

HEALTH CARE REFORM AND RETIREES

5/12/2010

Prepared by Pete Benner for the Minnesota Retired State
Employee Association, AFSCME Retiree Chapter 6

Income for Minnesota Seniors

- The Minnesota Department of Revenue reported that in 2006:
- 30% of senior households had income of \$21,786 or less
- 50% had income of \$36,470 or less.
- 70% had income of \$56,729 or less.

Social Security Benefit Amounts

- February 2010 average monthly benefits
- Retired Worker - \$1167.14
- Retired Couple - \$1742.60
- Widow or Widower - \$1125.86

Social Security Online Beneficiary Data accessed March 3, 2010

MSRS Average Benefits

- MSRS Paid the following average benefit for new retirees for FY09
- General Plan - \$1367/month
- State Patrol - \$3793/month
- Corrections Plan - \$1671/month
- Judges Plan - \$4594/month
- Legislators - \$1531/month

MSRS 2009 Comprehensive Annual Financial Report

2010 Premiums for Pre-65 Retirees

- SEGIP Advantage Single - \$447.28/month
- SEGIP Advantage Family - \$1315.34/month
- Personal Blue \$1000 deductible age 60-64 - \$570/month (non-smoking rate)
- Medica Direct Value \$1000 deductible age 60-64 - \$656.95 (Metro area)
- Medica Direct Value \$1000 deductible age 60-64 - \$610.96/month (Non-Metro area)
- In individual market, rates are based on age of enrollee.

Medicare Coverage

- Medicare Part A – out of pockets (\$1100 deductible plus high copays for inpatient stays over 60 days)
- Medicare Part B – premiums equal to 25% of program costs. \$155 deductible plus 20% coinsurance for most services.
- Medicare Part D – \$310 deductible and 25% coinsurance before donut hole, 100% coinsurance in donut hole and 5% coinsurance after donut hole. Donut hole for 2010 from \$2830 to \$6440 in Rx costs.

2010 Medicare Supplement Premiums

- Medicare Part B Premium - \$96.40/month (\$110.50) for incomes up to \$88,500 and up to \$353.60/month for incomes over \$214,000
- SEGIP Blues - \$301.91/month
- SEGIP HealthPartners - \$257.40/month
- SEGIP UCare - \$256/month
- Platinum Blue + Medicare Blue RX Premier - \$195.20/month (generics only during donut hole)
- HealthPartners Freedom III Enhanced - \$297.50/month (covers donut hole – Rx deductible, \$10 generic and \$45 brand name copays)

HEALTH EXPENDITURES DIFFER BY AGE

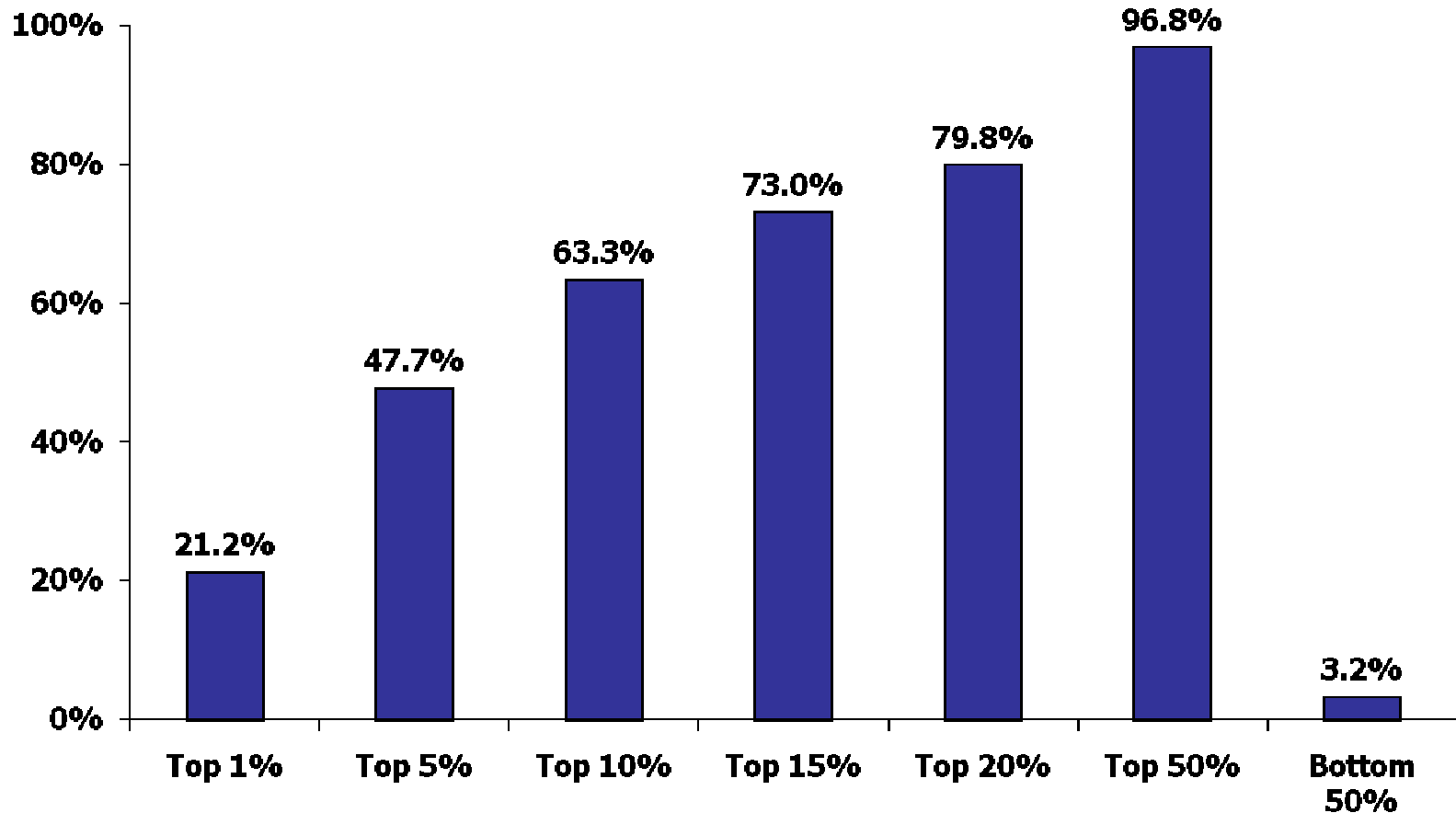
AGE	PER CAPITA HEALTH CARE SPENDING 2004 (Most recent)
0-18	\$2650
19-44	\$3370
45-54	\$5210
55-64	\$7787
65-74	\$10788
75-84	\$16389
85+	\$25691

Source: Centers for Medicare and Medical Services, Office of the Actuary, National Health
Statistics Group

http://www.cms.hhs.gov/NationalHealthExpendData/04_NationalHealthAccountsAgePHC.asp

Concentration of Health Care Spending in the U.S. Population, 2006

Source: Kaiser Family Foundation slide dated January 6, 2009



Percent of Population, Ranked by Health Care Spending

Targets of Reform Legislation

- Cost of Care
- Quality of Care
- Affordability of Care
- Access to Care

COST

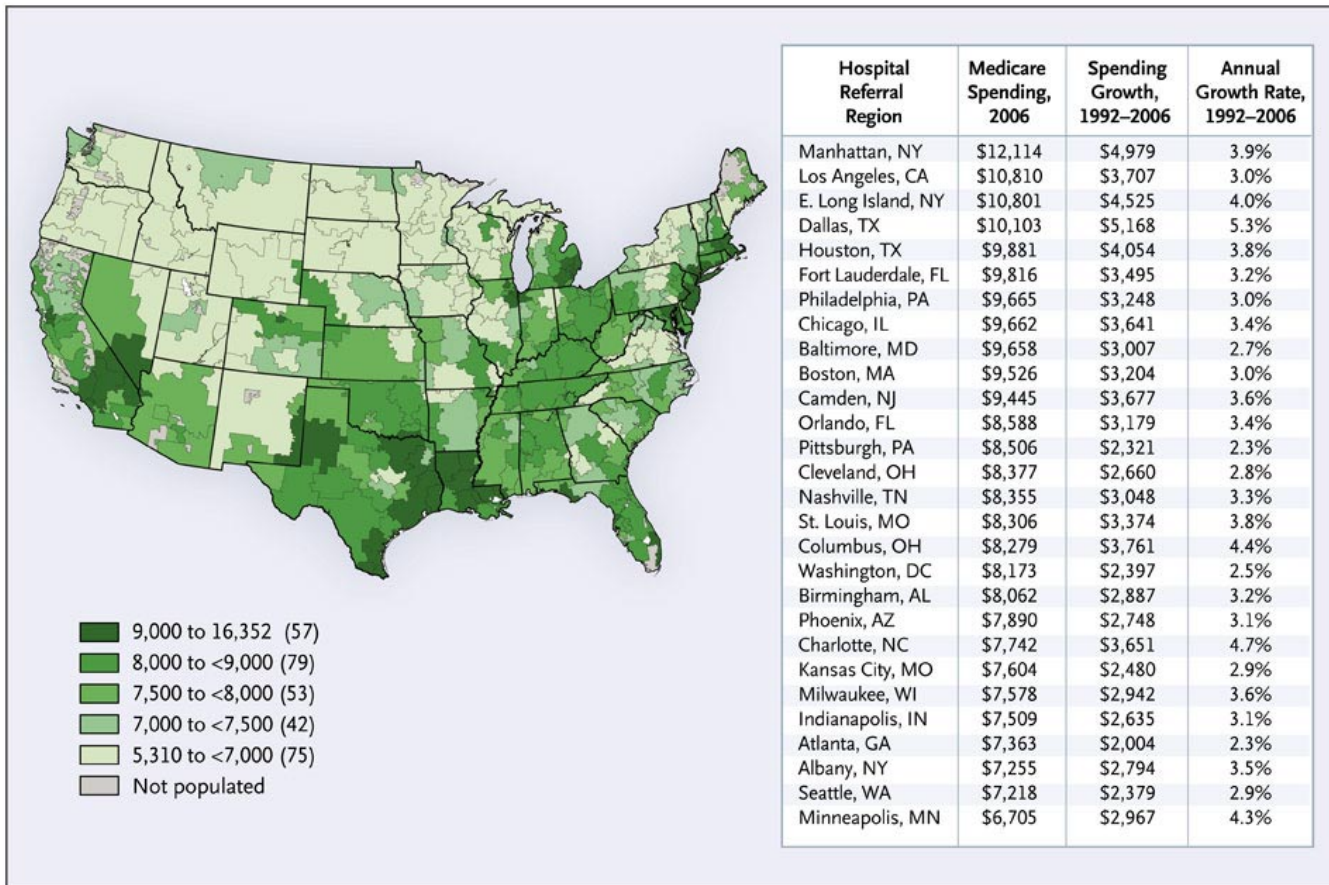
McKinsey Report

- In 2007 and 2008, the McKinsey Global Institute did a detailed study comparing the US health care system to those of other “western” industrial democracies.
- McKinsey looked at data collected by the Organization for Economic Cooperation and Development (OECD) on health care spending and use levels for 30 countries.
- McKinsey then adjusted that data for every possible variable.

US Health Care is More Expensive

- Hospital Care is 40% more expensive
- Outpatient Care is 36% more expensive
- Prescription Drugs are 27% more expensive
- Administrative Costs are 82% more expensive
- Physicians Make twice OECD average

Source: 2007 McKinsey Report pages 31 and 51



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Cost of Care Varies within Minnesota

GROUP	LEVEL	RAPMPM
A	1	\$374.62
H	1	\$413.02
I	2	\$417.83
EE	2	\$454.11
FF	3	\$471.57
OO	3	\$469.74
PP	4	\$486.97
ZZ	4	\$696.59

GROUP = PROVIDER GROUP

LEVEL = BENEFIT LEVEL

RAPMPM = RISK ADJUSTED PER MEMBER PER MONTH

July 2008 State Employee Group Insurance Plan (SEGIP) Data

Challenge of Containing Cost

- The \$2.4 trillion health care expenditure is a \$2.4 trillion health care revenue for someone!
- Cutting costs is cutting someone's income stream. Those who will lose income will resist and will give good reasons why their piece of the pie should not be touched.
- McKinsey tells us that cost cutting will need to involve not only insurance companies and health plans, but providers, pharmaceutical companies, and device makers.

Cost of Care

- We know that some providers have significantly better cost footprints than others. We want providers to practice closer to those with the lowest cost footprints.
- We need all providers to get more cost effective.
- We need provider payment systems which reward quality and efficiency.
- We need to get at suppliers, pharma and device makers.

Cost of Care Changes

- Cut back on Medicare spending by reducing payments or rates of payment increase to providers and to Medicare Advantage plans.
- Require pilot payment reforms for Medicare. There are some smaller payment increases in both bills for rural providers and some primary care providers. The goal is to reward the more efficient and the higher quality.
- Require administrative simplification to reduce costs of health plans and providers.
- Ask Medicare to take lead in more fundamental payment reform.
- Medicare is such a big part of clinic and hospital revenue that Medicare payment reform is central to making state and private sector reform sustainable.

QUALITY

Quality of Care

- There is significant variation in quality.
- We measure and publicly report a very small amount procedures.
- We reward for quality (\$ and/or patients) on only some of what we measure and report.
- We know some of what providers need to do to improve quality.
- We know less about what it takes to incent them to make the effort. A lot of this goes back to payment reform.

Optimal Diabetes Care – Top 10

- Fairview Oxboro Clinic 44.8%
- Apple Valley Medical Clinic 44.3%
- HealthPartners – Inver Grove Heights 42.2%
- Family HealthServices MN – White Bear Lake 40.0%
- Franciscan Skemp – Caledonia 40.0%
- Southdale Internal Medicine 40.0%
- Park Nicollet Clinic - Minnetonka 36.8%
- Allina Medical Clinic - Eagan 36.7%
- Immanuel St Joseph's – St Peter 36.7%
- Western Wisconsin Med Assoc – New Richmond 36.7%
- Statewide Average 19%

- Minnesota Community Measurement (MNCM) Data 2009 – for 2008 Services

Optimal Diabetes Care – Bottom 12

Minnesota Community Measurement (MNCM) Data 2009 - for 2008 Services

Overall Primary Care Performance In 2008

- MNMCM measures how well medical groups do on 13 primary care measures.
- HealthPartners Medical Group was above average in 12 of 13
- Park Nicollet was above average in 9 of 13
- Fairview Health Services was above average in 8 of 13
- HealthEast was above average in 7 of 13.

Minnesota Quality Reform Efforts

- Minnesota Department of Health has developed a set of health care measures for all providers in state (both hospitals and clinics).
- Minnesota Community Measurement has been selected to do data collection and reporting.
- There will be 5 clinic and 17 hospital in-patient measures for 2010 with additional primary care and hospital measures for 2011.

Federal Quality Reform Efforts

- Call for and fund major expansion of measurement and public reporting.
- Instruct Medicare to build rewards for quality into its payment systems.
- Call for major federal investments in learning what specific provider actions improve quality and then disseminating those findings.
- Minnesota has opportunity to draw down a lot of the federal development money because of work done to date.

AFFORDABILITY

Affordability of Care

- Care must be affordable to individual families – they must be able to cover their share of premium and out of pockets.
- Care must be affordable to employers – they must be able to cover their share of premiums.
- Care must be affordable to public payers – they must be able to raise taxes or borrow money to cover their share.

Federal Affordability Reform Efforts

- Expand Medicaid for adults.
- Establish affordability standards for Exchange purchased plans.
- Permit employees to buy into Exchange if their employer does not cover enough of premium.
- Require health plans and employers to add adult children as dependents (up to age 26).
- Subsidize pre-65 retirees. Employers will get 80% of costs between \$15,000 and \$90,000/year paid by feds for retirees between 55-65.
- Close Medicare Part D “donut hole”.

Affordability Standard – Pre Medicare

- At 200% of Poverty (\$21,660 for one and \$29,140 for 2 people) premiums capped at 6.3% of income or \$113.72/month for single and \$152.99/month for 2 person family
- At 300% of Poverty (\$32,490 for one and \$36,425 for 2 people) premiums capped at 9.5% of income or \$257.20/month for single and \$288.36/month for two person family
- At 400% of Poverty (\$42,320 for one and \$58,280 for 2 people) premiums capped at 9.5% of income or \$335.03/month for one and \$461.38 for two people.

Federal Affordability Reform Efforts

- Call for Medicaid expansions with 100% federal medical assistance percentage (FMAP) for initial years.
- Medicaid expansions and Exchanges will eliminate need to things like General Assistance Medical Care and MCHA (Minnesota's high risk pool).
- Medicare payment reforms will lower cost increases both for federal government and for seniors.

Federal Tax Changes

- Change rules for FSA, HRA and HSA to limit coverage for drugs to prescription Rx, increase penalty for withdrawal to 20%, and cap at \$2500.
- Increase threshold for itemized medical deductions to 10%.
- Increase Medicare Part A tax by 0.9% of individuals making over \$200,000 on an individual return and \$250,000 on a joint return
- Tax unearned income for Medicare Part A.
- Reduce Part D subsidy for those making over \$85,000.
- End indexing of Part B premium thresholds.

ACCESS

Access

- Access depends on affordability and the rules for being allowed to purchase coverage.
- In individual market, pre-existing condition limitations do not permit some to buy coverage.
- In group markets, employers can exclude access by employment status – waiting periods and exclusions of various not full time workers.
- In all markets, rules on age banding or pooling can make coverage too expensive for older and/or sicker individuals or groups.
- The Congressional Budget Office estimates there will be 50 million uninsured people in 2010, rising to 54 million by 2019.

Federal Access Reform Efforts

- Establish temporary high risk pools.
- Eliminate pre-existing condition limitations.
- Restrict age banding.
- Put requirements on employers to limit exclusions based on hours or length of employment.

Medicare Benefit Improvements

- 2010 - \$250 rebate for donut hole.
- 2011 – Phase out of donut hole starts. To be completed by 2020. This will mean Medicare will pay 75% of cost of all drugs up to top of donut hole and 95% beyond that.
- 2011 – Brand drugs will be discounted 50% in donut hole – but count at 100% for moving through donut hole.
- 2011 - Cover Health Risk Assessment, screening and preventive services without deductible and copays under Part B.
- Limitations on provider payment increases will have effect of reducing Medicare Part B and Medicare Supplement premium increases.

What to Expect Next

- Premium Increases for Pre-65 retirees in SEGIP or U of M plans will be less than projected for 2011-2013.
- Starting in 2014, pre-65 retirees can sign up with Exchanges and get income based premium subsidies.
- Starting in 2011, combination of Medicare changes should show lower premium increases for Medicare Supp plans.

For More Reading

Free Web Sites

- Congressional Budget Office – www.cbo.gov
 - Kaiser Family Foundation – www.kff.org
 - McKinsey Global Institute – www.mckinsey.com/mgi
 - Robert Wood Johnson Foundation – www.rwjf.org
 - Minnesota Health Reform – www.health.state.mn.us/healthreform/index.html
 - Minnesota Community Measurement – www.mnhealthscores.org
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- Contact Pete Benner at Peter.Benner@afscmemn.org.