“Medicare in the New Millennium”

San Antonio Association of Health Underwriters

August 26, 2015
Under federal law, it is the employer’s responsibility to annually inform its insurer or third-party administrator, such as Blue Cross and Blue Shield of Texas, of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. In the absence of employer-provided employee counts, the Centers for Medicare and Medicaid Services requires that the employer’s group health plan coverage be considered primary to Medicare.
Agenda

- Overview of Current Medicare Expenses
- Med Sup and Medicare Advantage Enrollment
- Retiree Plans
- Employer Group Waiver Plans
- COBRA issues
- Providers and Network Trends

(Agenda continued next slide)
Agenda

• Star ratings
• Financing Medicare
• IRMAA
  – Income Related Monthly Adjustment Amounts
• Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
Medicare spending is projected to grow at a slower rate between 2013 and 2022.

### Exhibit 3

#### Net Medicare Spending, 2010-2024

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual Net Outlays</th>
<th>Projected Net Outlays</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$446</td>
<td>$512</td>
</tr>
<tr>
<td>2011</td>
<td>$480</td>
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<tr>
<td>2012</td>
<td>$466</td>
<td>$563</td>
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<tr>
<td>2013</td>
<td>$492</td>
<td>$570</td>
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<tr>
<td>2014</td>
<td>$512</td>
<td>$579</td>
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<tr>
<td>2015</td>
<td>$524</td>
<td>$641</td>
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<tr>
<td>2016</td>
<td>$563</td>
<td>$686</td>
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<tr>
<td>2017</td>
<td>$570</td>
<td>$736</td>
</tr>
<tr>
<td>2018</td>
<td>$579</td>
<td>$821</td>
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<tr>
<td>2019</td>
<td>$641</td>
<td>$839</td>
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<tr>
<td>2020</td>
<td>$686</td>
<td>$858</td>
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<tr>
<td>2021</td>
<td>$736</td>
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<td>2022</td>
<td>$821</td>
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<tr>
<td>2023</td>
<td>$839</td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>$858</td>
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#### Share of Federal Outlays

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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP</td>
<td>3.0%</td>
<td>3.1%</td>
<td>2.9%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.8%</td>
<td>2.8%</td>
<td>2.9%</td>
<td>3.0%</td>
<td>3.1%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Federal Outlays</td>
<td>12.9%</td>
<td>13.3%</td>
<td>13.2%</td>
<td>14.2%</td>
<td>14.5%</td>
<td>13.9%</td>
<td>14.0%</td>
<td>13.6%</td>
<td>13.2%</td>
<td>13.8%</td>
<td>14.0%</td>
<td>14.3%</td>
<td>15.0%</td>
<td>14.7%</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

NOTE: All amounts are for federal fiscal years; amounts are in billions and consist of Medicare spending minus income from premiums and other offsetting receipts.

Medicare as a Share of the Federal Budget, 1980 - 2020

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare Spending (in billions)</th>
<th>Federal Spending (in billions)</th>
<th>Medicare as a Share of the Federal Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>$34</td>
<td>$591</td>
<td>5.8%</td>
</tr>
<tr>
<td>1990</td>
<td>$107</td>
<td>$1,253</td>
<td>8.5%</td>
</tr>
<tr>
<td>2000</td>
<td>$216</td>
<td>$1,789</td>
<td>12.1%</td>
</tr>
<tr>
<td>2010</td>
<td>$520</td>
<td>$3,456</td>
<td>15.1%</td>
</tr>
<tr>
<td>2020</td>
<td>$889</td>
<td>$4,932</td>
<td>18.0%</td>
</tr>
</tbody>
</table>

**Source:** Historical spending for 1980 – 2010 from Congressional Budget Office (CBO) Budget and Economic Outlook: Historical Budget Data (January 2011); projected spending for 2020 from CBO Update to the Budget and Economic Outlook: Fiscal Years 2012 to 2022 (August 2012).
Medicare Enrollment, 1970 - 2030

Number in millions:

<table>
<thead>
<tr>
<th>Year</th>
<th>Historical</th>
<th>Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>20.4</td>
<td></td>
</tr>
<tr>
<td>1975</td>
<td>24.9</td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>28.4</td>
<td></td>
</tr>
<tr>
<td>1985</td>
<td>31.1</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>34.3</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>37.6</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>39.7</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>42.6</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>47.7</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>55.7</td>
<td>64.0</td>
</tr>
<tr>
<td>2020</td>
<td>73.2</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2030</td>
<td>81.0</td>
<td></td>
</tr>
</tbody>
</table>

Characteristics of the Medicare Population

Percent of total Medicare population:

- Per Capita Annual Income below $22,000: 50%
- Per Capita Savings below $53,000: 50%
- 3+ Chronic Conditions: 40%
- Fair/Poor Health: 27%
- Cognitive/Mental Impairment: 23%
- Under-65 Disabled: 17%
- 2+ ADL Limitations: 15%
- Age 85+: 13%
- Long-term Care Facility Resident: 5%

NOTE: ADL is activity of daily living.

Part B and Part D Out-of-Pocket Spending as a Share of Average Social Security Benefit

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2010</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Monthly Social Security benefit payment</td>
<td>$1,001</td>
<td>$1,151</td>
<td>$1,242</td>
</tr>
<tr>
<td>Average monthly out-of-pocket spending on Part B and Part D</td>
<td>$136</td>
<td>$299</td>
<td>$339</td>
</tr>
</tbody>
</table>

NOTE: SMI is Supplementary Medical Insurance. Out-of-pocket spending includes SMI (Part B and Part D) premiums and out-of-pocket cost-sharing expenses for SMI covered services.

Medicare Trustees Report projects large increase in Part B deductible

Medicare Trustees report was released last week with the news that the long-term outlook of Medicare has improved overall. In addition to the numbers and explanations for this improvement, there was one interesting piece of information found in the report that is of particular interest to Medicare Supplement carriers and seniors with traditional Medicare FFS.

Already been reported by several sources that Part B premiums are projected to increase by 52%, but hasn't yet been reported is that the same section of the report also projects that the Part B deductible will also increase by 52%. This could mean a double-whammy for many seniors who will end up paying a higher premium for their Part B coverage, and also end up paying more out-of-pocket costs in order to meet their deductible.

The projected increase in the Part B deductible also impacts Medicare Supplement carriers, and CSG is working with many of our clients to analyze what the impact will be to Medicare Supplement carriers for 2016, as well as how it translates to rate adjustments being filed here in the next several months.
The 2016 Part B deductible is projected to increase to $223 per year in 2016, which is up from $147 per year in 2015. The large projected increase in the Part B deductible is due in part to a projected increase in the Part B premiums (from $104.90 to $159.30 per month) which is caused by a harmless provision in the law and the expected 0% cost-of-living adjustment to Social Security. See in the chart below that this large of an increase has not been a common occurrence in recent years.
Exhibit 6

Solvency Projections of the Medicare Part A Trust Fund, 2005-2014

Year of Medicare Trustees Report


2020 2018 2019 2019 2017 2029 2024 2024 2026

### Exhibit 1

Medicare spending per beneficiary has been relatively flat in recent years

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Medicare spending (in billions)</th>
<th>Number of beneficiaries (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$445</td>
<td>45.2</td>
</tr>
<tr>
<td>2009</td>
<td>$487</td>
<td>46.3</td>
</tr>
<tr>
<td>2010</td>
<td>$510</td>
<td>47.4</td>
</tr>
<tr>
<td>2011</td>
<td>$531</td>
<td>48.5</td>
</tr>
<tr>
<td>2012</td>
<td>$551</td>
<td>50.5</td>
</tr>
<tr>
<td>2013</td>
<td>$566</td>
<td>51.9</td>
</tr>
<tr>
<td>2014</td>
<td>$580</td>
<td>53.7</td>
</tr>
</tbody>
</table>

NOTE: Medicare spending equals payments for benefits, net of recoveries from providers for improper payments, adjusted for shifts in the timing of capitated payments. Years are federal fiscal years, which run from October through September.

SOURCE: RAND/Kaiser Family Foundation analysis of Congressional Budget Office, actual Medicare benefit payments, various years. Medicare Trustees historical enrollment (through 2013) and projected for 2014 from the 2014 Medicare Trustees report (enrollees in the Hospital Insurance program).
Several questions remain unanswered

• What are the primary reasons for the recent slowdown in Medicare spending?
• How are delivery system reforms influencing the Medicare spending trajectory?
• Are the Medicare changes in the ACA having an even larger effect on spending than expected?
• Can the slowdown be sustained and can this be done without adversely affecting access to or quality of care?
Exhibit 1

Medicare as a Share of the Federal Budget, 2013

Social Security 23%

Medicare¹ 14%

Nondefense Discretionary 17%

Defense 18%

Net Interest 6%

Other² 14%

Medicaid 8%

Total Federal Outlays, 2013 = $3.5 Trillion
Net Federal Medicare Outlays, 2013 = $492 Billion

NOTE: All amounts are for federal fiscal year 2013. ¹Consists of Medicare spending minus income from premiums and other offsetting receipts. ²Other category includes spending on other mandatory outlays minus income from offsetting receipts.
Exhibit 2

Medicare Benefit Payments, 2013

- Medicare Advantage: 25%
- Hospital Inpatient Services: 24%
- Physician Payments: 12%
- Outpatient Prescription Drugs: 11%
- Hospital Outpatient Services: 6%
- Skilled Nursing Facilities: 5%
- Other Services*: 14%
- Home Health: 3%

Total Medicare Benefit Payments = $583 billion

NOTE: *Consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services; also includes the effect of sequestration on spending for Medicare benefits and amounts paid to providers and recovered.

Exhibit 4

Historical and Projected Average Annual Growth Rate in Medicare Per Capita Spending and Other Measures

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare per capita spending: 6.1%</td>
<td>Medicare per capita spending*: 4.0%</td>
</tr>
<tr>
<td>Private health insurance per capita spending: 6.5%</td>
<td>Private health insurance per capita spending: 4.9%</td>
</tr>
<tr>
<td>GDP per capita: 3.0%</td>
<td>GDP per capita: 3.7%</td>
</tr>
<tr>
<td>CPI: 2.4%</td>
<td>CPI: 2.1%</td>
</tr>
</tbody>
</table>

NOTE: *Assumes no reduction in physician fees under Medicare through 2022.

SOURCE: Kaiser Family Foundation analysis of Medicare spending data from Boards of Trustees and Congressional Budget Office (CBO); private health insurance spending data from the CMS National Health Expenditure data; GDP data from CBO and U.S. Census Bureau, and CPI data from the Bureau of Labor Statistics (historical) and CBO (projected).
On the Horizon: H.R. 2

- Passed by the House of Representative
- Prohibits beneficiaries eligible for Medicare in 2020 or later years from purchasing a Medigap policy that covers the Part B deductible
- Proposals that prohibit first-dollar Medigap coverage are projected to reduce Medicare spending
- Higher up-front costs are expected to result in beneficiaries using fewer services – both necessary and unnecessary services
Medicare Health Plans Trends

Who is enrolling in what type of plan?
Figure 1
Share of 65-year old Medicare Beneficiaries with a Medigap Policy or Enrolled in a Medicare Advantage Plan, 2000-2010

- Medigap enrollment
  - 2000: 27%
  - 2002: 32%
  - 2004: 35%
  - 2006: 28%
  - 2008: 24%
  - 2010: 21%

- Medicare Advantage enrollment
  - 2000: 15%
  - 2002: 10%
  - 2004: 10%
  - 2006: 15%
  - 2008: 20%
  - 2010: 19%

Total age 65
- 2000: 2.0 million
- 2002: 2.0 million
- 2004: 2.1 million
- 2006: 2.3 million
- 2008: 2.6 million
- 2010: 2.5 million

Medicare Supplement

- 11,000,000 Med Sups in force
- $24.3B in force premium
- Factors driving enrollment:
  - Baby Boomer impact
  - Funding reductions in Medicare Advantage
  - Employers: Removing Medicare aged retirees from their health plan

*Source: CSG Actuarial Research Paper, 2013*
Future of Medicare Advantage

• “I thought these plans were going away?”
  – 99.7% of all beneficiaries have access to a MA Plan
• Medicaid coordination will increase
• More mergers & acquisitions
• Emergence of Accountable Care Organizations
• Pay for performance
  – Star ratings
Medicare Advantage

- Enrollment in 2014 is 16,800,000
- 31% of overall Medicare enrollment
- Enrollment has tripled since 2005
- 64% are enrolled in HMO plans
- 87% are located in urban counties
Figure 1
Medicare Advantage Market Share of Five Firms Reported to Be Discussing Mergers

Total Medicare Advantage Enrollment, 2015 = 16.8 Million

NOTE: BlueCross BlueShield excludes Blue Cross and Blue Shield plans operated by Anthem.
## Total Medicare Private Health Plan Enrollment, 1999-2015

### In millions:

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment</th>
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</thead>
<tbody>
<tr>
<td>1999</td>
<td>6.9</td>
</tr>
<tr>
<td>2000</td>
<td>6.8</td>
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<tr>
<td>2001</td>
<td>6.2</td>
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<td>2002</td>
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<td>2006</td>
<td>6.8</td>
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<td>2007</td>
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<td>2008</td>
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<td>2014</td>
<td>15.7</td>
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<td>2015</td>
<td>16.8</td>
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</table>

### % of Medicare Beneficiaries:

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>18%</td>
</tr>
<tr>
<td>2000</td>
<td>17%</td>
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<td>2001</td>
<td>15%</td>
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<td>2014</td>
<td>30%</td>
</tr>
<tr>
<td>2015</td>
<td>31%</td>
</tr>
</tbody>
</table>

**NOTE:** Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.

**SOURCE:** Authors’ analysis of CMS Medicare Advantage enrollment files, 2008-2015, and MPR, “Tracking Medicare Health and Prescription Drug Plans Monthly Report,” 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.
Figure 2

Distribution of Enrollment in Medicare Advantage Plans, by Plan Type, 2015

- Traditional Fee-for-service Medicare: 69%
- Medicare Advantage: 31%
- HMO: 64%
- Local PPO: 24%
- Regional PPO: 7%
- PFFS: 2%
- Other: 3%

Total Medicare Advantage Enrollment, 2015 = 16.8 Million

NOTE: PFFS is Private Fee-for-Service plans, PPOs are preferred provider organizations, and HMOs are Health Maintenance Organizations. Other includes MSAs, cost plans, and demonstration plans. Includes enrollees in Special Needs Plans as well as other Medicare Advantage plans.
Figure 5

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2015

National Average, 2015 = 31%

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: Authors’ analysis of CMS State/County Market Penetration Files, 2015.
Medicare Advantage “SNPs”

Special Needs Plans may be sold year round

1. Dual Eligible (Medicare and Medicaid)
   - Account for only 10% of all Dual Eligible
   - Huge growth opportunity

2. SNP Chronic
   - 80% of all Medicare claims come from 20% of the beneficiaries
     - CHF, cardiovascular disease, diabetes

3. SNP Institutional Plans
Impact of MA Payment reductions

ACA reduces Medicare’s payment rates by $716,000,000,000

- $260B hospital services
- $66B home health services
- $39B skilled nursing services
- $17B hospice services
- $156B MA program
- $25B Disproportionate Share Hospital
- $114B Independent Payment Advisory Board
- $39B Other
Social Security & Medicare Taxes

• Funded by FICA taxes at 15.3% of “wages”
  – Paid 50/50 by employees and employers
• ACA increased FICA taxes by 0.9% (1-1-13)
  – On high-income taxpayers & on unearned income
  – Single filers $200,000+
  – Joint filers $250,000+
Retiree Plans

• 1 in 4 Medicare beneficiaries are currently enrolled in a retiree plan
• FASB issues tie up cash flow
• Elimination of Retiree Drug Subsidy Deduction
• Agent competition
  – Competing with large organizations and other direct to consumer marketing organizations like:
    • ExtendHealth.com
    • gobloomhealth.com
    • eHealthInsurance.com
    • AON
    • Towers Watson
Actively at Work Employees

• More people age 65+ cannot retire
• Some do not want to retire
• 2-19 life groups
  • remove the 65 year old workers off the group health plan
  • Find group health premium savings by using Medicare related products
  • Convert the savings to other insurance and financial products
“Egg Whips”

- Employer Group Waiver Plan
  - Series 800 (EGWP)
  - Series 900 (Prescription Drug Plan or Part D)

- EGWP is creditable Part D coverage

- EGWP Trust Open Enrollment Period
  - Year round sales, no “lock-in”
  - No agent certification required to sell!
What makes an EGWP different?

- Different rules apply to an EGWP:
  - Enroll first of any month throughout the year
  - Options for changes during the year
  - No “Scope of Appointment” necessary
  - No certification is required
Beware of COBRA Issues

• When a person leaves a group health plan, many things could go wrong:
  – When should they enroll in Part B?
    • Beware of the 8 month rule!
  – Open Enrollment Period mistakes
    • Don’t let March 31st slip by!
  – Part B penalty for late enrollment
  – Don’t overlook the dependents!
Medicare Opportunities & Issues

Narrow Networks
High Value Networks
Accountable Care Organizations
Stars Ratings
Market Value Based Purchasing

• ACA designed this concept to pay hospitals differently based on their performance of federal quality measures

• Has not proven effective in demonstration programs*
  – Results so far suggest this concept has produced less high quality care
  – Providers focusing on more care that is financially rewarding than on the patient’s needs

*Heritage Foundation, July 27, 2012
HVN (High Value Network)

Goal is to improve all aspects of care:

• Coordination of records
• More patient centered
• Proactive, timely & more efficient care
• Monitor nutrition
• Increased activity
• Reduce wasteful spending
• More preventive care
Accountable Care Organization

• What is an ACO?
  – Coordination of care between all providers

• Objective: lower costs by improving quality

• Accountability through a network of relationships

• Disease management & care coordination

• Transition from FFS to value based payments

• Currently over 200+ ACO Medicare Demonstration Projects in place
Lack of Sufficient Providers

- Aging population
  - Increased demand for health care
  - Greater number of insured
- PCP’s are paid less than Specialists
  - Lifetime earnings for Specialists $3.5 million more
- Funding cuts to teaching hospitals
  - limits number of residency programs
- Electronic Medical Records
  - Up to $50,000 per office to become compliant
Lack of Sufficient Providers

Projected Supply and Demand, Physicians, 2008–2020

- **Demand**—All Specialties
- **Supply**—All Specialties

**Shortage** = 91,500
CMS Star Ratings

- ★ = poor performance
- ★★ = below average performance
- ★★★ = average performance
- ★★★★ = above average performance
- ★★★★★ = excellent performance
CMS Star Ratings

Derived from four sources of data

1. CMS Administration data on plan quality and member satisfaction
2. CAHPS - Consumer Assessment of Healthcare Providers and Systems
3. HEDIS - Healthcare Effectiveness Data & Info Set
4. HOS - Health Outcome Surveys
Star Ratings

Nine individual quality measures

1. Staying healthy: screenings, tests, & vaccines
2. Managing chronic (long term) conditions
3. Drug plan customer service
4. Ratings of health plans responsiveness and care
5. Health plan member complaints and appeals
6. Drug pricing and patient safety
7. Health plan telephone customer service
8. Drug plan member complaints, members who choose to leave, & Medicare audit findings
9. Member experience with drug plan
Figure 13

Enrollment in Medicare Advantage Contracts, by Contracts’ Star Quality Rating, 2013-2015

- **2013**
  - 5 Stars: 37%
  - 4.5 Stars: 14%
  - 4 Stars: 7%
  - 3.5 Stars: 15%
  - 3 Stars: 20%
  - 2.5 Stars: 4%
  - No rating: 3%

- **2014**
  - 5 Stars: 32%
  - 4.5 Stars: 24%
  - 4 Stars: 20%
  - 3.5 Stars: 21%
  - 3 Stars: 13%
  - 2.5 Stars: 2%
  - No rating: 1%

- **2015**
  - 5 Stars: 25%
  - 4.5 Stars: 32%
  - 4 Stars: 21%
  - 3.5 Stars: 8%
  - 3 Stars: 4%
  - 2.5 Stars: 2%
  - No rating: 2%

**NOTE:** Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations. Totals may not add to 100% due to rounding. Less than 1% of enrollees were in plans with 2 stars in 2013 and 2014.

**SOURCE:** Authors’ analysis of CMS’s Landscape and Enrollment Files for 2013 – 2015.
Star rating bonus

Total bonus payments, 2012 = $3.1 Billion

- UHC 18%
- BCBS 13%
- Kaiser 12%
- Humana 12%
- Wellpoint 5%
- HealthSpring 3%
- Aetna 3%
- Health Net 2%
- Coventry 2%
- Others 30%

CMS’s performance data files are available at
http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp
How do we finance Medicare going forward?

What options do we have?
Aging Population

- 1965 Medicare was introduced
- Raise Medicare eligible age to 67?
- Aging population
  - Will be twice as many people age 65 by 2030
- Life expectancy increase since 1965
  - Female: 1965 = 73.8        2010 = 80.8 (+5.1 yrs)
  - Male:    1965 = 66.8        2010 = 75.7 (+8.9 yrs)

US Census Bureau 2012 Statistical Abstract
Income Related Monthly Adjustment Amounts

• “IRMAA”
  – (Based on single tax filing in 2013; double figures for joint filing)

• 2015 Standard Part B premium
  $104.90  <$85,000 Gross Income in 2013
  $146.90  ($85,000-$107,000)
  $209.80  ($107,000 - $160,000)
  $272.70  ($160,000-$214,000)
  $335.70  ($214,000+)
Income Related Monthly Adjustment Amounts

• 2015 Part D plan premium plus:
  - $12.30  ($85,000-$107,000)
  - $31.80  ($107,000 - $160,000)
  - $51.30  ($160,000-$214,000)
  - $70.80  ($214,000+)

"Linking producer to markets"
### Overview of Medicare Part B and Part D Premiums in 2015

<table>
<thead>
<tr>
<th>Income for single people</th>
<th>Standard Part B and Part D premiums</th>
<th>Part B and Part D income-related premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to $85,000</td>
<td>$105</td>
<td>$160,001 - $214,000</td>
</tr>
<tr>
<td>$85,001 - $107,000</td>
<td>$147</td>
<td>$160,001 - $214,000</td>
</tr>
<tr>
<td>$107,001 - $160,000</td>
<td>$210</td>
<td>$160,001 - $214,000</td>
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<tr>
<td>More than $160,000</td>
<td>$273</td>
<td>$160,001 - $214,000</td>
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<tr>
<td>More than $214,000</td>
<td>$336</td>
<td>$160,001 - $214,000</td>
</tr>
</tbody>
</table>

### Monthly 2015
- **Part B premium**
  - Up to $85,000: $105
  - $85,001 - $107,000: $147
  - $107,001 - $160,000: $210
  - $160,001 - $214,000: $273
  - More than $214,000: $336
- **Part D premium** (based on the national average)<sup>1</sup>
  - Up to $85,000: $33
  - $85,001 - $107,000: $45
  - $107,001 - $160,000: $65
  - $160,001 - $214,000: $84
  - More than $214,000: $104

### Share of Part B and Part D<sup>2</sup> program costs beneficiaries pay
- 25%
- 35%
- 50%
- 65%
- 80%

**NOTE:** Amounts rounded to nearest dollar. <sup>1</sup>Part D standard premium reflects the national average monthly premium (unweighted) across all stand-alone PDPs and Medicare Advantage drug plans. Part D income-related premiums reflect the national average premium plus the income-related monthly adjustment amount. <sup>2</sup>The Part D standard premium covers 25.5% of program costs.

**SOURCE:** Kaiser Family Foundation illustration of 2015 Medicare Part B and Part D premiums.
# Medicare Part B and Part D Income-Related Premiums Before and After 2018

<table>
<thead>
<tr>
<th>Income thresholds</th>
<th>Standard Part B and Part D premiums</th>
<th>Part B and Part D income-related premiums</th>
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</thead>
<tbody>
<tr>
<td>Up to $85,000</td>
<td>$85,001 to $107,000</td>
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<tr>
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<tr>
<td>$107,001 to $133,500</td>
<td>More than $214,000</td>
<td></td>
</tr>
</tbody>
</table>

- **% of Part B/D costs paid...**
  - **...before 2018**
    - 25%
    - 35%
    - 50%
    - 50%
    - 65%
    - 80%
  - **...starting in 2018**
    - 25%
    - 35%
    - 50%
    - 65%
    - 80%

**NOTE:** Amounts rounded to nearest dollar. 

1. Part D standard premium reflects the national average monthly premium (unweighted) across all stand-alone PDPs and Medicare Advantage drug plans. Part D income-related premiums reflect the national average premium plus the income-related monthly adjustment amount.

2. The Part D standard premium covers 25.5% of program costs.

**SOURCE:** Kaiser Family Foundation illustration of 2015 Medicare Part B and Part D premiums.
Figure 4

Distribution of Medicare Part B Enrollees By Part B Premium Percentage in 2015

- Part B standard premium (25% of program costs):
  - 47.9 million (94%)
  - 2.9 million (6%)

Number and share of beneficiaries paying Part B income-related premiums:
- 1.1 million (2%)
- 0.9 million (2%)
- 0.3 million (1%)
- 0.5 million (1%)

Total Number of Medicare Part B Enrollees, 2015: 50.8 million

NOTE: 1Income thresholds are for single beneficiaries; for married couples, thresholds are twice the amounts shown.
Figure 5

Historical and Projected Number of Medicare Beneficiaries Paying Part B Income-Related Premiums, 2007-2017

Income-related premium percentage and income thresholds¹:

- 35% ($85,001-$107,000)
- 50% ($107,001-$160,000)
- 65% ($160,001-$214,000)
- 80% (>214,000)

In millions:

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<td>0.68</td>
<td>0.61</td>
<td>0.74</td>
<td>0.84</td>
<td>0.96</td>
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<td>0.21</td>
<td>0.21</td>
<td>0.21</td>
</tr>
</tbody>
</table>

NOTE: ¹Income thresholds are for single beneficiaries; for married couples, thresholds are twice the amounts shown.

Doc Fix is Fixed

- Sustainable growth rate was used to determine payment increases for physician services in Medicare
- The SGR was removed early 2015
- New plan is to reward docs based on results
- Discourages docs not to run unnecessary tests
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- a new law to repeal and replace Medicare’s Sustainable Growth Rate (SGR) formula for physician payments
- includes a provision to increase Medicare premiums for some higher-income beneficiaries to help offset the cost of the law
  - by $34.3 billion between 2018 and 2025
Hospital Readmissions

• Starting in fiscal year 2013, lower reimbursement under the ACA begin for readmissions

• Medicare Payment Advisory Commission:
  – 2/3rds of all readmits are avoidable
  – Average $7,200 per readmit; $15B per year problem

• CMS to withhold a % of payment
  – 1% in 2013
  – 2% in 2014
  – 3% in 2015 and thereafter
Role of the Agent

- As more changes take place, life becomes more complicated, increasing the need for advice
- Agents, brokers, & private companies to sell coverage on the exchange to individuals and employers through privately-run websites
- MA plans are a good example of what the agent’s role may be in health insurance exchanges
- Be prepared: adapt, survive and thrive
Questions?

Congrats on your new chapter!
Thank you STAHU!