Methodology & Assumptions:
Score of Medicare Extra Policy Proposal

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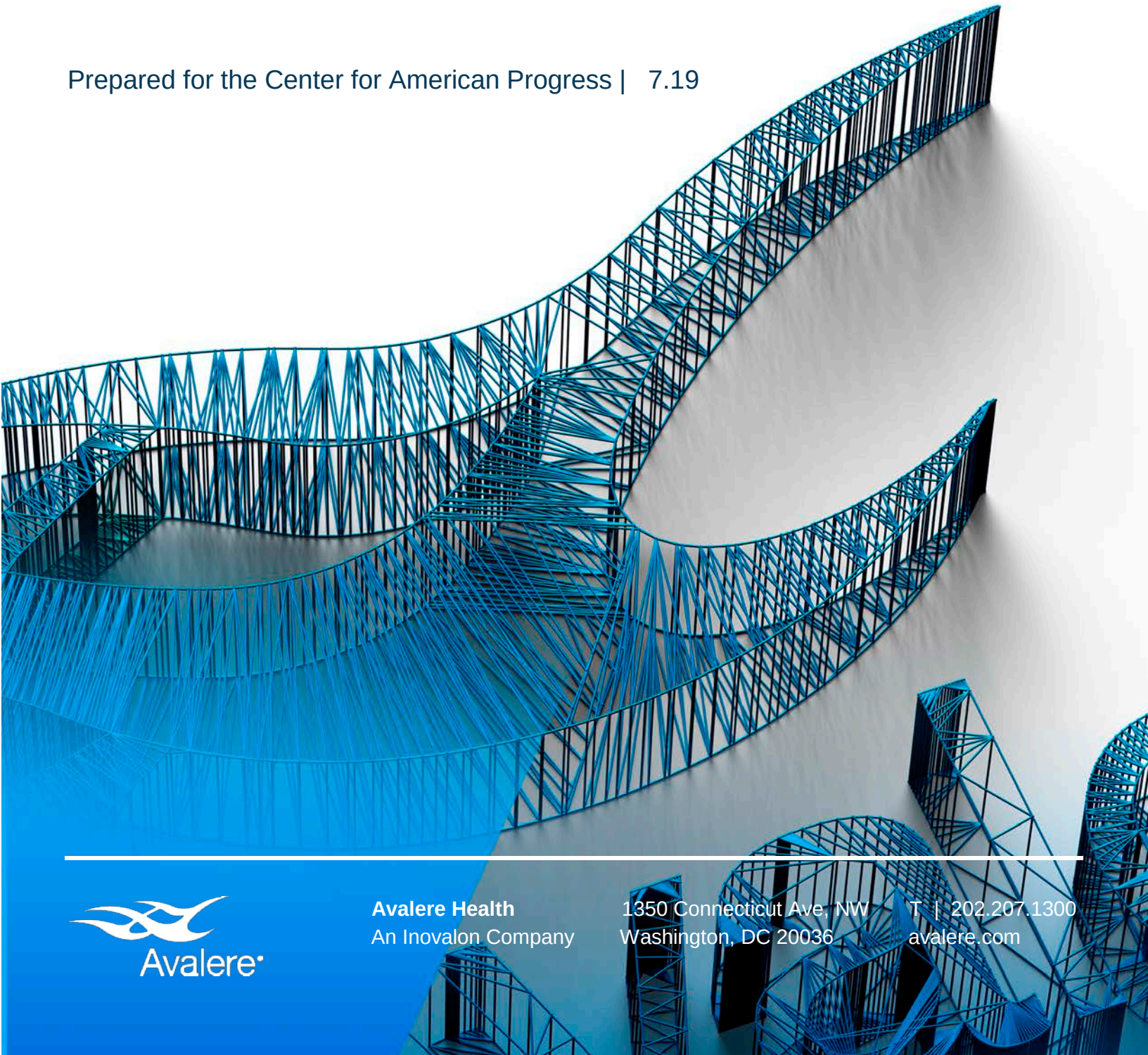

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Avalere

Overview

The Center for American Progress (CAP) commissioned Avalere to evaluate 'Medicare Extra' as a package of reform polices implemented and phased in over time across the US healthcare system. The overarching policy involves transitioning different segments of the US population (e.g. Medicare beneficiaries, Medicaid enrollees, private insurance enrollees) into eligibility for a new federal healthcare program (NFHP). Key characteristics of the NFHP involve income-based premiums and cost sharing, a new regulatory structure for reimbursing medical providers and products, new coverage options for employers/employees and Medicare beneficiaries, auto-enrollment for newborns, and the partial replacement of state Medicaid programs.

In addition to the establishment of the NFHP, the CAP proposal includes additional policies that alter benefits, payments, and federal funding for the current healthcare system. Many of these policies impact the current Medicare program, including Medicare FFS benefit redesign, a Part D MOOP, and competitive bidding in Medicare Advantage. Other polices include: a failsafe public option for the ACA Exchange markets, drug and hospital pricing policies, and new maintenance-of-effort payments required by states to the federal government in place of their state Medicaid spending.

Key Scoring Results

Under the policy, the analysis found that CAP's Medicare Extra policy would increase federal spending by $2.8 trillion over the 10-year budget scoring window, from 2022-2031. Under this policy, approximately 35 million uninsured individuals are projected to achieve coverage under Medicare Extra.

While the proposal would increase federal spending, total national healthcare expenditures in the United States are projected to be 4% lower than under current law by 2031, reducing total healthcare spending in the United States by approximately $300 billion in that year compared to baseline levels.

By the end of the scoring window, 199 million individuals would receive their coverage through Medicare Extra. The majority of these individuals would be enrolled from the ranks of Medicaid (71M), the Uninsured (35M), employer sponsored insurance (33M), and the individual market (12M). Nearly 121M individuals would continue to receive their health insurance coverage through their employers.

Overview of CAP Medicare Extra Policy Proposal

Redesign Current Medicare Program

- Additional Part B coverage for dental, vision, and hearing aid benefits
- Out-of-pocket maximum (MOOP) for Medicare Part A+B FFS benefits
- Out-of-pocket maximum (MOOP) for Non-LIS Medicare Part D enrollees
- Competitive bidding in Medicare Advantage

Create New Federal Health Program (NFHP)

- Transition ACA Exchange market enrollees, uninsured, ESI enrollees, Medicaid enrollees, and Medicare beneficiaries into the NFHP
- Other Policies
- Public option for areas with low competition for last two years of ACA Exchange markets prior to shift into Medicare Extra
- Maintenance-of-effort payments by states in place of Medicaid spending
- Reduce drug prices, hospital prices, and commercial rates for other medical services

Below is a detailed overview of Avalere's methodology for estimating the impact on federal spending from all policies, which together encompass CAP's Medicare Extra policy proposal.

Redesign Current Medicare Program

Avalere scored each of these policies using methods similar to those used by the Congressional Budget Office (CBO). Avalere used the 2018 CBO Medicare baseline, along with CBO's Long-term Budget Outlook, as the baseline for Medicare program spending in 2022-2031. In addition, Avalere used behavioral assumptions like CBO regarding how beneficiaries respond to changes in out-of-pocket costs, as well as the impact on medical costs from increases in the utilization of prescription drugs.

The establishment of the NFHP option for the Medicare-eligible population affects the 10-year budget impacts of each of these Medicare reform policies. Avalere expects many Medicare enrollees to shift into the NFHP option, starting in 2026, due to newly eligible Medicare enrollees (i.e. those turning 65) only being able to join the NFHP after 2026 and because Avalere expects many lower income non-Medicaid-eligible beneficiaries will see the NFHP as a more appealing option due to its lower premiums and cost sharing. Thus, over the budget window, the changes in FFS benefits created by these policies will apply only to the subset of the Medicare-eligible population that does not enter the NFHP. Similarly, Competitive Bidding in Medicare Advantage begins in 2022 and ends in 2025 because Medicare Advantage is replaced by Medicare Choice (MA within the NFHP) in 2026.

Policies

Additional Part B Coverage for Dental, Vision, and Hearing Aid Benefits

- **Approach**: Using data from the Medicare Current Beneficiary Survey (MCBS), Avalere estimated the expected percent change in Medicare costs from covering (as a standard Part B benefit) dental services, eyeglasses, and hearing aids that are currently not covered by Medicare. Estimates accounted for expected changes in utilization of these services due to beneficiaries having lower out-of-pocket costs with Medicare coverage.
- **Data Sources**: Medicare Current Beneficiary Survey (MCBS), 2018 CBO Medicare Baseline

Out-of-Pocket Maximum (MOOP) for Medicare Part A+B FFS Benefits

- **Approach**: Using a Medicare FFS benefit redesign model, Avalere estimated the expected percent change in Medicare costs from providing a maximum out-of-pocket (MOOP) cap for Medicare Part A+B FFS benefits. Avalere's Medicare FFS benefit redesign model is based on MCBS and claims data, with adjustments for additional dental/vision/hearing coverage (see policy above); the model accounts for behavioral responses by beneficiaries to having lower out-of-pocket costs for medical services.
- **Data sources**: Medicare Current Beneficiary Survey (MCBS), 2018 CBO Medicare Baseline

Out-of-Pocket Maximum (MOOP) for Non-LIS Medicare Part D Enrollees

- **Approach**: Using a Medicare Part D benefit redesign model, Avalere estimated the expected percent change in Medicare costs from providing a maximum out-of-pocket cap at the catastrophic threshold for Medicare Part D enrollees not eligible for the low-income subsidy. Avalere's Part D model is based on MCBS data; the model accounts for behavioral responses by beneficiaries to having lower out-of-pocket costs for prescription drugs, as well as reductions in medical costs due to higher utilization of prescription drugs.
- **Data Sources**: Medicare Current Beneficiary Survey (MCBS), 2018 CBO Medicare Baseline

Competitive Bidding in Medicare Advantage

- **Approach**: Avalere assumed that Medicare payments to private plans would be 95% of FFS Part A+B per capita payments under this policy, since the CAP policy proposal specified that payments to private plans could not exceed 95% of FFS Part A+B costs. Avalere assumed no change in Medicare Advantage enrollment due to this policy. Part A+B benefits include newly covered dental/vision/hearing coverage (see policy above) and a new MOOP for A+B benefits (see policy above).
- **Data Sources**: 2018 CBO Medicare Baseline

Create New Federal Health Program (NFHP)

Avalere scored this policy using methods like those used by the Congressional Budget Office (CBO). Avalere used the 2018 CBO baselines for Medicare, Medicaid, and Federal Subsidies for Health Insurance, along with CBO's Long-term Budget Outlook, as the baseline for health program spending in 2022-2031. In addition, Avalere used behavioral assumptions like CBO regarding how beneficiaries respond to changes in out-of-pocket costs, as well as the impact on medical costs from increases in the utilization of prescription drugs.

Avalere scored the overarching policy of creating the NFHP by modeling the budget impact of transitioning each of the different segments of the US population (e.g. Medicare beneficiaries, Medicaid enrollees, private insurance enrollees) into eligibility for the NFHP. Even though the NFHP offers a standard benefit across all enrollees, estimating the budget impact varies across the population segments because their current-law federal benefits and costs vary. Avalere's modeling also differs across population segments because NFHP is mandatory for some populations and optional for others.

Policies

Transition ACA Exchange Market Enrollees to NFHP

- **Approach:** Avalere estimated the impact on federal costs from transitioning all enrollees from ACA Exchange markets into the NFHP. For enrollees that transition from ACA Exchange markets into the NFHP, the change in federal costs per enrollee involves the replacement of federal exchange subsidies with expected medical costs under the NFHP, less income-adjusted premiums and cost sharing.
    - To estimate expected medical costs of Exchange enrollees under the NFHP, Avalere relied on premium and medical-loss-ratio (MLR) data from the Exchanges, with some adjustments to account for lower out-of-pocket costs under the NFHP.
    - To estimate both federal exchange subsidies and income-adjusted premiums and cost sharing under NFHP, Avalere relied on Medical Expenditure Panel Survey (MEPS) data to estimate the incomes of Exchange enrollees relative to the federal poverty level (FPL).
    - Avalere assumed that the standard (non-income adjusted) premiums for the NFHP are based on the expected risk of the pool of all NFHP enrollees and a targeted actuarial value (AV) for a given plan year, and that enrollees above the income thresholds for premium adjustments pay the standard premium amount.
- **Data Sources:** ACA Exchange market data, MEPS, 2018 CBO Federal Subsidies for Health Insurance Baseline

Transition Uninsured Persons to NFHP

- **Approach**: Avalere estimated the impact on federal costs from transitioning all uninsured individuals into the NFHP. Avalere assumed all uninsured individuals enrolled in the NFHP during their first year of eligibility. Avalere assumed the expected medical costs in the NFHP of previously uninsured individuals would be like ACA Exchange market enrollees; this method accounts for increased utilization of medical services due to acquiring insurance coverage. To estimate income-adjusted premiums and cost sharing under NFHP, Avalere relied on Medical Expenditure Panel Survey (MEPS) data to estimate the incomes of uninsured individuals relative to the federal poverty level (FPL).
- **Data Sources**: ACA Exchange market data, MEPS, 2018 CBO Federal Subsidies for Health Insurance Baseline

Transition Medicaid Enrollees to NFHP

- **Approach**: Avalere estimated the impact on federal costs from transitioning Medicaid enrollees (via auto enrollment) into the NFHP. For enrollees that transition from Medicaid into the NFHP, the change in federal costs per enrollee involves the replacement of federal Medicaid spending (based on FMAP) with expected medical costs under the NFHP, less income adjusted premiums and cost-sharing.
    - To estimate expected medical costs for Medicaid enrollees transitioned to the NHFP, Avalere relied on total computable per enrollee Medicaid costs and adjusted for Medicaid-to-Medicare payment rates. Avalere assumed NFHP payment rates will be like Medicare payment rates (except for inpatient hospital services), which are higher than Medicaid payment rates in most states.
    - Avalere assumed that Medicaid enrollees pay little or no premiums and cost sharing under either Medicaid or the NFHP.
    - Because the CAP policy (as modeled) assumes Medicare-Medicaid duals do not transition into the NFHP (as there is no difference in benefits for them between Medicare and the NFHP), Avalere assumed Medicaid aged enrollees are ‘transitioned’ to Medicare instead of to the NFHP. As such, states no longer pay aged-Medicaid enrollees’ Medicare premiums and cost sharing once they have been ‘transitioned.’
    - Because the CAP Policy (as modeled) does not address long-term care, Avalere assumed the NFHP does not cover long-term care costs. Avalere excluded long-term care costs from estimates of expected medical costs in the NFHP. Avalere assumed states and the federal government continue to pay long-term care costs as they do today. [1]
- **Data Sources**: CMS Medicaid data, 2018 CBO Medicaid Baseline

Transition Medicare Beneficiaries to NFHP

- **Approach**: Avalere estimated the impact on federal costs from transitioning Medicare-eligible enrollees from Medicare to the NFHP. For enrollees that transition from Medicare to the NFHP, the change in federal costs per enrollee involves the replacement of Medicare

benefits (Parts A, B, D) with expected medical costs under the NFHP, less income-adjusted premiums and cost sharing.

- To estimate expected medical costs for Medicare enrollees under the NFHP, Avalere relied on Medicare allowed costs (Medicare benefits + beneficiary liability (Part A and Part B deductibles and coinsurance) + Part D gross costs). Avalere adjusted expected medical costs based on its modeling of which Medicare-eligible beneficiaries would choose to transition to NFHP.
- Avalere expects lower-income, non-Medicaid duals, to choose NFHP because of lower premiums and cost sharing. The CAP policy restricts Medicaid duals from transitioning to the NFHP. Using MCBS-based modeling, Avalere estimated Medicare beneficiaries' incomes relative to the federal poverty level (FPL) to determine their income-adjusted premiums and cost sharing under NHFP, as well as their Medicare premiums and Medicaid eligibility.
- Avalere assumed Medicare beneficiaries can predict their relative premiums and cost sharing for Medicare vs. NFHP, and that all voluntary transitions to NFHP occur during the first year of NFHP eligibility.
- Avalere's estimates account for increased utilization under NFHP for some beneficiaries, due to lower out-of-pocket costs. Many Medicare beneficiaries experience reduced out-of-pocket costs for prescription drugs covered under Part D when they transition to NFHP; the resulting higher utilization of prescription drugs reduce expected medical costs in the NFHP.
- Avalere assumed that the standard (non-income adjusted) premiums for the NFHP are based on the expected risk of the pool of all NFHP enrollees and a targeted actuarial value (AV) for a given plan year, and that enrollees above the income thresholds for premium adjustments pay the standard premium amount.
- Regarding Medicare Choice, Avalere assumed that the replacement of Medicare Advantage with Medicare Choice does not change the total number of Medicare-eligible enrollees choosing private plans instead of FFS. In addition, Avalere assumed that payments to plans are 8% less than FFS Part A+B benefits because the CAP policy specifies that payments to private plans cannot exceed 92% of FFS Part A+B benefits.

- **Data Sources**: MCBS, 2018 CBO Medicare Baseline

Transition Employer Sponsored Insurance Enrollees to NFHP

- **Approach**: Avalere estimated the impact on federal costs from transitioning employer-sponsored insurance (ESI) plan enrollees to the NFHP. For enrollees that transition from ESI plans to the NFHP, the change in federal costs per enrollee involves the replacement of federal tax expenditure costs with expected medical costs under the NFHP, less income-adjusted premiums and cost sharing.
  - Using its employer-choice and employee-choice decision models, Avalere estimated the number of ESI enrollees that shift to the NFHP.

- Avalere estimates that many ESI enrollees shift due to their employer's decision to no longer offer ESI. Avalere's employer-choice decision model differentiates employers by size and industry, with differences in average wages and employer health benefit contributions driving their decision regarding whether to stop providing ESI.
- Avalere estimates that many employees that have employers that continue to offer ESI will nonetheless shift to the NFHP based on their own decision, which is shaped by comparing premiums and cost sharing under their ESI plan with their expected premiums and cost sharing under the NFHP.

  - Avalere's employer-choice decision model uses a combination of MEPS and Bureau of Labor Statistics (BLS) data to segment employers into 14 industry categories and calculate their average wages and contributions to ESI plans.
  - Avalere assumes that employers continue to offer ESI plans unless other options (sponsor NFHP coverage, maintenance-of-effort (MOE) payments, contribute 10% of payroll) allowed by the CAP policy are less expensive for the employer. As the cost differential between providing ESI and other options increases, more employers stop offering ESI.
  - Avalere estimates that most employers continue to offer ESI due to the impact that other CAP policies (see policies described below) have on the cost differential between offering ESI vs other options. Specifically, CAP detailed polices that require reduced drug prices and hospital prices, as well as reduce commercial-payer prices for other medical services so that they are similar to NFHP rates, greatly reduce ESI enrollee's expected medical costs ---this reduction in medical costs makes the 'MOE payments' and '10% of payroll' options more expensive relative to offering ESI for most employers, and also makes the costs of ESI similar to NFHP sponsorship.[2]
  - Avalere's employee-choice decision model assumes that employees prefer ESI unless the NFHP is perceived as significantly more appealing, in terms of offering lower premiums and cost sharing. Avalere uses CBO's finding that a 10% decrease in premiums results in a 5.7% increase in demand for insurance coverage as a cross-price elasticity assumption for employees choosing the NFHP over their ESI plan.[3] Avalere also includes an inertia factor (set at 30%) when modeling employee decisions, which is designed to account for their preference to keep their same coverage due to risk aversion and uncertainty.

- **Data Sources**: MEPS, BLS data, 2018 CBO Federal Subsidies for Health Insurance Baseline

Other Policies

Avalere scored each of these policies using methods like those used by the Congressional Budget Office (CBO). Avalere used the 2018 CBO baselines for Medicare, Medicaid, and Federal Subsidies for Health Insurance, along with CBO's Long-term Budget Outlook, as the baseline for health program spending in 2022-2031. In addition, Avalere used behavioral assumptions like CBO regarding how beneficiaries respond to changes in out-of-pocket costs, as well as the impact on medical costs from increases in the utilization of prescription drugs.

For CAP policies that reduce drug prices, hospital prices, as well as prices for other services, Avalere did not evaluate the impact of any specific polices. Instead, CAP's proposal detailed that unspecified policies are enacted with authority provided to relevant agencies to reduce prescription drug prices (retail and physician-administered) by a stated goal of 30%, reduce hospital prices to a rate higher than paid by the current Medicare program, assumed to be 110% of current Medicare rates—but much lower than current private payers, and that ESI plans would be able to match the provider payment rates set by the NFHP. These savings are applied immediately and throughout the budget window. Avalere determined the hospital payment rate reductions would allow hospitals to maintain 2% margins, on average, based on MedPAC analysis of current hospital margins. Avalere made no assessment regarding the sustainability of a 30% reduction in drug prices, or the reduction in other provider payment rates so that they are the same as paid by the NFHP.

Public Option for ACA Exchange Markets

- **Approach**: Avalere estimated the impact of a public option for ACA Exchange markets by 1) gauging the potential for 'abandonment' across each state market during the 2022-2023 time period that precedes the transition of the ACA Exchange markets into the NFHP, and 2) estimating the impact on federal exchange subsidies from introducing a public option for a portion of ACA Markets during 2022-2023.
    - Using CMS data on projected health insurance coverage in the ACA Exchange Markets in 2018, Avalere identified counties in states projected to have a small number of participating insurers as being most 'at risk' for 'abandonment' (having no insurers during the pre-NFHP time period). Avalere identified two 'at-risk' groups: counties in 9 states projected to have only one insurer participating in the ACA Exchange markets, and counties in 8 states projected to have only two insurers. Avalere assumed that the public option is implemented in the 9 most 'at-risk' states in 2022, and all 17 'at-risk' states in 2023.
    - To estimate the impact on federal exchange subsidies in ACA Exchange markets receiving a public option, Avalere used a 2013 CBO study that assessed the impact on premiums from introducing a public option into the ACA Exchange Markets. CBO found

that offering a public plan in the ACA Exchanges would put downward pressure on premiums, reducing them by 7-8%.

- **Data Sources**: ACA Exchange market data, 2018 CBO Federal Subsidies for Health Insurance Baseline

Reduce Drug Prices, Hospital Prices, and Prices for Other Medical Services

- **Approach:** Per the policy outlined by CAP, the policy would provide authority to relevant agencies and require that authority to be used to reduce prescription drug prices (retail and physician-administered) by 30%, reduce hospital prices to a rate higher than paid by the current Medicare program—but much lower than current private payers, and that ESI plans would be able to match the provider payment rates set by the NFHP. These savings were applied immediately and throughout the budget window.
    - Avalere inserted these price reductions into modeling described above, thereby impacting the results for those policies.
- **Data Sources**: 2018 CBO Baseline for Medicare, Medicaid, and Federal Health Insurance Subsidies; Other Avalere modeling for CAP polices (see above)

State Maintenance-of-Effort Payments to Federal Government for Medicaid

- APPROACH: Avalere estimated state maintenance-of-effort (MOE) payments for Medicaid costs using the payment mechanism formula described in the CAP policy proposal. The MOE payment calculation requires states to continue their state per enrollee Medicaid spending in a base year, plus a growth rate based on GDP per capita. For Medicaid expansion states, the annual growth rate exceeds GDP per capita growth by 0.2 percentage points; for non-Medicaid expansion states, the annual growth rate exceeds GDP per capita growth by 0.7 percentage points.
    - Avalere used the 2018 CBO Medicaid Baseline, along with CBO's Long-term Budget Outlook and economic assumptions, to estimate state MOE payments. Avalere used its state-level Medicaid forecasting model to estimate the share of state Medicaid spending, prior to the start of MOE payments, for Medicaid Expansion vs. Non-Medicaid Expansion states.
    - Because the CAP Policy (as modeled) does not address long-term care, Avalere did not include State Medicaid spending for LT care in the MOE payment calculations. Avalere assumed states and the federal government continue to pay long-term care costs as they do today.
- **Data Sources**: CMS Medicaid data, 2018 CBO Medicaid Baseline.

References

i. Note: the potential for a substantial decrease in private payer spending on long-term care, due to the transition of private payer enrollees shifting to the NFHP, is not accounted for in this analysis. This decrease in private payer spending would likely lead to an increase in LT care spending by both states and the federal government. This likely increase in federal costs is not accounted for in Avalere's analysis of CAP's policy proposal.

ii. Avalere notes that changes in employer/employee preferences for ESI vs. NFHP can greatly impact budget scores for CAP's policy package, due to the large size of the ESI enrollee population. Federal costs will increase if more ESI enrollees shift to the NFHP. If the unspecified CAP policies reducing drug and hospital prices, as well as reducing commercial medical service prices, are less successful than assumed, then a greater share of ESI enrollees will shift to the NFHP and the budget impact of the CAP proposal will increase accordingly.

iii. CBO Behavioral Assumptions, 1993.

iv. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2018-Projected-Health-Insurance-Exchange-Coverage-Maps.html

v. https://www.cbo.gov/budget-options/2013/44890

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Avalere is a vibrant community of innovative thinkers dedicated to solving the challenges of the healthcare system. We deliver a comprehensive perspective, compelling substance, and creative solutions to help you make better business decisions. As an Inovalon company, we prize insights and strategies driven by robust data to achieve meaningful results. For more information, please contact info@avalere.com. You can also visit us at **avalere**.com.

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