Current Issues in Medicare

Stuart Guterman
Senior Program Director
Program on Medicare’s Future
The Commonwealth Fund

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Current Issues

• Update on Medicare Prescription Drug Benefit
• The Role of Private Plans in Medicare
• Specialty Hospitals and Hospital Payment Changes
• Physician Payment Issues
• Part B Premiums
Update on Medicare
Prescription Drug Benefit
HHS Estimates of Prescription Drug Coverage Among Medicare Beneficiaries, As of June 11, 2006

No identified source of creditable coverage
4.4 million (10%)

Creditable Employer/Union Coverage
10.4 million (24%)

Other creditable coverage
5.4 million (13%)

Dual eligibles in PDPs
6.1 million (14%)

Medicare Advantage (MA) drug plan*
6.0 million (14%)

Stand-Alone PDP
10.4 million (24%)

* Approximately 0.5 million dual eligibles are enrolled in MA drug plans and are reported in this category.

HHS Estimates of Eligibility and Participation in the Medicare Part D Low-Income Subsidy, As of June, 11 2006

Full/partial dual eligibles and SSI recipients automatically receiving low-income subsidies and enrolled in Part D plan

Eligible but not receiving subsidy and not enrolled in Part D plan*

Eligible for subsidy but estimated to have creditable coverage = 0.6 million (4%)

SSA-determined eligible receiving subsidy and enrolled in Part D plan

1.8 million (14%)

Partial duals and SSI

= 0.9 million (7%)

Eligible but not receiving subsidy and not enrolled in Part D plan*

3.3 million

(25%)

Full duals=

6.6 million

(50%)

Beneficiaries Eligible for Low-Income Subsidy = 13.2 Million

* Includes future anticipated facilitated enrollment of 0.1 million beneficiaries.

Low-Income Subsidies: The Asset Test

• As of May 26, 2006, SSA had found 1.8 million beneficiaries eligible for low-income subsidies and 2.3 million ineligible

• An earlier analysis performed by SSA of ineligible applicants indicated that 57 percent of them had excess resources, 32 percent had excess income, and 11 percent had both excess income and resources

• Rice and Desmond (2005) estimated that 2.4 million Medicare beneficiaries with incomes below 150% of poverty would not qualify for additional assistance in 2006 because of assets exceeding the eligibility threshold

Deductibles Offered by Medicare Stand-Alone Prescription Drug Plans, 2006 and 2007

2006
- $0: 58% of plans
- $250: 34% of plans
- $50-$100: 8% of plans

2007
- $0: 60% of plans
- $265: 31% of plans
- $120-$250: 3% of plans
- $50-$100: 6% of plans

Source: CMS, PDP Landscape of Local Plans Source File as of November 15, 2005 and as of September 26, 2006.

2006

- Restricted coverage: 13% of plans
- All drugs on formulary: 3% of plans
- No coverage: 84% of plans

2007

- Restricted coverage: 27% of plans
- All drugs on formulary: 3% of plans
- No coverage: 71% of plans

Source: CMS, PDP Landscape of Local Plans Source File as of November 15, 2005 and as of September 26, 2006.

<table>
<thead>
<tr>
<th>Plan Premium</th>
<th>2006</th>
<th>2007</th>
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<tbody>
<tr>
<td>Standard deductible and no coverage</td>
<td>$30.74</td>
<td>$27.74</td>
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<tr>
<td>$0 deductible and no coverage</td>
<td>$35.91</td>
<td>$31.90</td>
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<tr>
<td>$0 deductible and restricted coverage</td>
<td>$48.09</td>
<td>$50.31</td>
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<tr>
<td>$0 deductible and all drugs on formulary</td>
<td>$61.28</td>
<td>$99.65</td>
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Source: CMS, PDP Landscape of Local Plans Source File as of November 15, 2005 and as of September 26, 2006.
Part D: Current Policy Issues

• Monitoring implementation
• Enrollment of low-income beneficiaries
• Coordinating coverage with States
• Impact on most vulnerable beneficiaries
• Ensuring quality and effectiveness
The Role of Private Plans in Medicare
Percentage of Medicare Beneficiaries Enrolled in Medicare Advantage Plans

### Projected Payments to MA Plans in Excess of FFS Costs, 2007-2011

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td><strong>Benchmark Rates</strong></td>
<td>$2.7B</td>
<td>$3.1B</td>
<td>$3.4B</td>
<td>$3.7B</td>
<td>$3.9B</td>
<td>$16.8B</td>
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<tr>
<td><strong>BNRA Policy</strong></td>
<td>$2.0B</td>
<td>$1.4B</td>
<td>$0.9B</td>
<td>$0.2B</td>
<td>$2.2B</td>
<td>$6.7B</td>
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<tr>
<td><strong>PPO Stabilization Fund</strong></td>
<td>$1.0B</td>
<td>$1.1B</td>
<td>$1.2B</td>
<td>$1.3B</td>
<td>$1.4B</td>
<td>$6.0B</td>
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<tr>
<td><strong>Total</strong></td>
<td>$5.7B</td>
<td>$5.6B</td>
<td>$5.5B</td>
<td>$5.2B</td>
<td>$7.5B</td>
<td>$29.5B</td>
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Comparison of Estimated Out-of-Pocket Costs for Individuals in Poor Health in 2005, Selected MA Plans vs. Fee-for-Service

Out-of-Pocket Costs for Medicare Advantage Plan

Out-of-Pocket Costs for Medicare Fee-for-Service Plus Medigap Plan F

Medicare Advantage: Current Policy Issues

- Level of payment
- Risk adjustment
- Impact on beneficiaries
- Coordination of care for those with special needs
- Quality improvement
Specialty Hospitals and Hospital Payment Changes
Specialty Hospitals: A Problem or a Symptom?

• Concerns over specialty hospitals include: physician owners controlling flow of patients and avoiding patients who are uninsured or underinsured

• Two congressionally mandated reports examined specialty hospitals
  – The MedPAC report concluded that specialty hospitals tend to treat more profitable patients and fewer Medicaid patients than do community hospitals in the same market
  – The CMS report found that in most study sites, Medicare cardiac patients treated in cardiac specialty hospitals were less ill than those treated in community hospitals

• Congressional findings indicate a need to refine the accuracy of Medicare payment rates

• The controversy over specialty hospitals indicates a much broader problem with the health care financing system

Source: S. Guterman, "Specialty Hospitals: A Problem or a Symptom?" Health Affairs. 25(1). (January/February 2006): 95.
Proposed Changes to Hospital Payment

- Refine DRGs to more fully capture differences in severity of illness (20 new DRGs and 32 modified DRGs)
- Move from charge-based to cost based DRG relative weights (3-year phase-in)
- Base weights on national average of hospitals’ relative values in each DRG (no change)
- Adjust relative weights to account for difference in prevalence of outlier cases (no change)
- Interpretation of EMTALA obligations
## Distribution of Changes in Estimated Medicare Payments, FY 2006 to FY 2007

<table>
<thead>
<tr>
<th>Percent change in PPS payments</th>
<th>Number of hospitals affected</th>
<th>Proposed rule</th>
<th>Final rule</th>
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<tbody>
<tr>
<td>Decrease 10%+</td>
<td></td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Decrease 5-10%</td>
<td></td>
<td>31</td>
<td>4</td>
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<tr>
<td>Decrease 1-5%</td>
<td></td>
<td>140</td>
<td>41</td>
</tr>
<tr>
<td>Decrease &lt;1%</td>
<td></td>
<td>106</td>
<td>30</td>
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<tr>
<td>Increase &lt;1%</td>
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<td>144</td>
<td>98</td>
</tr>
<tr>
<td>Increase 1-5%</td>
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<td>831</td>
<td>2711</td>
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<tr>
<td>Increase 5-10%</td>
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<td>1733</td>
<td>609</td>
</tr>
<tr>
<td>Increase 10%+</td>
<td></td>
<td>523</td>
<td>99</td>
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</table>
Physician Payment Issues
Annual Increases in Physician Fees and SGR-Related Expenditures Per Fee-for-Service Beneficiary, 1998-2005

Source: Letter to Glenn M. Hackbarth, Chair, Medicare Payment Advisory Commission, from Herb B. Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, dated April 7, 2006.
Annual Rates of Increase in Physician Fees and SGR-Related Expenditures Per Fee-for-Service Beneficiary, 1997-2001 and 2001-2005

Source: Letter to Glenn M. Hackbarth, Chair, Medicare Payment Advisory Commission, from Herb B. Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, dated April 7, 2006.
Are We Getting What We Pay For? Are We Paying For What We Want?

- Sustainable Growth Rate (SGR) mechanism offers no control over the volume and intensity provided by the individual physician
- Increasing physician payment would raise the Part B premium, placing more of a burden on beneficiaries
- Quality and coordination of care are lacking in the U.S. health care system; therefore, we must pay more attention to what we get for our money
- P4P initiatives show promise, but must be carefully designed and implemented
- Cost and quality should be evaluated together and on a broader basis than individual services or providers
- Changes to payment policy should be evaluated for their long-term impact

Medicare Physician Group Practice Demonstration

- The Everett Clinic (WA)
- Deaconess Billings Clinic
- Park Nicollet Health Services (MN)
- Marshfield Clinic (WI)
- St. John’s Health System (MO)
- Univ. of Michigan Faculty Group Practice
- Geisinger Health System (PA)
- Forsyth Medical (NC)
- Middlesex Health (CN)
- Dartmouth-Hitchcock Clinic

- 10 physician group practices
- 3-year project, began April 2005
- Bonus pool based on savings relative to local area
- Practices expected to save 2%, keep up to 80% of additional savings
- Actual bonuses depend on savings and quality targets

Improvement in Doctors’ Cervical Cancer Screening Rates Compared to Bonus Payments After Implementation of Quality Incentive Program

Current Factors Affecting Physicians’ Compensation

- **Productivity/Billing**: 58% Major Factor, 14% Minor Factor, 27% Not a Factor
- **Board Re-Certification Status**: 11% Major Factor, 28% Minor Factor, 60% Not a Factor
- **Measures of Clinical Care**: 8% Major Factor, 19% Minor Factor, 72% Not a Factor
- **Patient Surveys/Experience**: 8% Major Factor, 19% Minor Factor, 72% Not a Factor
- **Quality Bonus/Incentive Payments from Insurance Plans**: 4% Major Factor, 15% Minor Factor, 80% Not a Factor

Part B Premiums

Source: Board of Trustees, Federal HI and Federal SMI Trust Funds, 2006 Annual Report.
## Income-Related Part B Premiums in 2007

<table>
<thead>
<tr>
<th>Beneficiary Income (Proportion of Beneficiaries)</th>
<th>Premium</th>
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<tbody>
<tr>
<td>&lt;$80,000 (96.2%)</td>
<td>$93.50</td>
</tr>
<tr>
<td>$80,000-$100,000 (1.3%)</td>
<td>$105.80</td>
</tr>
<tr>
<td>$100,000-$150,000 (1.2%)</td>
<td>$124.40</td>
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<tr>
<td>$150,000-$200,000 (0.5)</td>
<td>$142.90</td>
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<tr>
<td>&gt;$200,000 (0.8%)</td>
<td>$161.40</td>
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