slide. This diagram separates beneficiaries by their income relative to their poverty and shows that more than 20 percent of beneficiaries in our sample have income below 125 percent of poverty. These beneficiaries with low incomes are going to be more financially strained by high out-of-pocket spending than would beneficiaries with higher incomes.

Some might think that out-of-pocket spending might not be an issue for poor beneficiaries because they might believe that poor beneficiaries almost always have Medicaid, but as you just found out we know that only about half of beneficiaries below poverty actually participate in Medicaid. Consequently, I think one key point is that there is substantial variation in income and that contributes to differences in the financial strain that beneficiaries feel from out-of-pocket spending.

Now, not only is there substantial variation in beneficiaries' income, there is much variations in beneficiaries' out-of-pocket spending. In this diagram, we have ordered beneficiaries from the lowest to the highest by the amount of total out-of-pocket spending. We found that beneficiaries with the 5 percent largest values of out-of-pocket spending have 20 percent of aggregate out-of-pocket spending, as indicated by the bar furthest on the right in this diagram. In contrast, beneficiaries with the 5 percent smallest values of out-of-pocket spending have essentially 0 percent of the aggregate.

The combined effect of large variations in income and large variations in out-of-pocket spending is substantial differences between beneficiaries and the percentage of their income that goes to out-of-pocket spending on health care. The average of this measure in 1998 was 18 percent. But half of beneficiaries spent less than 10 percent of their income out-of-pocket on health care. At the same time, 10 percent of beneficiaries spent at least 33 percent of their income out-of-pocket on health care.

Among beneficiaries who are below poverty, this measure can be very high with 10 percent of poor beneficiaries spending at least 82 percent of their income out-of-pocket on health care.

I hope that I can get this diagram clear. The burden a beneficiary feels from out-of-pocket spending depends not only on how much of their income is spent on health care, but also on the persistence on their out-of-pocket spending. For example, if a beneficiary has high out-of-pocket spending that lasts a number of years, the burden is likely greater than if it lasts only a short term.

We explored the persistence of total out-of-pocket spending and the results are illustrated in this table, which is comprised of beneficiaries who participated in Medicare -- or I should say fee-for-service Medicare -- from 1996 through at least 1998. What we did is we ordered beneficiaries from their lowest to

highest value of total out-of-pocket spending in 1996 and placed them in one of five percentile rages. These 1996 percentile ranges are the very first column on this table.

I'd like you to focus on the very bottom row. These are the beneficiaries who are above the 90th percentile of out-of-pocket spending in 1996. What we've done is we've determined their percentile rank for their out-of-pocket spending in 1998. What we found is that their level of out-of-pocket spending tends to be fairly persistent. For example, for these beneficiaries who are above the 90th percentile in 1996, 41 percent of them were still above the 90th percentile in out-of-pocket spending in 1998.

Now I'd like to refocus your attention to the very top row of numbers. These are the beneficiaries who are between the zero and 25th percentile in 1996. 74 percent of those beneficiaries were still between the zero and 25th percentile in 1998.

The bottom line issues for out-of-pocket spending, at least from my perspective, are how it impacts beneficiaries financially and whether it impedes their access to care. We examined the effect of out-of-pocket spending on financial status with two measures. First, we found that 11 percent of beneficiaries with income greater than poverty spend down to poverty. Second, we wanted to know how many beneficiaries have a high level of out-of-pocket spending, and we defined high out-of-pocket spending as $5,000.

That's somewhat arbitrary but what it is is comparable to the out-of-pocket spending limit in the Federal Employee Health Benefit Plan Blue Cross-Blue Shield's standard option. We found that about 6 percent of beneficiaries in 1998 were over the $5,000 threshold.

In regard to access to care, survey data indicates that about 10 percent of beneficiaries say they delayed care due to costs and 3 percent say they have trouble getting care. I'm not going to stick my neck out and say whether I think these access numbers are big or small, but I will say that research from several sources indicates that Medicare beneficiaries report fewer access problems than do the non-Medicare adult population. This may be a reflection that Medicare beneficiaries have some coverage, that is Medicare, but 18 percent of the adult non-Medicare population is uninsured.

Finally, to the extent that policymakers are concerned about how the cost-sharing or the benefit package affects beneficiaries' out-of-pocket spending, I think it's helpful to know which goods and services account for the largest share of beneficiaries' out-of-pocket spending, at least on average. In this diagram we break the 1998 per capital total out-of-pocket spending into several service components. Each bar indicates the per capita out-of-pocket spending amount within each specific component. For example, the category with the largest per capital out-of-pocket spending is supplemental insurance premiums, which averages $733 per beneficiary. As you can see, the next largest categories are Part B premiums, prescription

drugs, and medical providers.

I'd like to emphasize that these are averages and that some people pay much more than the amounts displayed and others pay much less. For example, as I said, the average beneficiary pays $733 in supplemental premiums. But people, for example, who purchase individual Medigap insurance typically pay much more. For these people, the average out-of-pocket spending on premiums is about $1,440 in 1998, and 5 percent of them paid more than $3,000 in premiums in that year.

Thank you.

MS. ROSENBLATT: I have fewer comments on this one, but I have the same comment on the tone of this. I mean, the tone does appear to say, as in the previous section, that Medigap is not good. Again, I've got lots of paragraphs circled so you can take a look at it.

Can you tell me how income was derived?

DR. ZABINSKI: Are you saying when I'm talking about out-of-pocket spending relative to income how I derive it?

MS. ROSENBLATT: Yes.

DR. ZABINSKI: As reported on the MCBS. They're supposed to report, as I say, all sources of income on the MCBS. Does that answer your question?

MS. ROSENBLATT: Yes, that does. Thank you. And I thought those percent of income and the three year things were very well done.

There's also a chart in here on admin costs for med sup. How were those admin costs estimated?

MR. WINTER: For that question, I'd like to invite up Jim Mays, who was our contractor on this. I can give you the broad outlines and Jim can fill in any details. Jim is from Actuarial Research Corporation.

What he did for Medigap is he used the required loss ratio under the various state laws. For M+C and ESI, I'm not quite sure how you derived that, so I'm going to defer to you.

MR. MAYS: Alice, you may have noticed, I don't know if it's in the tables, but the loading we were using for Medigap, I think you would consider it an illustrative loading. We used 0.4, rather than 0.3 or 0.5. We were not trying to be tremendously precise on that, but we thought that was consistent with what was probably observed with the range of compliance with respect to loss ratios.

Does that strike you as high?

MS. ROSENBLATT: It does strike me as high because I would say that since the bulk of Medicare supplemental is AARP or Blue plans, which was also mentioned in the text, they have I think lower admin costs, higher loss ratios, than is required by law. So I think you'd find Blue plans and AARP may be in the 10 to 15 percent range.

I'm concerned that it's misleading.

MR. MAYS: We'll certainly review that. Thank you.

MS. ROSENBLATT: Thank you.

MR. MAYS: The other issue with respect to employer-

sponsored insurance, we were using 15 percent there assuming that, based on national health accounts, employer-sponsored insurance in general appeared to be quite a bit lower, 10 percent or somewhat less. Our presumption was that if you did assign the administrative costs to the retiree medical, perhaps not just on average, but presumably reflecting the somewhat more complexity to the administrative cost. We went with a higher number, but again a fairly round 15 instead of 10.

MS. ROSENBLATT: The 15 sounds right. The individual 0.4 sounds high.

One other comment, there's a comment in here on the second page of the text, total resources spent on beneficiaries' health care, excluding long-term care, could be viewed as a budget constraint in redesigning the Medicare benefit package.

I think that gets into a lot of the issues we've been talking about today, where there are a lot of different things going on, employers, beneficiaries, and I'm just worried that's a dangerous statement.

DR. ROSS: Could I just interject one thing for sort of guidance to commissioners? The issue of tone and description of the individual market keeps coming up. But in fact, there's a real policy question here that staff have tried to bring to your attention to reflect some of the points that Bob has brought up, and I think Alice fairly represents the opposing point of view.

It would be very helpful for staff for commissioners to weigh in on what you think of this. One of the issues here is what do we make of having this -- I don't want to use a loaded word like fractured insurance market that's out there, but we need to hear from you. This goes beyond a tone issue. There's some real policy questions here.

DR. REISCHAUER: I presume you don't want to hear from me yet again.

Ariel and Dan, I think this is really good stuff. I commend you on these calculations. And having said that, that sup premium column and the total out-of-pocket spending by component seems awful high and doesn't really seem to jibe with the other numbers.

Dan, you just said well, it's a $1,400 average for Medigap, I think you said in your presentation. When that's '98 and we have, in the previous tab, a $1,200 average for 2001. I just am sitting here doing my weighted average and assuming that Medicaid is zero, the uninsured is zero, Medicare+Choice back then 70 percent of the people were zero and the others were very small.

And I go it and I can't get a number that's much above $400.

DR. ZABINSKI: First, there are no Medicare+Choice in here. The reason why I left them out is because in the MCBS I don't think their data are reliable. In the MCBS they cross-reference with claims information to make sure the beneficiaries' use reporting is complete and thorough and there's no claims to cross-reference with the Medicare+Choice.

By their own admission, CMS believes that the use rates for the Medicare+Choice are severely understated in the MCBS.

DR. REISCHAUER: So I take 17 percent out and I still have a hard time coming up with a $750 number. You and I can argue it out.

DR. ZABINSKI: Just a couple of points. When I talk about Medigap, I'm talking about people who have -- you know, most of these people who have Medigap are Medigap only. But some also have Medigap and employer sponsored. But that drives up their average of that $1,440.

I know that the General Accounting Office for 1998 has an average for people who are pure Medigap of something like $1,350. So I took that as pretty much in the ballpark, being pretty close there. We can talk about it.

Also, for the people who have employer-sponsored, their average is $569.

MS. ROSENBLATT: Is there a spouse coverage issue? If you have employer coverage and you're paying for yourself and your spouse?

DR. ZABINSKI: That could be. I'm not sure how much that would drive that up, but that might be an issue if that's going on.

MS. ROSENBLATT: Could you check that?

DR. ZABINSKI: Yes, no problem.

DR. REISCHAUER: It's not a problem if your spouse is on Medicare, too.

MS. ROSENBLATT: It is, if you're counting it two. If you're counting it as a per capita when it's really two.

DR. REISCHAUER: But presumably your spouse is in the denominator and a numerator with a zero, because you've paid her or his bill. But it's possible that it's people with younger spouses, which would be a big effect. Even 4 or 5 percent of the people could really...

DR. BRAUN: I just wanted to bring up, in the text in a couple of places we have -- I think on page three and page 10 -- researchers say out-of-pocket spending generally is not an obstacle to beneficiaries getting the care they need. That care they need, I'm presuming you're not thinking about prescription drugs, which I'm sure is one of the things for the out-of-pocket spending that really is a problem with access to care.

And I guess both of those places I wondered if we shouldn't make some reference to the fact that that does interfere with getting care.

DR. ZABINSKI: I really agree with that and I think there's some good -- for example, I think there's a good JAMA article to cite on that particular point.

DR. BRAUN: Thank you. The other thing I wondered is do you have any information on what percentage of federal poverty level gives you Medicaid benefits in the various states? Because I think a lot of people have the idea that you're on Medicaid if you're federal poverty level. And you're not on full Medicaid, you're on QMB. Or you can be on QMB, but you're not on full Medicaid. And I think a lot of people have the wrong idea on that. Really it's a much lower percentage than federal poverty

level that puts you on full Medicaid.

DR. ZABINSKI: We can add that. Just one other thought on that is that there's also these resource requirements that I don't think a lot of people think about when they're thinking about Medicaid eligibility. Maybe I can add that discussion in there, as well.

MR. HACKBARTH: Remind me, for QMB and SLIMB, are there any asset tests or are those just income?

DR. ZABINSKI: QMB there's an asset test, I know. I'm not sure about SLIMB.

MR. HACKBARTH: Jeanne, is there an asset test for both?

DR. LAMBREW: On Medicaid, to the question of eligibility, states do have an option to extend coverage, full Medicaid coverage to 100 percent of poverty. About 16 states have availed themselves of that option.

Otherwise, you're looking at the SSI levels, which is about 75 percent of poverty. So in the vast majority of states, you're only eligible for full Medicaid up to 75 percent of poverty unless you have high health care costs that impoverish you.

On the second question, yes, there is asset tests that are basically twice the SSI levels, which is $4,000 for a single and $6,000 for a couple. There are excluded things like a house and other expenditures that get excluded.

But Dan's absolutely right, if you just look at income, there are maybe one out of 10 people who may look eligible by income, but they get excluded because of assets.

MR. FEEZOR: Just a question. Dan, one of the exhibits that was attached to the paper had distribution of income across beneficiaries basically broken into $5,000 increments and then $40,000 and above. Is that a fairly static distribution? Or is that changing? In other words, do we have a different kind of Medicare or different, maybe a more affluent Medicare eligible coming on line? Is there any way of judging that up or down?

DR. ZABINSKI: I don't know. I have the information available to do that, but I don't know. My guess is that it's pretty static, but I'm not certain.

MR. FEEZOR: Static by the time you count cost of living and other issues?

DR. ZABINSKI: Yes, adjusted for price level differences between years.

MR. FEEZOR: And then the second question, on the last exhibit in the materials that was part of the overhead slides, the percentile of out-of-pocket spending by percentile rank in 1998. Fair interpretation would be that 75 and above, that's about 50 percent of the out-of-pocket spending?

DR. ZABINSKI: What are you looking at? Now that I have the diagram, what's your question?

MR. FEEZOR: If you drew a line at 75 and above, a rough interpretation would be about 50 percent then of the out-of-pocket spending occurs at 75 and above?

DR. ZABINSKI: Yes, that's about right.

MR. HACKBARTH: Any others?

Okay, since we are making a pretty significant change in focus here, why don't we take a five minute quick break.