CHOOSING TRADITIONAL MEDICARE OR MEDICARE ADVANTAGE

Presentation to PSC Retiree Chapter

October 4, 2021

The main choices

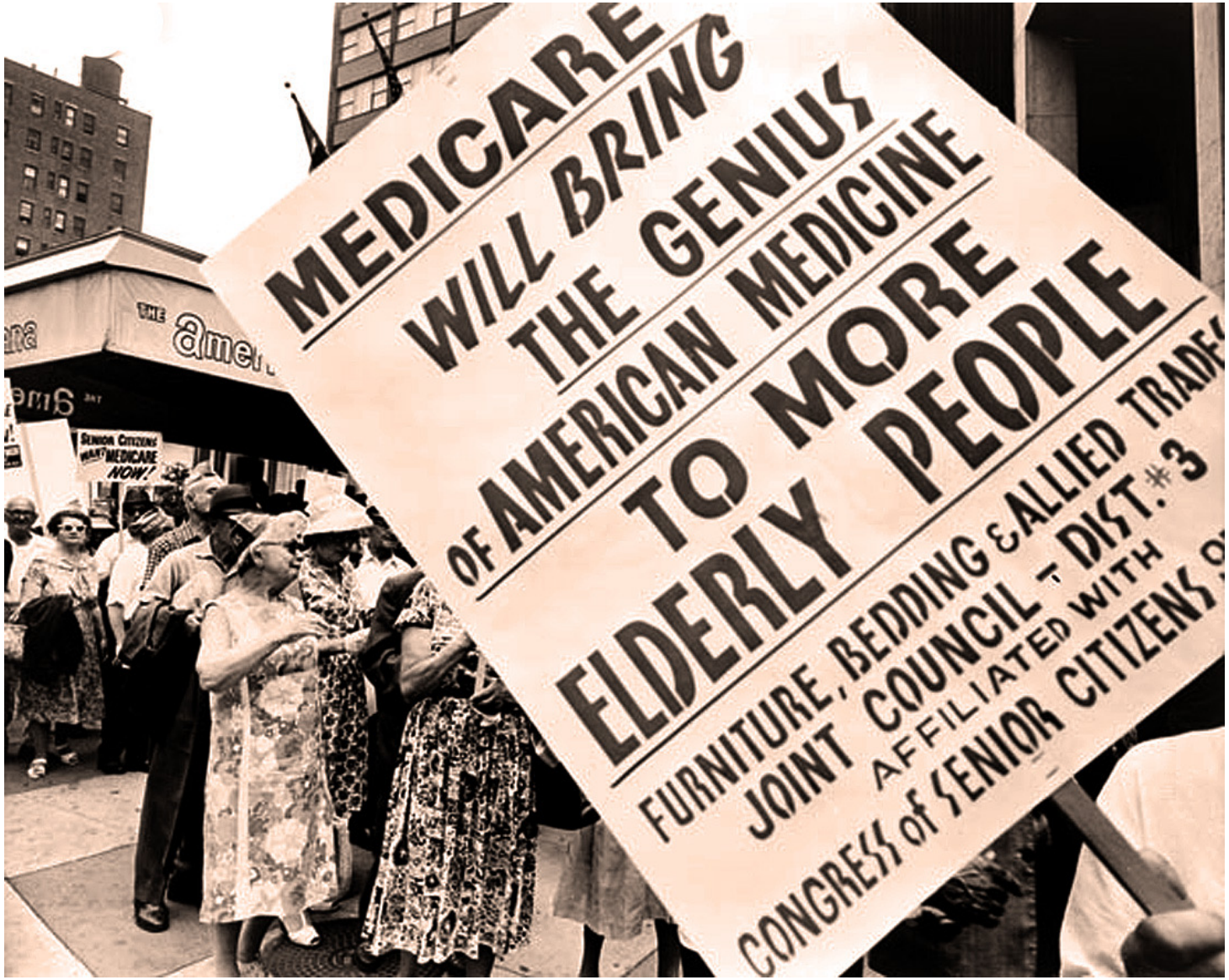
- No employee contribution for the new City **Medicare Advantage Plus PPO** replacing Medicare Parts A & B with an Empire/Emblem plan. After $253 deductible and some modest copays, would cover almost all out of pocket costs for medical care.
- Continuation of the current plan for $191/month ($2,292/year) employee contribution for **Senior Care.** Senior Care is the supplemental policy which plugs holes in Medicare coverage with insurance provided jointly by Emblem and Empire Blue Cross. After $253 deductible and some modest copays, a retiree will usually be made whole.

Agenda

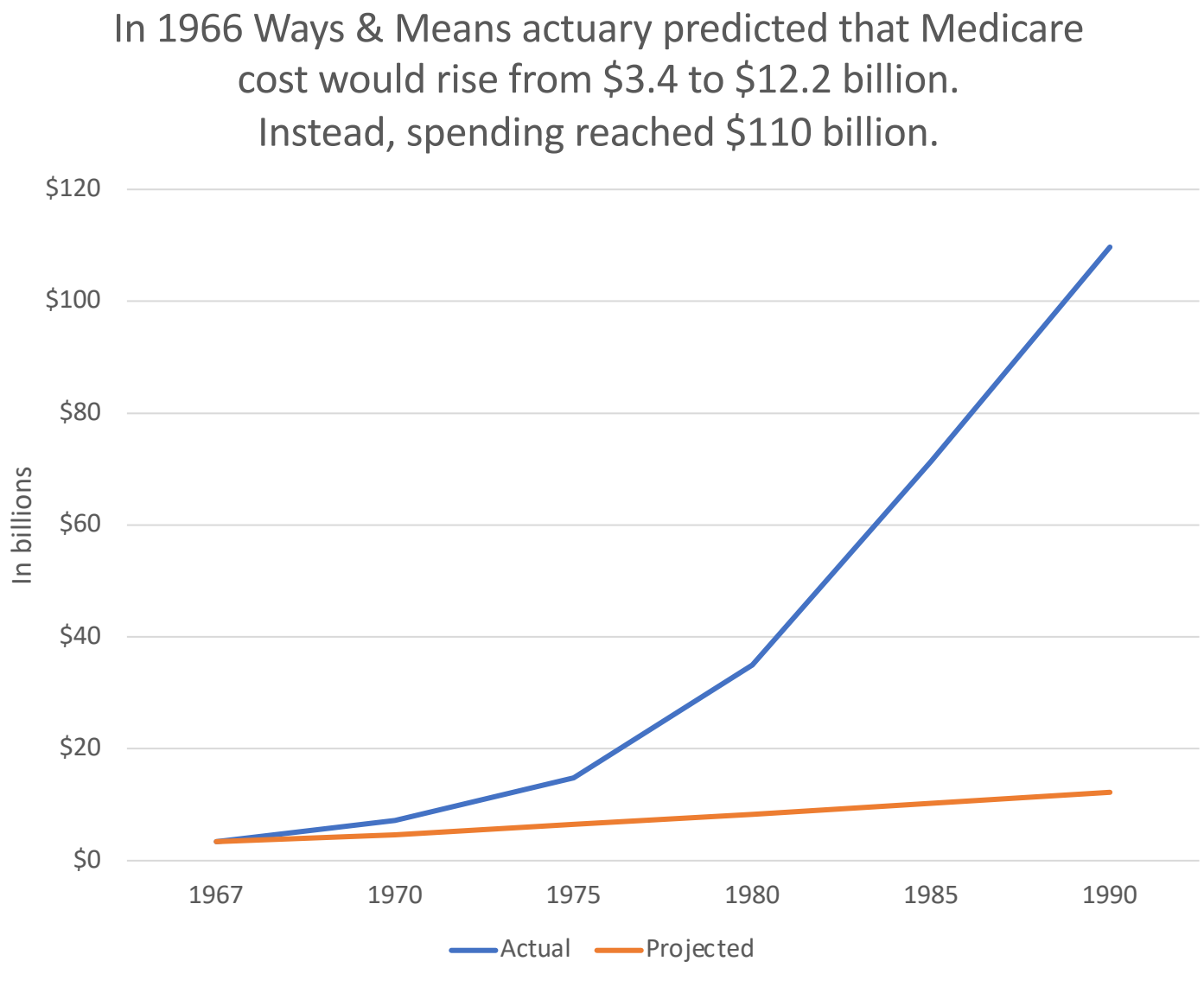
- Putting Medicare Advantage in context.
- Medicare Advantage and retiree health benefits in 2021.
- What we don’t know can kill us – what else we need to know.
- Questions to ask yourself.
- Medicare is forever.

Medicare was built on the system we had.

- Medicare would pay what care costs – translation: what providers charge
- Only MDs and hospitals, etc. can determine what services people need – Medicare will not interfere in “practice of medicine.” All licensed providers are welcome, can do whatever they wish, and bill for it.

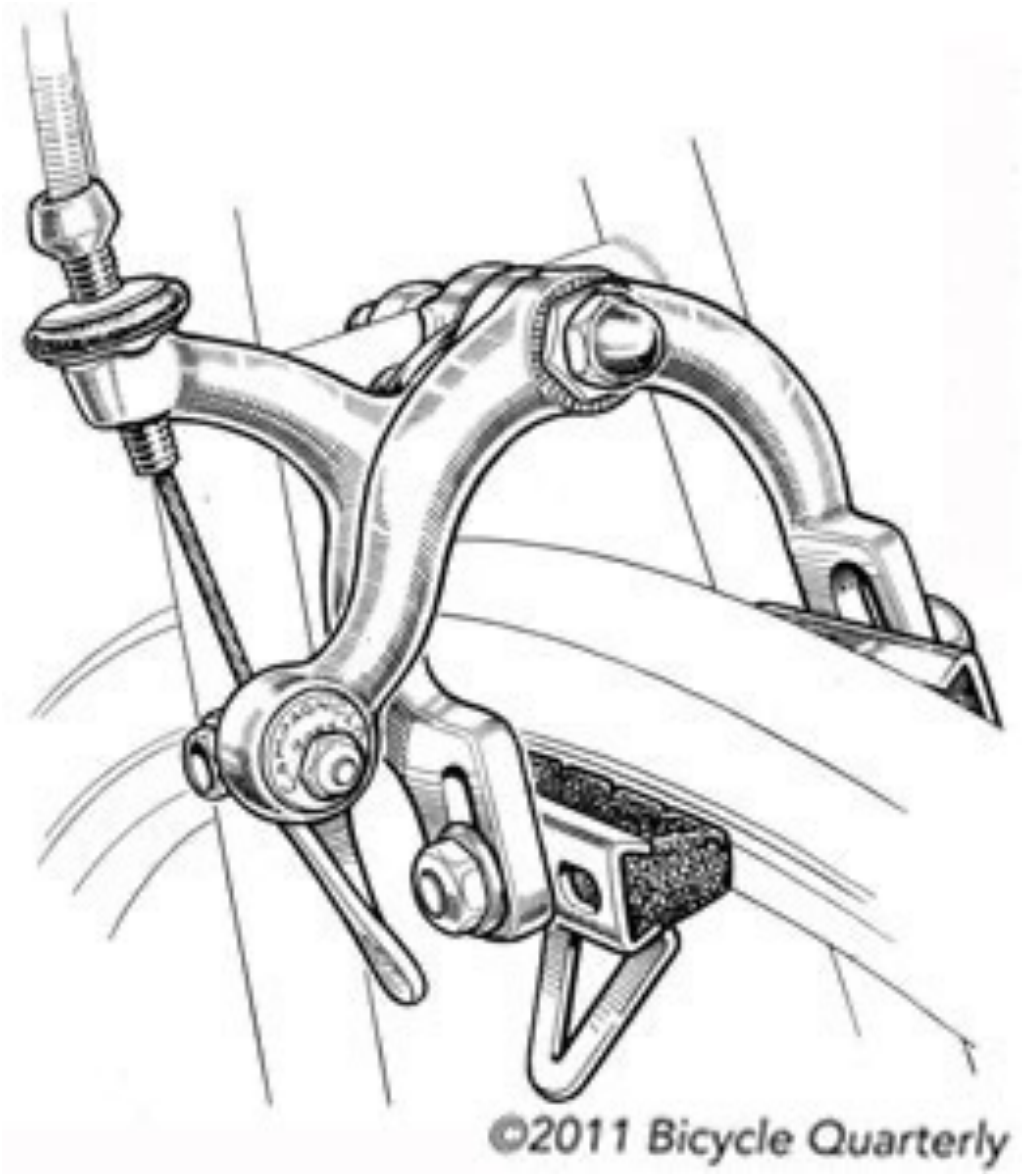


They didn't reckon with demand, inflation, & greed



In 1972 introduced private sector brake to change incentives

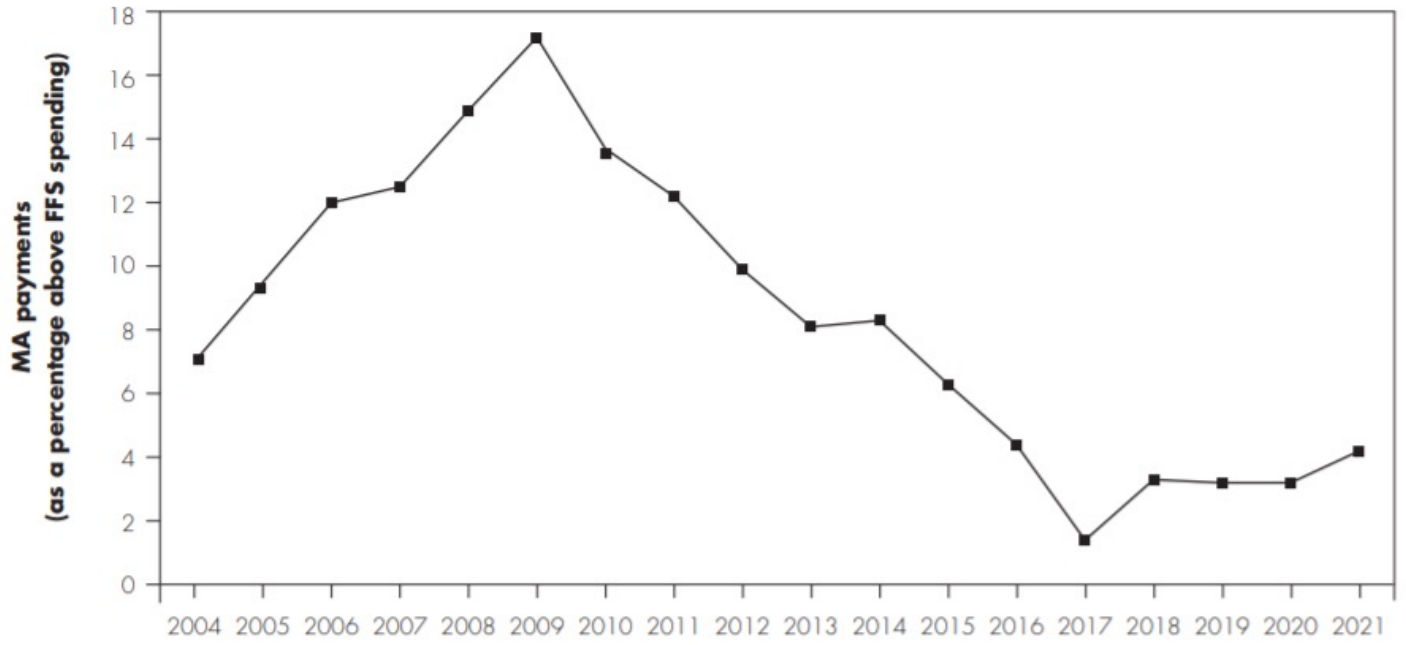
Conquer inflation bypassing the law and use commercial insurance companies to run Medicare. Instead of paying every claim from every doctor, set a fixed amount per person (capitated) regardless of number of visits or procedures. Incentives to keep people out of the hospital.



The private sector was even less able to hold down spending.

Despite the theory, MA didn't deliver savings.

Medicare Advantage has always cost more than traditional Medicare. It hit 16% more in 2010 when the ACA significantly reduced MA payments.

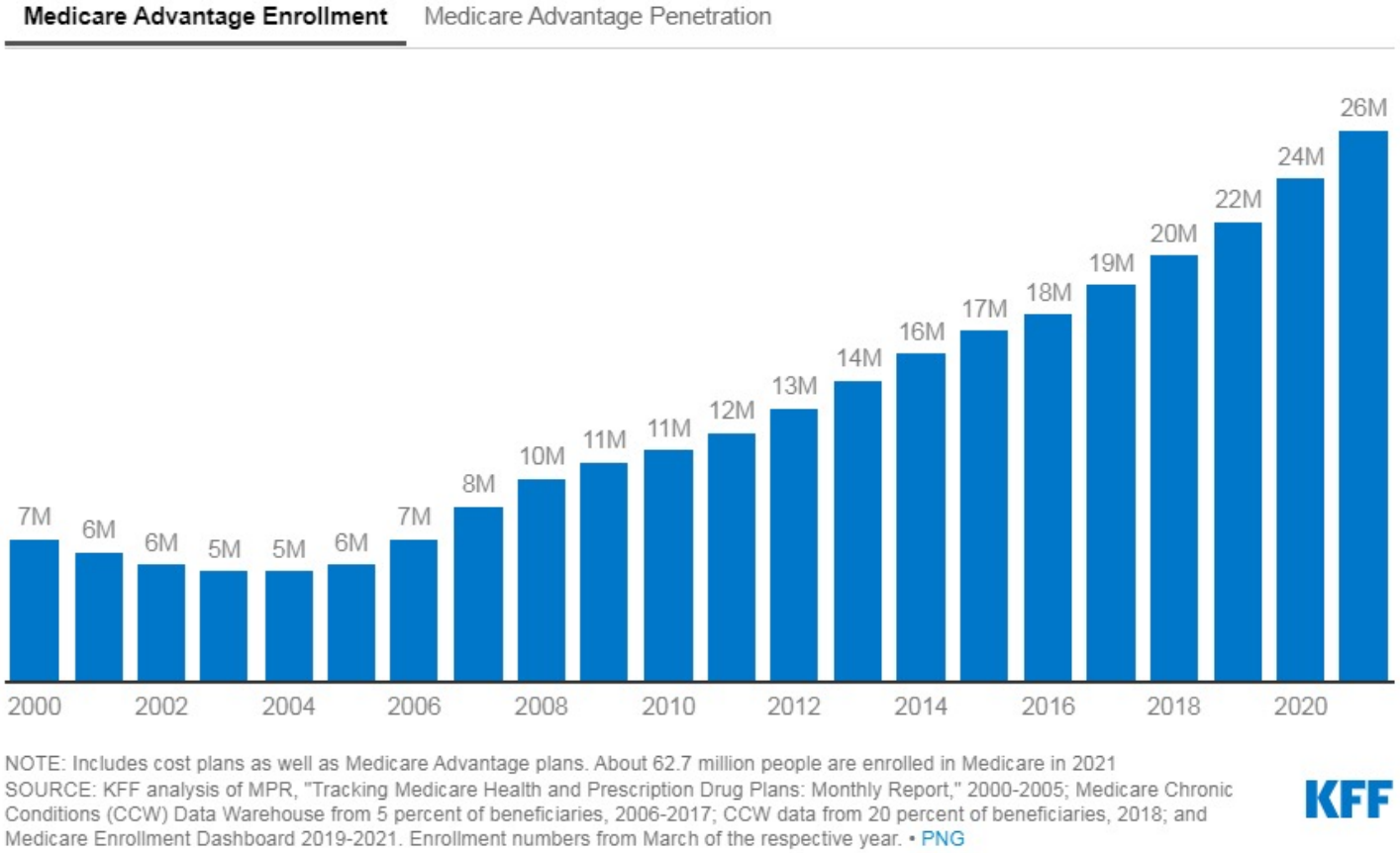


MA was created with two objectives

- First, save money. It didn't
- Second, attract more retirees to MA by including additional services and covering most deductibles and copayments. Working.

Figure 1

Total Medicare Advantage Enrollment, 2000-2021



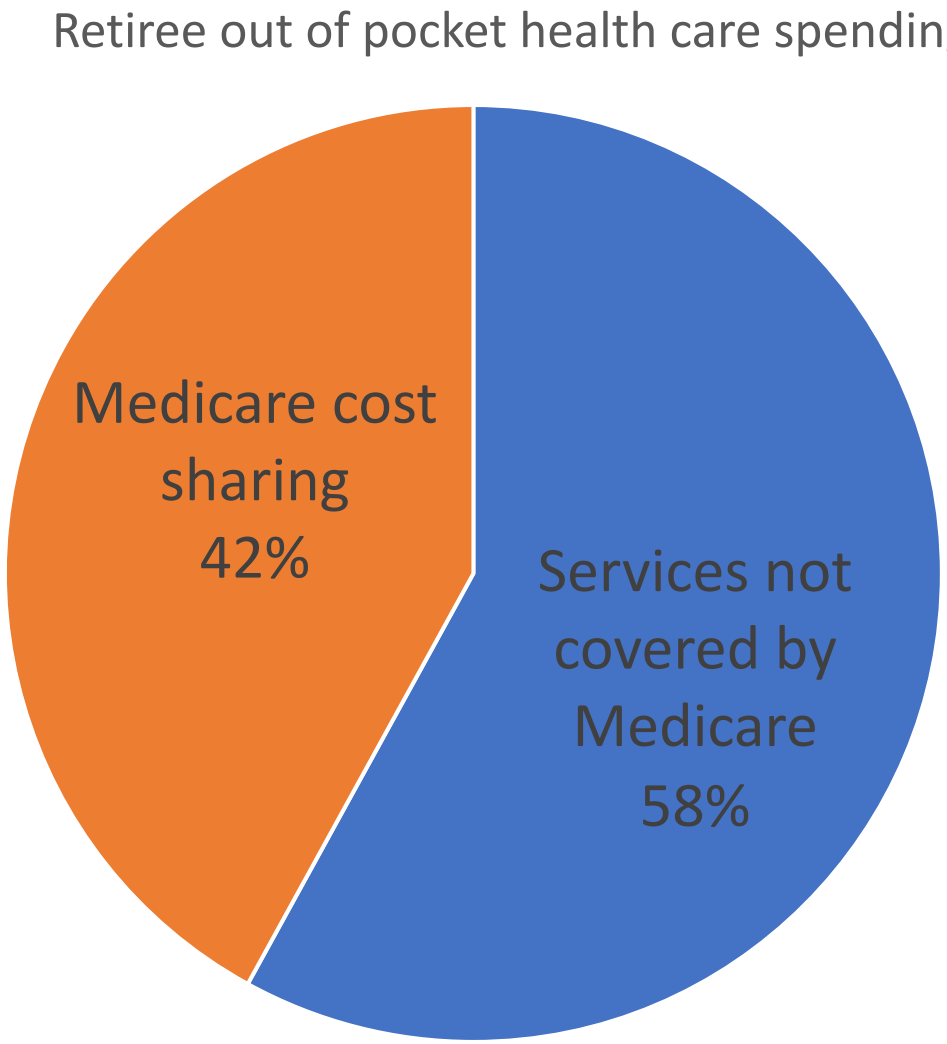
NOTE: Includes cost plans as well as Medicare Advantage plans. About 62.7 million people are enrolled in Medicare in 2021
SOURCE: KFF analysis of MPR, "Tracking Medicare Health and Prescription Drug Plans: Monthly Report," 2000-2005; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2006-2017; CCW data from 20 percent of beneficiaries, 2018; and Medicare Enrollment Dashboard 2019-2021. Enrollment numbers from March of the respective year. • PNG

KFF

To retirees - MA fills gaps left by Medicare

On average, retirees spend 12% of income on health care.

- Medicare cost-sharing.
  i. Part A deductible - $1,484 inpatient deductible plus co-insurance for long stays
  ii. Part B premium ($148.50/month), deductible ($203) & coinsurance (20%)
  iii. Part D premiums, coinsurance, deductible depending on plan
- Services not covered – long-term care, dental, vision, hearing, etc.

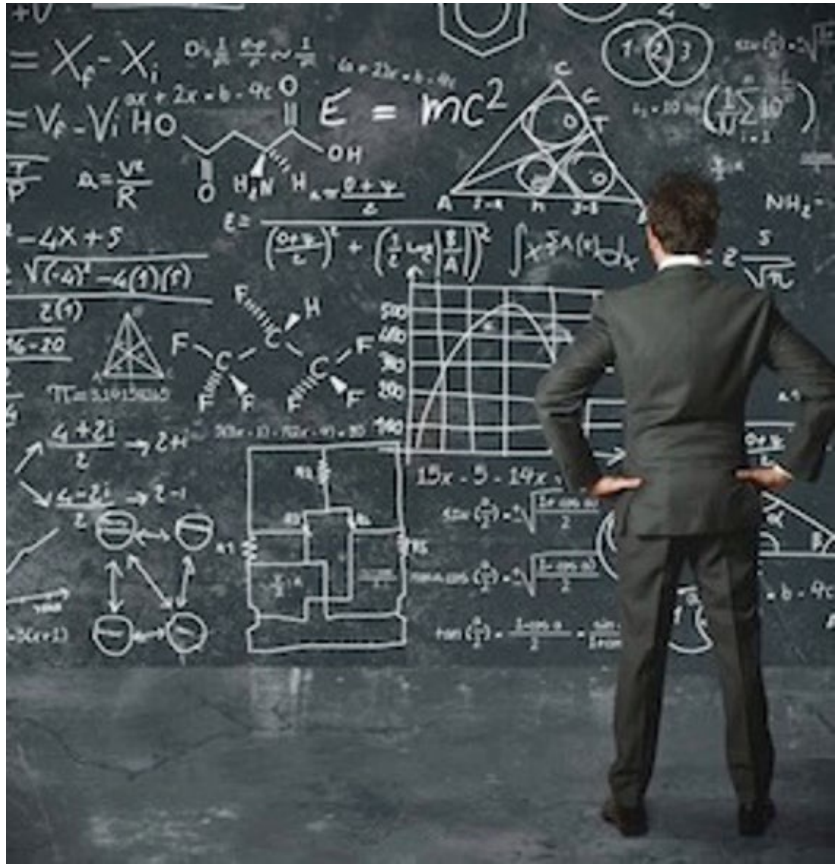


The theory of MA plans

By creating managed networks and rewarding quality (stars), MA plans reduce the cost of health care.

- Retirees are given access to comprehensive, high-quality primary and preventive services.
- Good medical care management leads to fewer big-ticket services like inpatient care and high-tech imaging.

Unfortunately, the literature shows that higher quality, coordinated care results in better care and sometimes better outcomes. It does not cost less.



Since theoretical savings aren't likely, MA insurers need to find other ways to cut costs and/or increase CMS payments.

- Typically, they reimburse hospitals about the same amount as Medicare -- one-third to one-half of what commercial insurance pays.
- Since Medicare, on average, pays more for ancillary services like lab and x-ray, MA plans use commercial fee schedules.
- MA plans organize networks where in exchange for market share and quick payment, doctors accept lower rates. Retirees have incentives to get their care in-network.
- MA plans require pre-authorization for expensive services. Most are approved, but the process keeps some from asking.
- MA plans use every trick at their disposal to enhance both the quality ratings and the risk adjustment factors to increase CMS rates.

How can the MA plans be cheaper than Medicare?

Secret sauce

networks

Networks – each has a different list of MDs, hospitals & other services– often differentiated by how much each is paid.

- Blue Access (employer-sponsored
- Connection (employer-sponsored
- Individual network (NYSoH Marketplace plans
- PPO/EPO (Employer-sponsored)

- Commercial: CPB, national & Tristate
- Network Access plan
- Medicare Choice PPO

If 90% opt-in, NYC retiree health benefit spending reduced by $605,000,000.

	2021	2022	
		Senior Care (10% enrollees)	Medicare Advantage (90% enrollees)
Medicare	$13,100	$13,746	$12,966
Senior Care premium	$2,454	$2,292	
MA premium			$90
Part B reimbursement	$1,782	$1,871	$1,871
Estimated NYC cost (265,000 enrollees)	$1,122,540,000	$49,581,500	$467,698,500

What we don't know. Seeing the Alliance contract will help.

- Most Medicare Advantage plans do not promise unlimited out-of-network benefits on the same terms as in-network. They depend upon their network management and plan design to keep spending down. How can the Alliance earn a margin unless it reneges on its promise to the retirees, the City, Emblem or the Empire's shareholders? What are the contractual escape clauses?

- What networks will Empire and Emblem be using? What providers will be in-network. The City is asking retirees to declare their intentions before they publish a network directory.
- What guarantees will the Alliance make that once listed, a provider will be considered in-network (and the member held harmless), even if the provider opts out before the end of the contract period? What does the contract between the City and the Alliance provide?

A few questions to consider.

- Does my doctor participate in Medicare? 96% do. Half of non-Medicare MDs are psychiatrists.
- Is my doctor in-network. Most likely she isn't and that might be a problem, especially is years 2-5.
- How concerned am I about pre-authorizations? On average, 8% of MA claims are denied. If appealed, 75% are reversed.
- Can I afford the Senior Care premium ($2292/person/year)? How much is access to every Medicare doctor worth to me?

You will be able to opt-out once a year.

One last thing . . . don’t panic.

MEDICARE IS FOREVER.

If you opt out and then can’t afford your Senior Care, you will revert to original Medicare.

Between Jan. 1 and March 31, you can buy a Medigap policy. Or you can join the Alliance plan in October to begin the following January.