Funding Considerations for Medicare Recipients Under Oregon's Universal Health Care Plan

INTRODUCTION

At the August 18 meeting of the Joint Task Force On Universal Health Care, there was discussion about how to include Medicare beneficiaries and funding in the Universal Health Care (UHC) program. The plan under consideration would require those beneficiaries who currently pay Part B and D premiums to continue to do so under the UHC. Those beneficiaries would also pay an additional personal income tax (PIT). My initial concern is that those paying both the Part B and D premiums as well as the PIT would experience a significant increase in costs while future beneficiaries would simply opt out of Parts B and D. I also noted that the discussion didn't appear to include consideration of how Medicare Advantage plans currently affect beneficiary decisions and funding.

After further analysis, I have concluded that securing sufficient funding from Medicare contributions to the Oregon UHC will likely depend on most, if not all, Oregon beneficiaries paying Part B premiums. Therefore, it will be critical that the UHC program incentivize Oregon Medicare beneficiaries to opt into Part B coverage. In this comment document, I suggest plans for the TF to consider that could attract Medicare beneficiaries and could also be attractive to federal authorities who must agree to it. In any case, it is important to understand the complexities of the current state of costs for Medicare beneficiaries in order to develop a plan that provides better coverage at a lower cost overall.

CURRENT STATE

For qualifying individuals with 10 years or more employment in the US, Medicare Part A which covers hospital visits, skilled nursing care, home health care, and hospice care is provided at no additional cost. Those who do not meet the employment minimum can buy into Part A at a premium of around $499 per month in 2022.

The standard Medicare Part B premium in 2022 is $170.10 per month. Some beneficiaries pay an additional amount based on income for a total of up to $578.30 per month at the highest income levels.

Medicare recipients who elect Part D coverage can choose to have their premium deducted from their Social Security check; however, all premiums are paid to private insurance providers and private insurance providers administer the plans. The national average Part D premium in 2022 is $33.37 per month.

Medicare Advantage (MA) plans provide both Medicare Part A and B benefits. Medicare beneficiaries who opt for an MA plan pay two premiums – one to Medicare and one to the private MA insurance provider. According to a recent Kaiser Family Foundation (KFF) analysis ("Medicare Advantage in 2022: Enrollment Update and Key Trends", published August 25, 2022), "…nearly 7 in 10 beneficiaries (69%) are in zero-premium individual Medicare Advantage plans with prescription drug coverage (MA-PDs), and pay no premium other than the Medicare Part B premium…". The remaining 31% of beneficiaries who are in plans with a MA-PD premium pay an average premium of $58 per month. Premiums for MA plans have declined over time.

Some Medicare beneficiaries get help paying for their MA plans through Medicare Savings Programs (MSPs) made available by the Centers for Medicare and Medicaid Services (CMS.) Beneficiaries who meet the requirements for low-income, disability, or certain chronic health conditions can receive help from MSPs to pay for some plan costs, which may include premiums. Those with qualifying medical conditions may qualify for an MA Special Needs Plan (SNP) and may also be eligible for Medicaid. For those eligible for both MA SNP and Medicaid, Medicaid helps pay for most of the costs of joining a plan. These costs include premiums, coinsurance, and copayments.

Traditional Medicare (TM) reimburses Part B providers directly using a fee for service (FFS) structure of payments. Medicare Advantage (MA) providers (private insurance companies) are paid per member per month. In 2019, MA plans received an average of $996 per person per month from Medicare and approximately $960 per person per month was paid by Medicare through FFS for other Medicare Part B enrollees.

Medigap plans that help fill gaps in Original Medicare vary widely in both premiums and coverage. A beneficiary must have Medicare Part A and Part B to qualify for a Medigap plan. Plans are sold by private insurance companies and may also be referred to as Medicare Supplement Insurance. One estimate puts the average premium cost for a Medigap plan in 2022 at $128.16 per month.

UHC FUNDING

In order to achieve a single-payer system and reap the administrative savings for both the payor and providers, the UHC will need to replace private insurance and Traditional Medicare FFS for Medicare beneficiaries. Although supplemental insurance through private insurers would be allowed, Medigap plans that cover Medicare deductibles, copays, and coinsurance would be unnecessary under the envisioned UHC as would Part D plans.

The anticipated coverage of the UHC seems to match or exceed what is currently provided by Medicare Advantage plans so it would make sense that Oregon would negotiate with CMS to receive the same funding as a Medicare Advantage plan for those beneficiaries who are paying Part B premiums. According to a recent Kaiser Family Foundation (KFF) analysis, "…nearly half of eligible Medicare beneficiaries…are now enrolled in Medicare Advantage (MA) plans." ("Medicare Advantage in 2022: Enrollment Update and Key Trends", published August 25, 2022.) The KFF analysis further indicates that the share of Oregon beneficiaries enrolled in Medicare Advantage (and paying Part B premiums) is between 50 and 60%. But, what about those beneficiaries who are not paying Part B premiums? Those Oregonians would need to receive the same care but the plan would receive little funding from Medicare. What would stop all Oregon Medicare beneficiaries from disenrolling or never enrolling in Part B coverage, eliminating most of the Medicare contribution to the UHC?

It seems that the personal income tax (PIT) portion of the UHC funding would need to be structured such that a Medicare beneficiary would save money by paying the Part B premium. For example, the UHC PIT calculation could start with the Medicare income-based formula for determining Part B premiums then double the result. Those beneficiaries who pay the Part B premium would then need to be exempt from, or receive a significant reduction in the PIT. In addition to the premium assistance available from Medicare, low-income Oregonians would also qualify for an Oregon tax refund to pay some or all of the Part B premium. I don't have the information necessary to perform an analysis of how

a structure like this, or an alternative, would ultimately impact the funding of the UHC. But it is clearly something that needs to be studied and modeled carefully before any final recommendations are made.

ABOUT THE AUTHOR

I am submitting this public testimony as an Oregon citizen with insight into the operations and administration of private health insurance. Before retiring in September 2020, I spent nearly five years behind the scenes at a local, non-profit health insurance provider. This provider's largest member segment, by far, is made up of Oregon Medicaid (OHP) beneficiaries assigned through Oregon's Coordinated Care Organization (CCO) program. The second largest member segment is enrolled in the organization's Medicare Advantage plan. The small remaining membership segment is enrolled in small employer plans. The provider does not offer ACA marketplace or other individual plans. Through my experience at this insurance provider, I gained a great deal of knowledge about claims processing and payment, prior authorizations, and plan administration.

Since retiring, I have spent significant time investigating, researching, and studying health care costs, especially related to private health insurance. I have closely followed the workings of the Joint Task Force on Universal Health Care and its ERA subcommittee. I am appreciative of the amount of effort, consideration, analysis, and discussion that has brought the task force to this point in preparing a report for the Oregon Legislature. While these particular comments may prove too late for consideration in the official report to the Legislature, I am hopeful that they will provide the task force with additional information upon which to base its knowledge transfer to the next phase of this effort.