National Journal LEADERSHIP COUNCIL

Medicare Primer

An Overview of the Current State of Medicare and Possible Reforms

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Who Is On Medicare?

Medicare Beneficiaries by Age, Demographics, and Poverty Level

Medicare Eligibility Details:

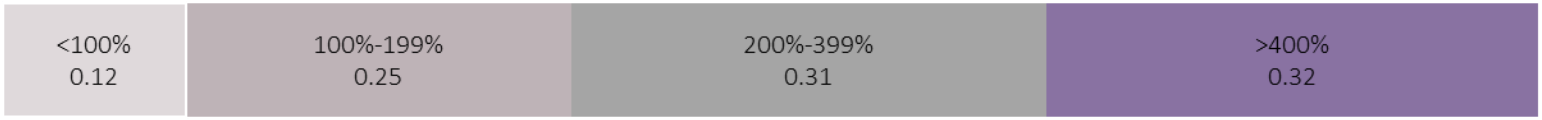
- US citizens who are 65 and older, lived in the US for at least 5 years, and worked at least 10 years in Medicare-covered employment are eligible for Medicare with benefits for both part A and part B.
- Citizens under 65 can qualify for Medicare if they have end stage renal disease (ESRD), Amyotrophic Lateral Sclerosis (ALS), or received Social Security Disability Income for 24 months.

**Medicare by Gender: 45% Male, 55% Female*

Medicare by Demographics

Medicare by Age

Medicare by Federal Poverty Level



Sources: "2015 Employer Health Benefits Survey", Kaiser Family Foundation, September 22, 2015; "Distribution of Medicare Beneficiaries by Race/Ethnicity" Kaiser Family Foundation, April 18, 2016; "Medicare Beneficiary Demographics", MedPac, June 2015.

Coupled Together, Medicare Parts A & B are Often Referred to as 'Original Medicare'

Costs and Services of Medicare Parts A and B

Part A – Inpatient/Hospital Coverage

What Does It Cover?

- Part A will cover health care costs once admitted to a hospital for a period of more than two midnights
- If one doesn't qualify for part A coverage, the insurance can cost as much as $407 per month

Services Include:

- Hospital care
- Skilled nursing facility care
- Hospice and home health services

How Much Does It Cost?

- The first 60 days are fully covered by Medicare after a deductible of $1,260 (rate in 2015)
- After 60 days, patients pay $315 per day in co-insurance, and then $630 per day beyond 90 days for 60 lifetime reserve days. After they are used up, Medicare pays nothing.

Part B – Outpatient/Doctor Coverage

What Does It Cover?

- Part B is insurance for regular health care visits and needs.
- It covers most medically necessary doctors' services, preventive services, hospital outpatient services, laboratory tests, physical and occupational therapy, ambulance services, and more

How Much Does It Cost?

- Part B has an attached premium, which depends on your income bracket. The higher your income, the higher your premium, which ranges from $104 to $360 per month.

What Isn't Covered in A or B

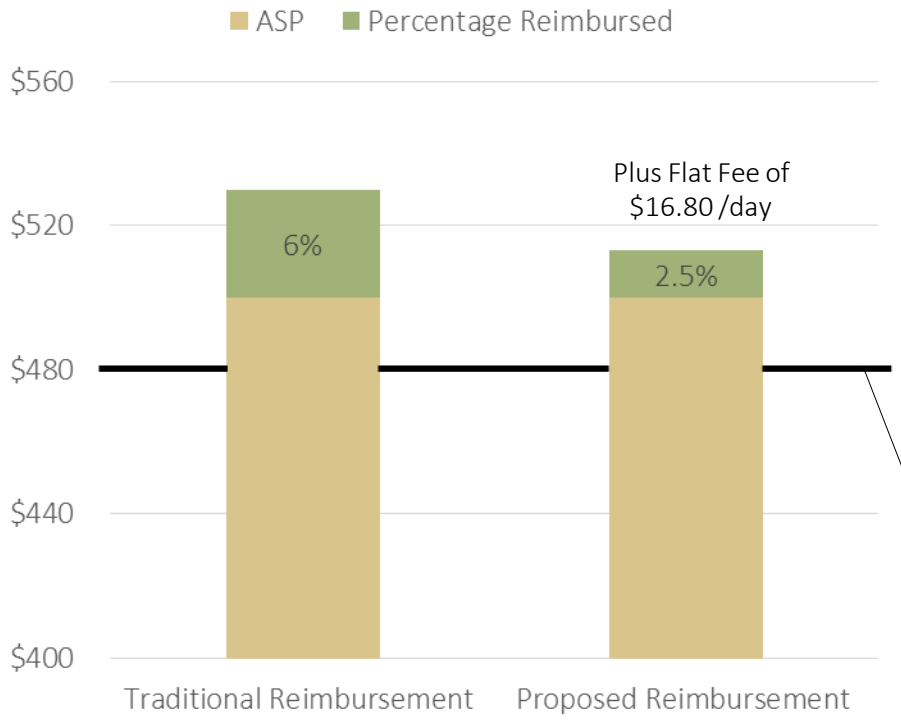
- Out-of-country medical care
- Hearing, vision, dental, or podiatric care
- Cosmetic surgery
- Alternative treatments
- Custodial care (No assisted living without medical necessity)

Sources: "The Four Parts of Medicare", Universal American, April 19, 2015; Sean Williams, "Surprise! 10 Services Medicare Part A and Part B Probably Wont Cover," The Motley Fool, April 17, 2016; Tom Campbell, What does Medicare Part A Cover?" The Motley Fool, April 19, 2016; Sergey Demushkin, Wojciech Zasina, Noun Project, May 9, 2015; Dan Caplinger, "Heres What Medicare Part B Costs and Covers in 2016," The Motley Fool, January 18, 2016.

Proposed Part B Change Would Cut Reimbursement For Drugs Costing More than $480/Day

Proposed Medicare Part B Payment Rule

On March 8, 2016 the Centers for Medicare and Medicaid Services (CMS) proposed a new pricing model aimed at lowering physician-administered drug costs and reducing financial incentives for prescribing more expensive drugs under Medicare Part B



Analysis

- CMS Innovation Center plans to perform an experiment to see whether lowering the percentage reimbursement for higher cost drugs will encourage physicians to prescribe cheaper alternatives.
- Under the proposal, about half of physicians who administer Part B drugs would be reimbursed according to the traditional model, or 106% of the drug's **average sales price (ASP)**, while the other half would be paid 102.5% of the ASP plus an additional flat fee of $16.80 /drug/patient /day

$480

According to analysis by Avalere Health, $480 is the tipping point for reimbursement under the new rule – drugs that cost providers more than $480 per day would result in lower reimbursement, whereas drugs costing less would receive higher payments

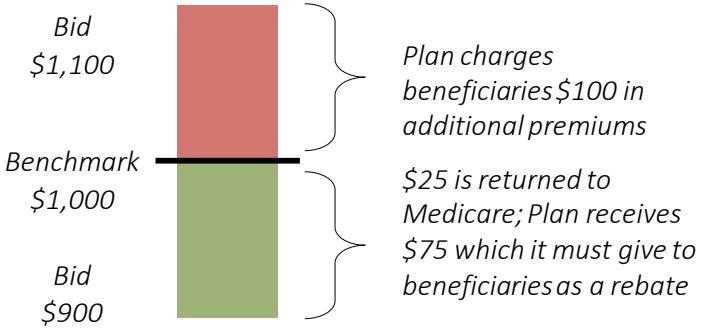
Sources: Fauzea Hussain and Adam Borden, "Proposed Medicare Part B Rule Would Reduce Payments to Hospitals and Some Specialists, While Increasing Payments to Primary Care Providers," Avalere Health, April 7, 2016; Gregory Twachtman, "Medicare Part B Drug Payment Proposal Could Cost Some Doctors," Family Practice News, April 9, 2016.

Medicare Part C (Medicare Advantage) Allows Beneficiaries to Receive Medicare Benefits Through Private Insurers

Overview of Medicare Part C (Medicare Advantage)

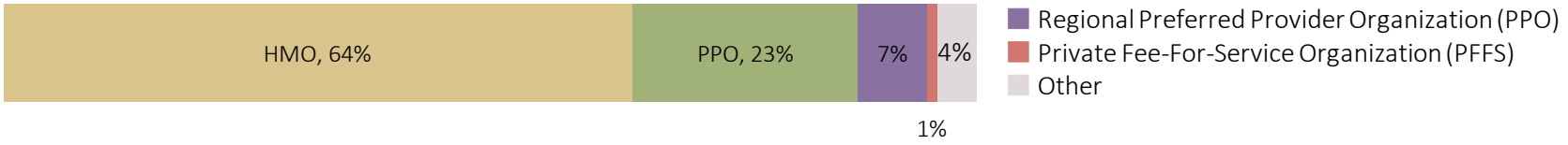
- Since 1972, Medicare beneficiaries have had the option to choose a private insurer to receive their benefits (Medicare Part C); in 2003, this program was officially renamed Medicare Advantage (MA).
- Initially, the program produced savings for the government, however access to increased benefits through MA plans led to an imbalance in payments. For example, in 2009, Medicare paid private plans 14% more per beneficiary than for traditional Medicare.
- To address this imbalance, the Affordable Care Act reduces payments to Part C plans over time, and requires plans to maintain a medical loss ratio of at least 85%, meaning that MA plans must spend at least 85% of premium revenues on medical costs

How Medicare Advantage Plans Are Paid: The Bidding System



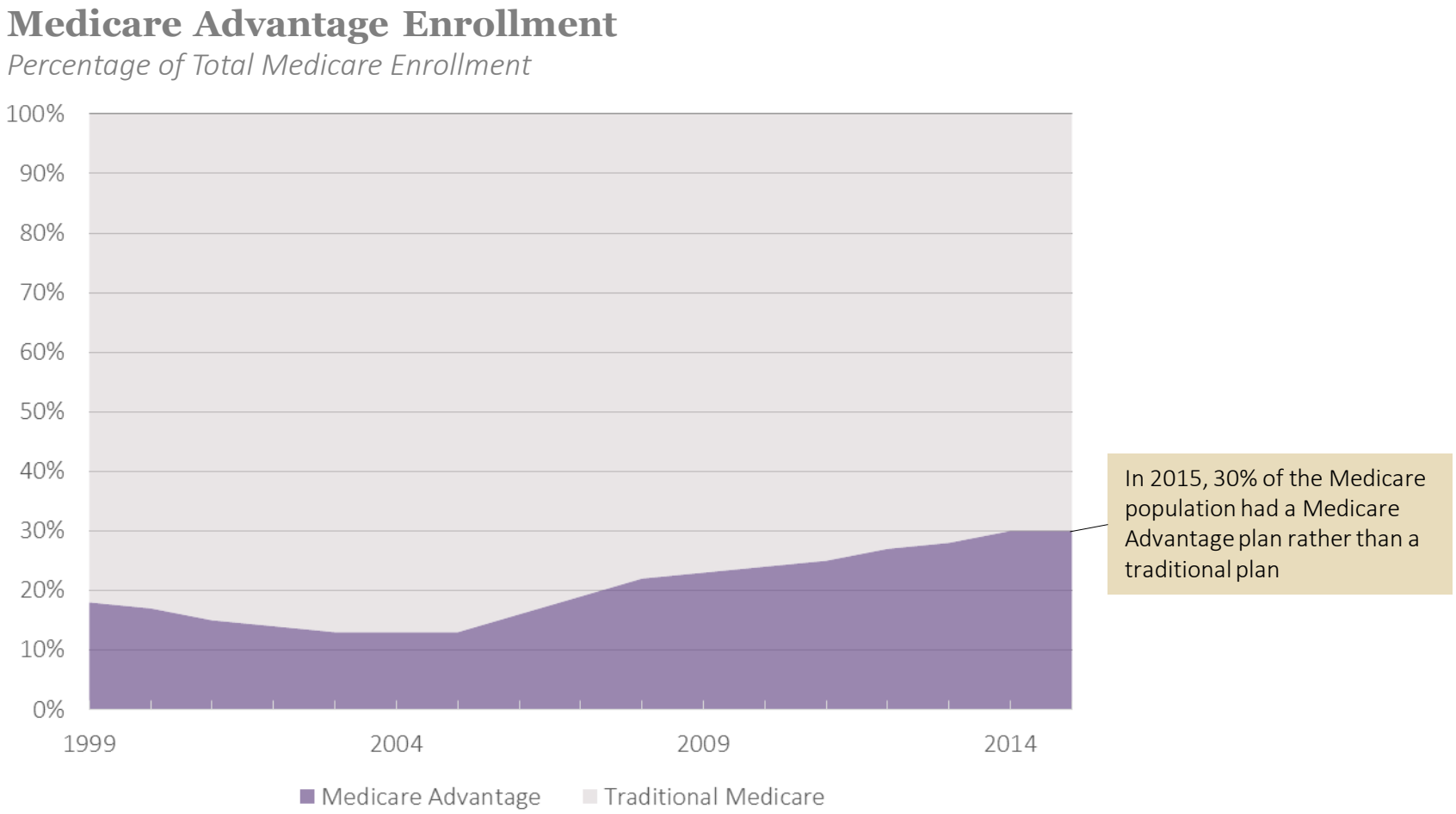
- Since 2006, Medicare has paid plans under a bidding process: plans submit bids based on estimated costs per enrollee for services under Medicare parts A and B
- Bids are compared to benchmark amounts that are the maximum amount Medicare will pay a plan in a given area
- If a plan's bid is higher than the benchmark, enrollees pay the difference, whereas if the bid is lower than the benchmark, the plan and Medicare split the difference

Breakdown of Types of Medicare Advantage Plans



Sources: HCFO, "Learning from Medicare: Medicare Advantage", Changes in Health Care Financing & Organization, August 2011; "Medicare Advantage" Kaiser Family Foundation, June 29, 2015.

Medicare Advantage Is Increasing as a Share of the Medicare Population

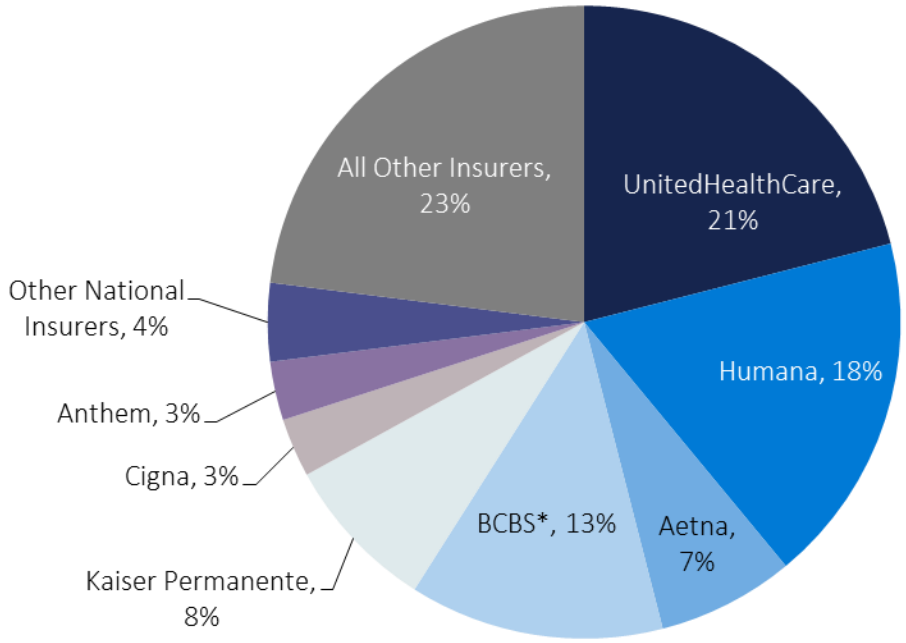


Sources: HCFO, "Learning from Medicare: Medicare Advantage", Changes in Health Care Financing & Organization, August 2011; "Medicare Advantage" Kaiser Family Foundation, June 29, 2015.

Medicare Advantage Enrollment is Highly Concentrated Among Small Number of Insurers

Medicare Advantage Enrollment, by Firm or Affiliate, 2016

Total Medicare Advantage Enrollment, 2016 = 17.6 Million



Notes: BCBS are BlueCross and BlueShield affiliates, excluding Anthem BCBS plans; Other national insurers include Wellcare, Centene, and Universal American; All other insurers includes firms with less than 2% of total MA enrollment

Sources: Gretchen Jacobson, Giselle Casillas, Anthony Damico, Tricia Neuman, and Marsha Gold, "Medicare Advantage 2016 Spotlight: Enrollment Market Update," Kaiser Family Foundation, 2016.

Administration Finalizes Changes to Medicare Advantage, But With Two-Year Transition Period

Overview of Medicare Advantage (MA)

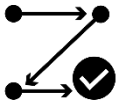
Medicare Advantage Plans (MA) and Risk Scores

- MA is the private managed-care version of Medicare: the government pays health plans monthly amounts for every member they cover
- These payments are adjusted based on how sick someone is, and members who have more chronic conditions have higher risk scores and plans that cover them receive higher payments

Details of April 2016 CMS Medicare Advantage Announcement

MA Payment Rates Raised Less than Expected:

- In 2017, the U.S. government will pay U.S. health insurers who provide MA plans to elderly and disabled Americans about 0.85% more on average than in 2016
- This is less than the 1.35% increase HHS proposed in February



Cuts to Employer-Sponsored MA plans to be Phased In Over Two Years:

- Despite intense lobbying efforts from insurers, unions, and trade groups, CMS decided to decrease payments to employer-based MA plans; however, these cuts will be phased in over a two-year period rather than immediately
- Medicare currently uses a complex bidding-benchmark process to pay for MA plans - CMS will terminate the bidding process for Employer Group Waiver Plans (EGWPs) and instead use predetermined payments that effectively lowers revenue
- In 2017, half of employer MA plans will be based on their own bids and the other half will be based on county benchmarks – by 2018, the policy will be in full force

Scale Back Shift to Use Encounter Data to Determine Risk Scores:

- For 2017, 75% of MA risk scores will be based on traditional fee-for-service data and 25% will be based on encounter data that more closely track with medical claims; previously, CMS expected the split for 2017 to be 50/50
- By 2020, all MA risk scores will be based on encounter data

Sources: Mary Ellen McIntire, "After Intense Lobbying, Administration slows Retiree Health Plan Changes," Morning Consult, April 4, 2016; Caroline Humer, "US to Raise Payments to Insurers for Medicare Advantage 2017 Plans," Reuters, April 4, 2016; Bob Herman, "Final Medicare Advantage Rates Largely Shun Health Plan Lobbying," Modern Healthcare, April 4, 2016; Noun Project, Peipei Feng.

Medicare Part D Coverage Gap Still Gaping, Getting Smaller by 2020

Overview of Medicare Part D

What Does it Cover?

- Implemented in 2006, Medicare Part D is a voluntary outpatient prescription drug benefit for Medicare beneficiaries

What Drugs are Included?

- Plan formularies must include drug classes covering all disease states, and at least 2 distinct drugs in each class, and must cover all drugs in six 'protected' classes (Immunosuppressants, Antidepressants, Antipsychotics, Anticonvulsants, Antiretrovirals, and Antineoplastics)

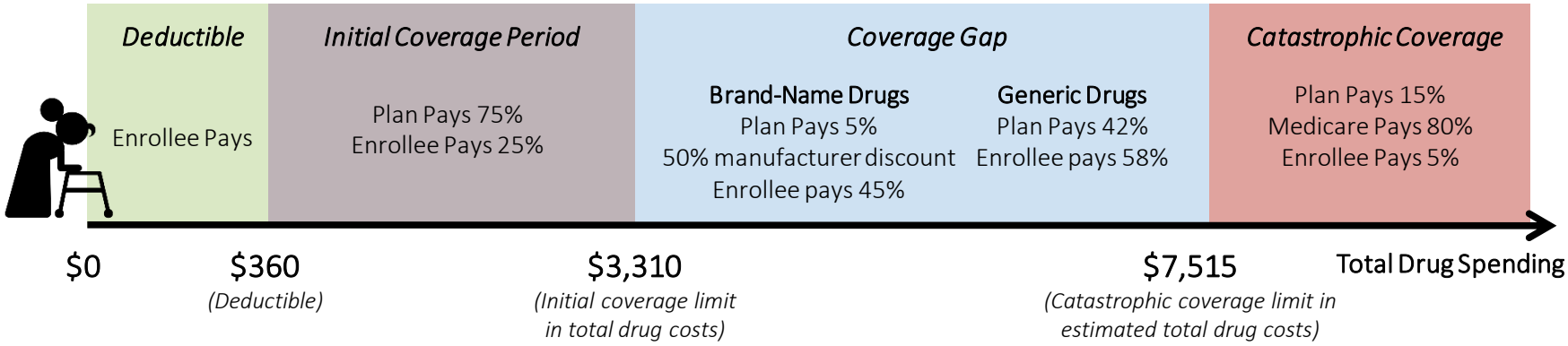
What Kinds of Plans are Offered?

- The federal government approves private plans for Part D, which come in two forms:
  1) stand-alone prescription drug plans (PDP) that supplement traditional Medicare and
  2) 2) Medicare Advantage prescription drug plans (MA-PD)

How Much Does it Cost?

- Part D includes a monthly premium, which varies across plans, regions and income levels
- Plans must offer a defined "standard benefit" (pictured below) or an alternative equal in value, and can provide enhanced benefits
- The ACA gradually decreases the amount of out-of-pocket spending in the coverage gap; Medicare will phase in additional subsidies, ultimately reducing the beneficiary coinsurance rate to 25% by 2020

Structure of Standard Medicare Part D Benefit in 2016



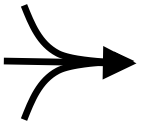
Sources: "The Medicare Part D Prescription Drug Benefit," Kaiser Family Foundation, October 13, 2015; Jack Hoadley, Juliette Cubanski, Tricia Neuman, "Medicare Part D at 10 Years: The 2015 Marketplace and Key Trends 2006-2015", Kaiser Family Foundation, October 5, 2015; Elizabeth Hargrave et al. "Drugs on Specialty Tiers," NORC at the University of Chicago, February 23, 2009; Noun Project, Anushay Qureshi.

MedPAC Approves Part D Package Recommendations, Potentially Saving the Program $10 Billion Over 5 Years

MedPAC Outlines Pay Overhaul and Backs Part D Changes, to be Sent to Congress in the Commission's June 2016 Report:

Shift Risk to Plan Sponsors

Currently, once a beneficiary exceeds $7,500 in costs, plans are responsible for 15% of the cost to Medicare's 80%. MedPAC recommends that once the patient exceeds the limit, plans would assume 80% of the costs. This proposal is meant to incentivize plans to better manage drug spending



Increased Flexibility for Sponsor Plans

For the benefit of plan sponsors, MedPAC recommends streamlining the process for formulary changes. Additionally they will allow the creation of tiers of preferred and non preferred drugs, as well as a split fill program, which allows patients to try drugs for periods of less than a month when gauging their tolerance.

Reduce cost-sharing for low-income subsidy beneficiaries

MedPAC recommends eliminating or lowering co-pays for generic drugs for low-income subsidy beneficiaries

Coverage Gap (Donut Hole)

Widen Coverage Gap to Increase Beneficiary Cost Sharing for Most Expensive Drugs

MedPAC recommended to not include the value of a manufacturer rebate against a beneficiary's out of pocket (OOP) expenses while in the coverage gap (donut hole). This would increase time spent in the coverage gap, increase beneficiary's cost sharing, and therefore encourage beneficiaries to switch to generics. According to estimates, 50% of beneficiaries who currently reach the catastrophic coverage benefit would not do so under this change

Change in Protected Classes of Drugs

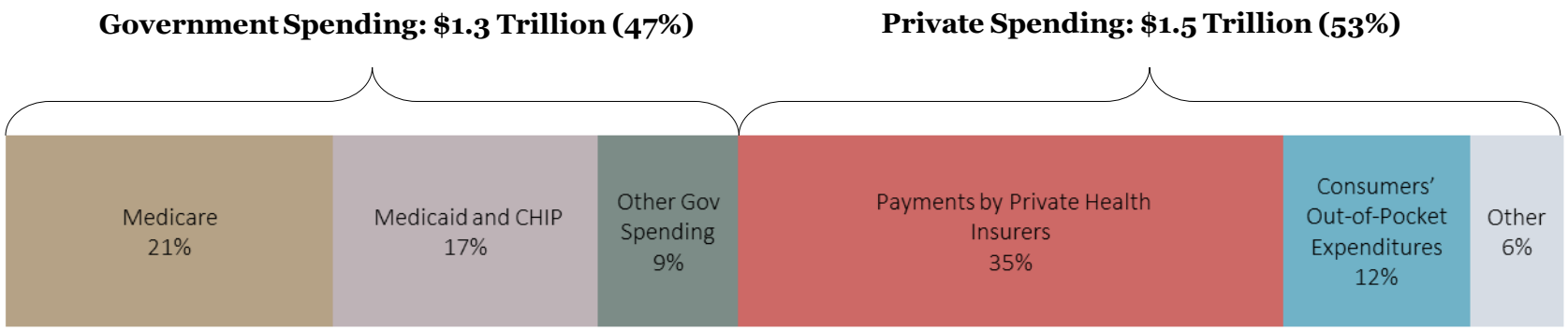
Perhaps the most controversial of the proposed changes, MedPAC proposed to remove anti-depressant and immunosuppressants for transplant rejection from the protected classes of drugs - this allows the plan sponsors more flexibility when managing spending by encouraging the use of generic alternatives.

Sources: Melissa Andel, "MedPAC Approves Package of Part D Recommendations Designed to Shift More Risk to Plan Sponsors", Applied Policy, April 28, 2016; Dan Diamond, "Health Spending Growth Stays Below 5 Percent," POLITICO Pulse, April 8, 2016; Virgil Dickson, "MedPAC Outlines Post-acute Pay Overhaul, Backs Part D Changes", Modern Healthcare, April 7, 2016; Photo: Mediklik, April 8, 2016; "A Data Book" MedPAC, June 2015; Jordan Rau, Med City News, July 22, 2013; Noun Project, Mint Shirt, Juan Pablo Bravo.

Government Spending on Health Care Constituted Nearly Half of Total Health Care Spending in 2013

Distribution of Health Care Spending, 2013

Percentage of Total Healthcare Spending, by (Total = $2.8 trillion)

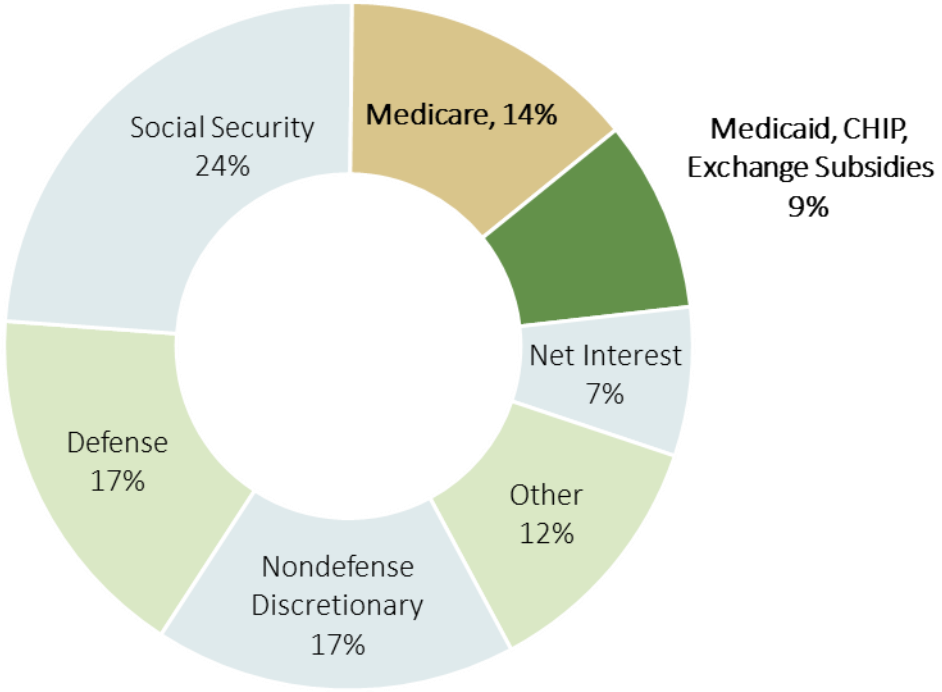


Source: "The Long-Term Outlook for Major Federal Health Care Programs," Congressional Budget Office, June 23, 2015.

Combined Health Care Spending Nearly 25% of Total Federal Outlays in 2014

Distribution of Federal Outlays, 2014

Total Federal Outlays in FY2014 = $3.5 Trillion

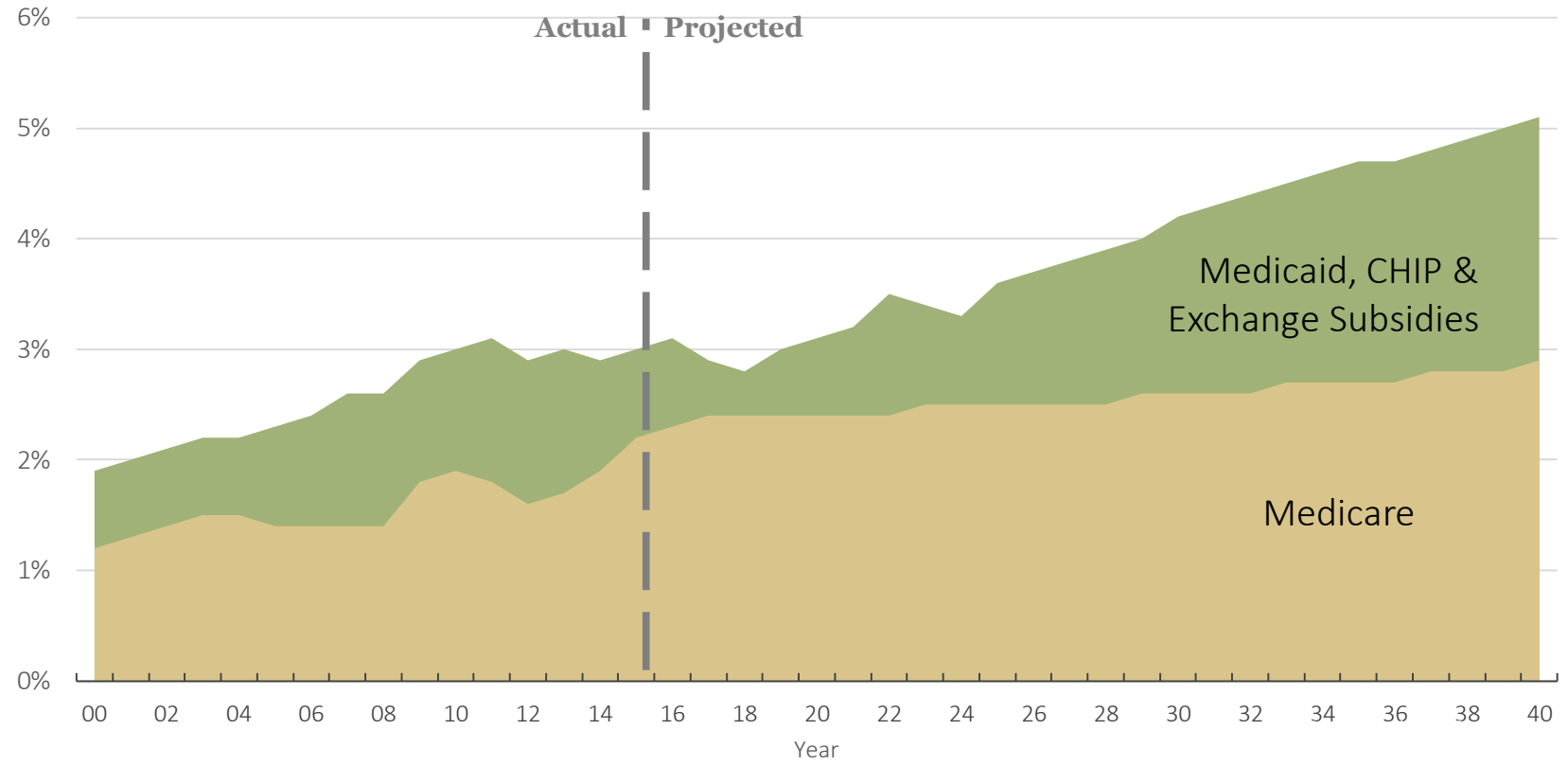


Sources: "The Facts on Medicare Spending and Financing," Kaiser Family Foundation, July 24, 2015.

Federal Spending on Major Health Care Programs, by Category

Actual & Projected Federal Spending on Health Care Programs

Percentage of Gross Domestic Product

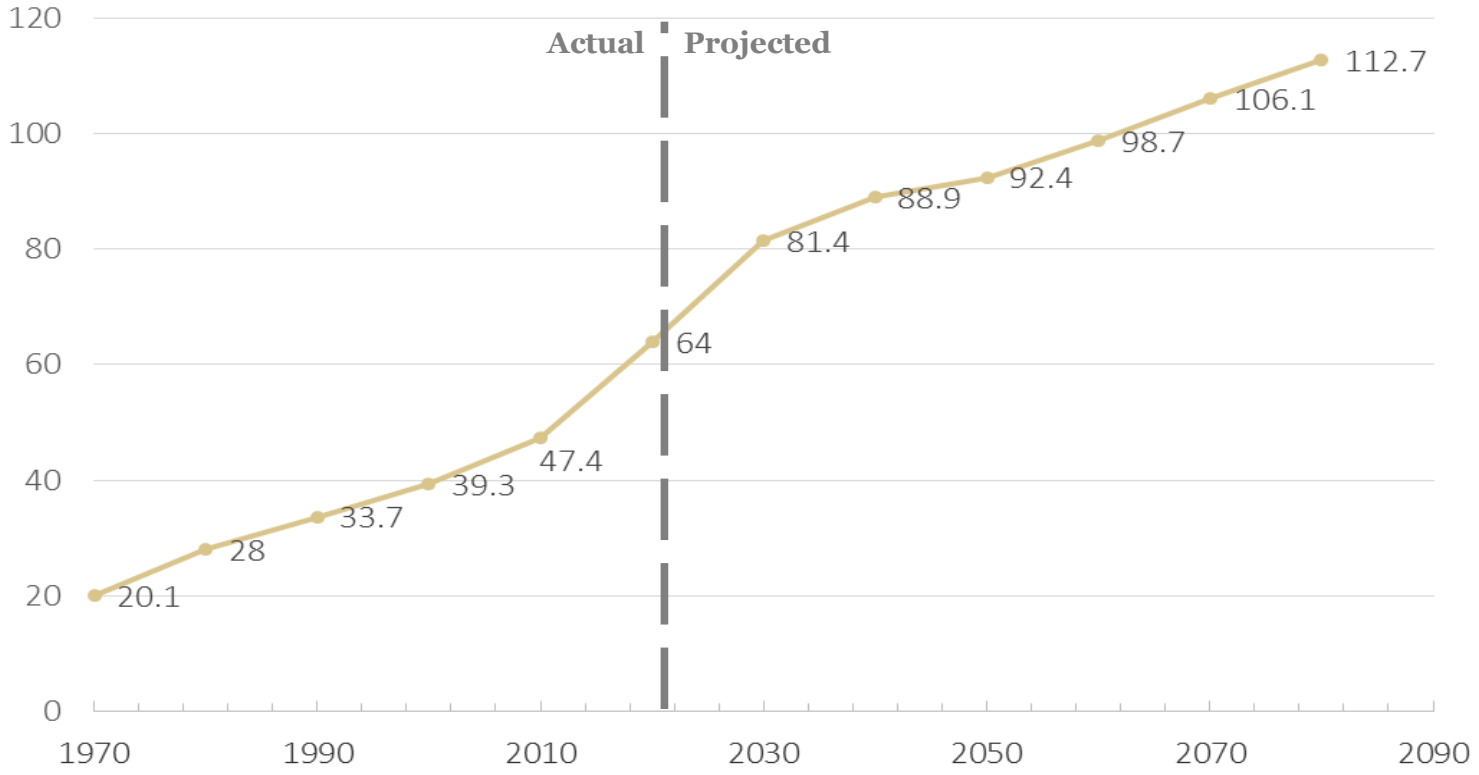


Source: "The Long-Term Outlook for Major Federal Health Care Programs," Congressional Budget Office, June 23, 2015.

Medicare Beneficiaries Projected On Track to Steadily Increase Over Time

Projected Increase in Medicare Beneficiaries Over the Next 60 years

Beneficiaries in Millions



Source: "The Long-Term Outlook for Major Federal Health Care Programs," Congressional Budget Office, June 23, 2015.