Pension & Health Benefits Committee

California Public Employees' Retirement System

Agenda Item 7

November 18, 2014

ITEM NAME: Potential Options for Medicare

PROGRAM: Health Benefits

ITEM TYPE: Information

EXECUTIVE SUMMARY

This item provides information on the overall Medicare Program, the Medicare Plans administered by the California Public Employees' Retirement System (CalPERS) and potential options the Pension and Health Benefits Committee (PHBC) may consider in relation to the program.

STRATEGIC PLAN

This agenda item supports Goal A: Improve long-term pension and health benefit sustainability by ensuring high quality, accessible and affordable health benefits.

BACKGROUND

In June 2014, the PHBC raised concerns after the announcement of the 2015 Medicare rate increases of up to 38 percent from the prior year. Also in June 2014, staff presented an update on the Health Benefits Purchasing Initiatives. The section that addressed options for Medicare provided information on Medicare exchanges – what they are, how they might benefit members and potential issues that might arise from adopting this option.

The item also reported that a careful analysis of the benefits and challenges was needed, and that staff would update the PHBC on its progress. This item provides one such update.

ANALYSIS

<u>History of Medicare</u>

The idea of a national health insurance program was first discussed as early as 1912, but was not seriously debated until the presidency of Harry S. Truman in 1945. President John F. Kennedy made an unsuccessful push for a national health care program for seniors after a national study showed that 56 percent of Americans over the age of 65 were not covered by health insurance. It was largely unavailable or unaffordable, as rates were up to three times as high for this age group compared to younger groups.

Not until 1965 did the idea come to fruition as a healthcare safety net for those 65 and older. That year, under the leadership of President Lyndon B. Johnson, Congress created Medicare under Title XVII of the Social Security Act. When Medicare coverage began in 1966, more than 19 million individuals were enrolled with a budget of $10 million. According to the Kaiser Family Foundation, by 2013 these numbers had grown to 54 million individuals with costs of $538 billion.

Following are major changes to Medicare since its inception.

1965: The “original” Medicare consists of two parts. Medicare Part A provides hospital insurance financed by payroll deductions and with no premium costs to those who have contributed. Medicare Part B is an optional medical insurance program for which enrollees pay a monthly premium. (More detail on the parts of Medicare is in that section below.)

1972: Medicare eligibility is extended to individuals under age 65 with certain long-term disabilities or end-stage renal disease.

1980: Home health services are expanded as part of the Omnibus Reconciliation Act, and Medicare supplement insurance, or “Medigap,” is brought under federal oversight.

1982: Hospice services for the terminally ill are added to the growing list of Medicare benefits.

1988: The Medicare Catastrophic Coverage Act includes the most significant changes since enactment of the program. It improves hospital and skilled nursing facility benefits, covers mammography, includes an outpatient prescription drug benefit and a cap on patient liability.

1990: New legislation requires state Medicaid programs to cover premiums of the new Specified Low-Income Medicare Beneficiary eligibility group, which are those eligible for Medicare with incomes between 100 and 120 percent of the federal poverty level.

1997: Legislation allows private insurance plans, originally called Medicare+Choice or Part C (later renamed Medicare Advantage), to offer beneficiaries the option of choosing an Health Maintenance Organization (HMO)-style Medicare plan instead of the traditional fee-for-service Medicare program.

2006: Medicare Part D is launched. This optional prescription drug benefit, established under the Medicare Modernization Act of 2003, allows beneficiaries to pay an additional premium to private insurers for this federally subsidized coverage.

2010: The Patient Protection and Affordable Care Act mandates that Medicare beneficiaries receive certain preventive care services and health screenings free of charge and reduces the out-of-pocket expenses of Part D enrollees.

What is it?

Medicare is the federal health insurance program for people 65 and older, certain younger people with disabilities and people with end-stage renal disease. Medicare spreads the financial risk associated with illness across society, even to people who cannot use it and may not want it or need it. This differentiates it from private insurance, which involves a risk pool of insured individuals and adjusts premiums according to projected risk.

Medicare covers about half of the health care charges for those enrolled in Medicare. Beneficiaries must then cover the remaining approved charges with either supplemental insurance or with another form of out-of-pocket coverage, which varies depending on medical needs. Supplemental insurance may also include uncovered services, such as long-term care, dental, hearing and vision.

Each part of Medicare is funded differently (parts described in the next section).

Part A	Funded primarily by payroll taxes deposited in the Hospital Insurance Trust Fund
Part B	Funding comes from general revenues and premiums paid by Medicare beneficiaries
Part C	Paid for by general revenues and beneficiary premiums
Part D	Funded by general revenues, premiums and state payments

What are the different parts (A, B, C, D)?

Different parts of Medicare cover different services, commonly referred to as Part A, Part B, Part C and Part D, described in detail below.

"Original" Medicare, administered directly by the federal government, is the way most people get Medicare coverage. It has two parts.

> **Part A** (hospital insurance) covers most medically necessary hospital, skilled nursing facility, home health and hospice care. It is free if an individual has worked and paid Social Security taxes for at least 40 calendar quarters (10 years). Those who have worked and paid taxes for less time pay a monthly premium.
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> **Part B** (medical insurance) covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services,

laboratory tests, x-rays, mental health care and some home health and ambulance services. Beneficiaries pay a monthly premium for this coverage.

Part C is not actually a separate benefit. It is the part of Medicare policy that allows private health insurance companies to provide Medicare benefits. These private Medicare health plans, such as HMOs and Preferred Provider Organizations (PPOs), are known as Medicare Advantage (MA) plans. Beneficiaries can choose to get their Medicare coverage through a MA plan instead of Original Medicare.

The MA plans must offer at least the same benefits as Original Medicare but can do so with different rules, costs and coverage restrictions. Most offer Part D (see below) as part of the benefits package. Many different types of MA plans are available. Beneficiaries pay a monthly premium for this coverage, in addition to the Part B premium.

Part D (outpatient prescription drug insurance) is the part of Medicare that provides outpatient prescription drug coverage. Part D is provided only through private insurance companies that have contracts with the government. It is never provided directly by the government, like Original Medicare is.

Who's eligible?
There are certain eligibility requirements for Medicare coverage.

65 and Over Most people qualify for Medicare beginning at age 65. Further requirements include U.S. citizenry or legal residency, a minimum five years U.S. residency and at least 10 years working in Medicare-covered employment. If these criteria are met, beneficiaries should automatically receive a Medicare card just prior to becoming eligible, showing benefits for Part A and Part B.

Those meeting certain conditions may not be automatically enrolled and will need to apply for coverage, known as "voluntary enrollment," and must pay premiums for both Part A and B. These include those who have not applied for Social Security or Railroad Retirement benefits, are employed by the government or have kidney disease.

Under 65 Generally, those under age 65 will qualify for Medicare if they have end-stage renal disease or have received Social Security Disability Income payments for 24 months (or in the first month of disability for ALS, "Lou Gehrig's Disease").

Medicare will not cover all medical costs for these individuals, but they have the option to buy additional coverage from private insurance companies – Medigap, Part D coverage and MA plans.

Difference between supplemental and MA plans
Because many Medicare beneficiaries want benefits beyond original Medicare and coverage for deductibles and copayments, they will opt to enroll in either a Medicare Supplemental (Medigap) or MA health insurance plan. The choice will depend on individual needs and preferences.

Medicare Supplemental (Medigap) Medigap insurance plans that work in conjunction with regular Medicare benefits. They cover many expenses not covered under Original Medicare, such as additional hospital days or international travel. They often cover deductibles or copayments. They do not include prescription drug benefits, so most people obtain this coverage through a Part D plan.

Plan benefits are standardized by the federal government so that plans sold by different insurance companies all offer the same benefit. These ten plan types, known as the “alphabet” plans, range in coverage and cost options. Different insurers can charge different premiums for each of the standardized plan types to reflect regional variations in cost.

Medicare Supplement plans are generally more expensive than Medicare Advantage plans, but have a larger network of providers.

Medicare Advantage (MA) The MA replaces Original Medicare. It is funded by Medicare but offered by private health plans, which are required to provide the same coverage as traditional Medicare. Plans vary beyond these minimum benefits in terms of coverage and copayments. Most charge a premium in addition to the Part B premium, and most include Part D coverage.

Since most MA insurers are HMOs, they will have a smaller network of doctors than those that accept Original Medicare, but are generally less expensive than Medigap plans.

<u>CalPERS Medicare program</u>

Enrollment
As of July 2014, there were 237,436 CalPERS members enrolled in Medicare plans. The majority, 119,887, are enrolled in HMO (MA) plans, with 110,897 in PPO (Medigap) plans and the remaining 6,652 in Association plans. The table below shows the number of Medicare subscribers, dependents and total covered lives by plan.

CALPERS MEDICARE ENROLLMENT, JULY 2014

Plan	Subscribers	Dependents	Total Covered Lives
Anthem EPO	1	0	**1**
Anthem HMO Select	15	6	**21**
Anthem HMO Traditional	39	20	**59**
Blue Shield EPO	260	118	**378**
Blue Shield Access+	22,250	8,140	**30,390**
Blue Shield NetValue	5,093	2,050	**7,143**
CAHP	2,654	1,447	**4,101**
CCPOA	476	203	**679**
Health Net Salud y Mas	7	6	**13**
Health Net SmartCare	2	1	**3**
Kaiser	59,351	20,617	**79,968**
Kaiser/Out of State	1,251	443	**1,694**
PERS Choice	41,979	17,302	**59,281**
PERS Select	884	337	**1,221**
PERSCare	39,080	11,315	**50,395**
PORAC	1,272	600	**1,872**
Sharp	24	16	**40**
UnitedHealthcare	141	36	**177**
Total	**174,779**	**62,657**	**237,436**
HMOs	88,434	31,453	**119,887**
PPOs	81,943	28,954	**110,897**
Association Plans	4,402	2,250	**6,652**

Plan options

The type of Medicare plan members have depends on whether they enroll in a PPO or HMO plan.

Members who enroll in one of the CalPERS Medicare PPO plans will be in a Medicare Supplemental plan. These plans coordinate with the Medicare program to help pay costs not covered by Medicare, a traditional fee-for-service Medicare approach.

Members who enroll in a Medicare HMO plan will be participating in Medicare Part C, or MA plans. These plans have been approved by the Medicare program and receive a monthly premium directly from Medicare to provide Medicare benefits.

Who's exempt and why?

There are four categories of age-eligible members who are exempt from enrolling in Medicare. These members are permitted to remain in a Basic (non-Medicare) plan.

Not Eligible Members who did not pay into Social Security or complete the required number of working quarters to be eligible for Part A. These are members who are not eligible for Medicare Part A without cost through their own work history or that of a current, former or deceased spouse. These are individuals who did not work 40 quarters in employment covered by Social Security of Medicare. California Code of Regulations (CCR) 599.517 (4) defines "Medicare-eligible" as eligible for Medicare Part A without cost and Part B.

Pre-1985 Exempt Prior to 1985 the CalPERS Board of Administration allowed Medicare age-eligible members to remain in the Basic plan. This is allowed by Government Code Section 22844(a) "Employees, annuitants and family members who become eligible to enroll on or after January 1, 1985, in Part A and Part B of Medicare may not be enrolled in a Basic health benefit plan…"

2001 California State University Exempt California State University (CSU) members are exempt from enrolling in Medicare and remain in the Basic plan. The CCR 599.417(a)(2) defines those "Post 2000 CSU Basic Health Plan Enrollees" who are allowed to remain in a Basic plan.

Pre-1998 Exempt Medicare eligible members between 1985 and 1998 who are enrolled in the Basic plan are exempt from enrolling in Medicare to avoid paying federal late enrollment penalties. The CCR 599.417(a)(1) defines those "Post 1997 Basic Health Plan Enrollees" who are allowed to remain in a Basic plan.

How are rates set?

The Centers for Medicare and Medicaid Services (CMS) use different rate setting methods depending on the type of Medicare plan. There are also differences between medical and prescription drug rate setting.

With Medicare Supplemental plans (mostly fee-for-service), on the medical side, CMS sets benefit designs and payment schedules to providers, and the health plan typically pays whatever portion of the medical claim is not covered by CMS (e.g., coinsurance and deductibles).

On the prescription drug side, the plan pays for the drugs in full, then CMS reimburses plans a portion of their costs through the Medicare Part D Employer Group Waiver Plan (EGWP).

With MA plans (mostly HMOs), CMS provides a subsidy to the health plan. The subsidy is based on an amount related to the average cost of health care for Medicare enrollees. This amount is adjusted by the health status of enrollees and the county the enrollee lives in. Typically, this is not enough to cover the full cost of Medicare care for MA enrollees. The remaining portion is covered by the health plan. There is also a bonus for MA health plans that receive a four or five star quality rating from CMS.* The MA plans typically have a drug component that works like Medicare Part D plans.

**Note: CMS' Star Rating System measures how well MA and Part D plans perform. Plans are scored annually on how well they did in several categories, including quality of care and customer service. Scores range from 1 to 5 stars, with five being the highest and one being the lowest. In addition to scores for each category, CMS assigns an overall score to summarize the plan's performance as a whole. The categories plans are rated on are listed below.*

Medical plans

- *Staying Healthy: Screenings, Tests and Vaccines*
- *Managing Chronic (Long-Term)Conditions*
- *Plan Responsiveness and Care*
- *Member Complaints, Problems Getting Services and Choosing to Leave the Plan*
- *Health Plan Customer Service*

Drug (Part D) plans

- *Drug Plan Customer Service*
- *Member Complaints, Problems Getting Services and Choosing to Leave the Plan*
- *Member Experience with Drug Plan*
- *Drug Pricing and Patient Safety*

The premium rates for CalPERS health plans are based on the portion of healthcare costs (both medical and pharmacy) not covered by CMS.

How does this relate to OPEB liabilities?

Other Post-Employment Benefits (OPEB) are those benefits an employee will begin to receive at the start of retirement, excluding pension benefits. The OPEB includes benefits such as life insurance premiums, healthcare premiums and deferred-compensation arrangements.

Beginning in June 2004, the Government Accounting Standards Board (GASB) established accounting and reporting standards for OPEB offered by state and local governments through Statement 45 (GASB 45). These accounting standards are used by these entities to prepare federally-compliant financial statements.

Prior to GASB 45 public agencies typically reported the cost of retiree healthcare and other non-pension benefits on a "pay as you go" basis as annual expenses, with no other liabilities or funding requirements reported. The GASB believed this method did not accurately reflect the true costs governments accumulate and that future benefits are an expense that must be recorded rather than deferred.

Generally, public agencies must now account for and report the annual cost of OPEB and the outstanding obligations related to OPEB in the same way they had for pensions. It is believed that disclosure of this information will lead to improved accountability and more informed policy decisions about the level and types of OPEB they choose to offer.

Though governments are not required by GASB 45 to fund these future obligations, they must now report them in their financial statements. For those who choose to fund them, the Annual Required Contribution represents the amount the employer would be required to contribute for the year to fund the obligation over time.

California's OPEB liability is reported by the State Controller's office for three pre-funding categories: none, partial and full. The State is currently not pre-funding, but reports all categories. The most recently available figures (June 30, 2013) are as follows.

No pre-funding	$64.6 billion
Partial pre-funding	$51.8 billion
Full funding	$42.5 billion

Each Public Agency (PA) is responsible for calculating and reporting its own OPEB liability and CalPERS does not collect that information. Additionally, PAs vary as to their level of pre-funding. For these reasons, an OPEB liability estimate for PAs participating in CalPERS health program cannot be estimated.

Once retiree health coverage was required to be reported as a liability (1990's), private employers began doing away with retiree health coverage. According to the Pension Research Council, in 1998 about 66 percent of private sector employers offered retiree health care; by 2013 only 25 percent did.

Potential Options Outside our Current Medicare Plan Offerings

Based on the information provided above, following are a few options the PHBC may consider for CalPERS Medicare health benefits.

Medicare Exchanges

Medicare exchanges are private companies that administer employers' Medicare health benefits. Costs are funded by employer contributions, and are used to pay premiums and sometimes out-of-pocket costs if there is a surplus from the contribution after premiums are paid. There are two primary types of Medicare exchanges.

Multi-carrier exchange In a multi-carrier Medicare exchange, the exchange contracts with a number of health insurance carriers. Multiple plans with different benefit designs may be offered by carriers and they may offer both Medicare Supplemental and Medicare Advantage benefit designs.

A multi-carrier exchange would provide members the most flexibility and choice. It could also provide the best geographic coverage, not just in California, but for out-of-state members, as well. Non-Medicare members may have equity concerns, as they would not have access to the wide choice offered by the exchange, including more and possibly lower-cost plans.

This option also introduces the notion of "guaranteed issue" rights, which guarantee that an insurance company will not underwrite applicants or refuse to sell them a policy during the initial enrollment period. After that time, if a member wishes to change plans, they could be subject to underwriting and higher rates. This represents a substantial diversion from the CalPERS employer group design, in which members are free to change plans during each year's open enrollment with no penalty for doing so. Historically, there is limited movement during open enrollment, so the actual impact to members might be minimal.

Currently, CMS requires guaranteed issue rights for anyone enrolling in a MA plan. Non-MA plans are subject to state regulation and vary from state to state. In California, non-MA Medicare members have guaranteed issue rights every year on their birthday.

Single-carrier exchange The PHBC could consider using a single-carrier exchange for all Medicare members. Single carriers can offer multiple plan options, and as with multi-carrier exchanges, the choice of Supplemental and Advantage plans.

This option would provide members with less flexibility and choice. There could be coverage issues with a single carrier who does not operate or have provider contracts in some areas (e.g., rural, limited states). Equity concerns may arise on the part of Medicare members, who would not have as much choice as non-Medicare (Basic) members who have access to all CalPERS carriers and plans.

Guaranteed issue is not as relevant with a single-carrier exchange, as most carriers will permit enrollees to change plans within that carrier without underwriting.

A benefit to CalPERS of either Medicare exchange option is the reduction of administrative responsibilities and costs to provide program oversight and support to these members, which would be the responsibility of the exchange. However, my|CalPERS modifications may be required to implement either type of exchange.

In the current program, when members achieve Medicare age, they can simply transition from a Basic plan to a Medicare plan with their current carrier, as carriers are required to offer a Medicare plan alongside their Basic plan offerings. Using a Medicare exchange could require them to leave the plan they are enrolled in to enroll with a carrier in the Medicare exchange, possibly having to change doctors. This would be less of an issue with a multi-carrier exchange, as chances would be greater that their current carrier might be available.

Many large employers have opted to use Medicare exchanges for their eligible populations. Public employers include the states of Wisconsin, Ohio and Nevada, as well as the University of California system. Private employers include Ford, General Motors and Chrysler.

Single-carrier (no exchange)

The PHBC could consider using a single, non-exchange carrier for all Medicare members. This option would have the same limitations as a single-carrier Medicare exchange in terms of choice, equity and the need to change plans upon turning 65.

Guaranteed issue is not relevant because it is not an exchange and members have only one carrier choice. Members moving from a Basic plan could be required to change plans, as with the Medicare exchange options.

CalPERS would retain administrative tasks for the Medicare population with this option, and it would have less impact to my|CalPERS systems.

Pilot an option on a subset of membership

The PHBC may also consider conducting a pilot program of one of the above options with a subset of Medicare members (e.g., out-of-state or from a single plan). The pilot could help determine whether the option is appropriate for CalPERS membership before being rolled out to the entire Medicare population.

No change

A final consideration is maintaining the status quo, in which all members have the choice of all carriers and plans, restricted only by their status (Medicare or non-Medicare) and residency (how it applies to plan availability).

BUDGET AND FISCAL IMPACTS

Upon receiving direction from the PHBC concerning potential options, staff will be in a position to provide budget and fiscal impacts.

BENEFITS AND RISKS

Option	Benefits	Risks
Multi-Carrier Exchange	• Less administration responsibilities for CalPERS • Lower administration cost • Most flexibility • Most choice • Most coverage, including out of state	• Equity concerns • my|CalPERS modifications • Underwriting concerns • Program oversight – members will be enrolled in individual Medicare plans, limiting the support and authority CalPERS provides through group coverage
Single Carrier Exchange	• Less administration responsibilities for CalPERS • Lower administration cost	• Potential coverage limitations • Equity concerns • my|CalPERS modifications • Possible need to change plans at 65
Single-Carrier (No Exchange)	• No underwriting concerns • Less impact on CalPERS systems	• Potential coverage limitations • Equity concerns • Possible need to change plans at 65
Pilot an Option on a Subset of Membership	• Opportunity to test different options	• Delays implementation of full-scale change
No Change	• No disruption for existing members	• Potentially higher than necessary costs

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