Medicare: Implications of Recent Changes for Future Retirees

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Medicare Strengths and Challenges

- Half of the elderly uninsured before Medicare. Gains in life expectancy and improved quality of life
- National program; near universal participation
- Elderly one of few groups where U.S. health and percent poor compares well internationally
- Compared to private insurance for under 65 population
  - Higher rates of satisfaction; fewer access problems
  - 30 year record on costs: outperforms private insurance
  - Low administrative costs
- Yet benefit gaps and rise in medical care costs put beneficiaries and Trust Fund at risk
Medicare Bill

• Prescription drug coverage

• Structural change
  – Increased role for private plans: PPO, HMO and new drug only plans.
  – Divides up Medicare risk pool
  – Premium support demos
  – Potential increased beneficiary liability

• Health savings accounts
Prescription Drug Coverage Begins 2006

- **Benefit:** Voluntary, optional Part D coverage
  - Average premium $35 per month. $58 in 2013
  - $250 deductible
  - 75% coverage from $250 to $2,250
  - Gap: No coverage between $2,250-$5,100
  - 95% coverage above $5,100 ($3,600 out-of-pocket)
  - Premiums, coinsurance/size of gap, formularies can vary by plan. “Actuarial equivalent”
  - Deductible and cost sharing thresholds indexed to increase with drug spending

- Free standing “drug only” plans or HMO, PPO. No Medigap drug coverage allowed

- Subsidies for employer retiree RX coverage

- Low income subsidies premium/cost-sharing for beneficiaries with incomes below 150% poverty
Prescription Drug Benefit 2006: Beneficiary Cost Sharing

- $420 estimated annual premium
- Average spending in 2006 = $3,160
- About one-third of beneficiaries have drug expenses under $1,000
- About one-fifth of beneficiaries have drug expenses over $5,000
Employer Retiree Plans

• New benefit much worse than employer retiree plans covering about 13 million beneficiaries
• Retiree plans subsidies—28% payment for drug costs between $250 & $5000.
• Employers can provide premium and cost-sharing assistance
• Employer contributions do not count toward out-of-pocket calculation for catastrophic threshold
• Long term downward trend in retiree health coverage
Structural Change: Privatization

• Stand-alone private drug plans. 15 regions with two or more plans.

• Subsidies to HMOs and PPOs (in 2006) above Medicare payment levels
  – PPO encouraged. $10 billion stabilization fund plus extra payments to attract plans

• Premium support demonstration in 2010. Move from defined benefit toward defined contribution

• Could leave those in traditional Medicare paying more if risk pool is older and sicker

• History of M+C unstable and failure to yield savings.
Before Reform: Projected Out-of-Pocket Health Care Spending as a Share of Income, 2000 and 2025

- All Elderly: 22% in 2000, 30% in 2025
- Poor Health, Medicare Only*: 44% in 2000, 63% in 2025
- Age 65-74, High Income: 6% in 2000, 8% in 2025
- Low-Income Women Age 85+, Poor Health: 52% in 2000, 72% in 2025

* No insurance beyond Medicare basic benefits

1999 Study Estimates of Out-of-Pocket Costs for “Average” Medicare Beneficiary in Traditional Medicare as a Share of Income Under Premium-Support Options, 2025

Implications for Future?

• **RX benefit uncertain:**
  - Relief from RX costs IF drug plans emerge AND beneficiaries participate

• **Health savings accounts:** new tax shelter. More likely for more affluent.

• **Private plans**
  - Divide Medicare risk pool
  - Potential to increase beneficiary out of pocket liability.

• **Structural change could dilute power of Medicare to assure access or leverage system change.**