Aflac | Federal Relations Advisory

ALSTON&BIRD

EXPLORING MEDICARE PROPOSALS PART II:

The president's executive order and addressing inevitable out-of-pocket expenses

By Carolyn Smith and John Hickman, Alston & Bird, LLP

The president issued an executive order in October focusing on ways to enhance benefits under Medicare. This article provides a high-level overview of the proposals outlined in the EO. It also discusses potential exposure to out-of-pocket expenses and options to help individuals plan for such expenses, including the role of supplemental health benefits.

Background

In an earlier article, we addressed some current high-profile legislative proposals relating to Medicare, commonly referred to as "Medicare for All" proposals. These proposals are designed to expand eligibility for Medicare to allow more individuals to have Medicare or a Medicare-like plan as their primary health insurance. Some proposals would allow older individuals, age 50 and 55 or older, to enroll in Medicare. Others are more expansive and would allow all individuals to enroll in Medicare.

The president's latest EO focuses on regulatory changes to the existing Medicare program, including possible changes to both traditional Medicare — often called original Medicare — and Medicare Advantage. Traditional Medicare is a fee-for-service program under which the federal government pays health care providers directly. Private insurance companies that contract with the federal Medicare program offer MA plans. Our earlier article provides a high-level overview of the differences and similarities between traditional Medicare and MA plans. Data from the federal agency that oversees Medicare indicates that roughly two-thirds of those with Medicare are enrolled in traditional Medicare and one-third are enrolled in MA plans.

The president's EO on Medicare

The EO directs the federal Department of Health and Human Services to take action to accomplish a number of goals, including:

- Encouraging innovative MA benefit structures and plan designs, such as reducing barriers to Medicare medical savings accounts and promoting telehealth services and certain additional benefits.
- Encouraging MA payment models that allow beneficiaries to share more directly in savings from the program.
- Identifying approaches to modify traditional Medicare fee-for-service payments to inject market-based pricing.
- Adjusting network adequacy requirements for MA plans to account for the competitiveness of the health market in the state in which the plan operates and the enhanced access to health outcomes made possible through innovative technologies.
- Enabling providers to spend more time with patients.
- Encouraging innovation for patients such as through reducing the time it takes for required governmental approvals.
- Improving transparency of quality and cost information.

Because the EO is new, specific regulations aren't proposed in these areas yet, but HHS is expected to act fairly quickly in response to the president's direction.

The reality of out-of-pocket expenses

The practical reality is that individuals face health-related out-of-pocket expenses regardless of their primary health insurance. Some of the common circumstances that result in out-of-pocket expenses ***in addition to*** premiums for health insurance include the following:

- **Limits on payments for covered services**. If services are covered by your health plan, you may have out-of-pocket expenses due to:
  - Deductibles: The amount you owe for covered health care services before your health plan begins to pay any amount.
  - Copayments: A fixed amount you pay for a covered service (e.g., $25 for a primary care visit).

- Coinsurance: Your share of the cost of a covered service calculated as a percent (e.g., 20%) of the allowed amount for the service.
- Treatment limits: Some plans may limit the number of treatments for a particular service (e.g., a limit on the number of days of skilled nursing care or physical therapy treatments for an injury). In such cases, treatments in excess of the plan's limit are not covered services.
- Out-of-network benefits: Some health plans, including some MA plans, only cover services if the provider is in the plan's network. If services from out-of-network providers are covered, the individual will have higher out-of-pocket costs for seeing an out-of-network provider compared to the costs for seeing an in-network provider.

- **Noncovered health services.** The specific services that are covered and not covered by a health plan will vary based on the plan.
- **Other accident or health-related expenses**. Individuals may face a variety of expenses in the event of an injury or illness that primary health insurance is not designed to cover, such as transportation to the doctor or hospital, meal and lodging expenses to be near a hospitalized family member, respite care, nonmedical bills or household expenses.

The problem with out-of-pocket expenses

The Kaiser Family Foundation (KFF) reported in 2019 that the **average out-of-pocket expense** for persons in both Medicare Parts A and B in 2016 was **$5,806,** including medical expenses, long-term care services, and premiums for Medigap and other supplemental insurance.[1]

The KFF also recently reported that the average deductible alone for employer-sponsored plans with a **deductible is $1,573.**[2]

Yet, the Federal Reserve recently reported (May 2019) that almost 40% of Americans would have **difficulty in handling an unexpected $400 expense**, either having to borrow or sell something to pay for the expense or not being able to cover the expense at all.[3]

of adults reported skipping medical care in 2018 because they were unable to afford the cost.[3]

Addressing out-of-pocket health-related costs

One way to plan for health-related costs is through supplemental insurance policies. Supplemental coverage is designed to provide an additional layer of financial protection in the case of an accident or illness. These types of policies aren't intended to serve as primary health insurance or a substitute for such coverage. For this reason, federal and state law has long recognized these plans as "excepted benefits." They are generally "excepted" from requirements that apply to health insurance, including the Affordable Care Act requirements. Note: These policies are different from Medigap policies, which are regulated at both the federal and state level and are specifically designed to fill in the gaps in traditional Medicare coverage.

Dental and vision coverage

Health insurance often does not cover dental exams, eye exams and corrective lenses, and other related services other than certain preventive pediatric services. Traditional Medicare does not cover these services; some MA plans, however, do provide such coverage. In the employment-based health care market, vision and dental are often offered by employers through what is known as supplemental or "stand-alone" coverage that is limited to dental or vision care.

Stand-alone dental or vision coverage is generally available in a number of forms:

- Expense incurred: The plan pays a benefit to the provider or policyholder of a stated percentage of the cost of the covered service (e.g., 80%), up to a maximum dollar amount. If the insured goes to a provider outside the plan's network, benefits may be lower or the services may not be covered.
- Fixed indemnity: Plan pays cash to the policyholder based upon the particular service (for example, $YY for a cavity and $XXX for a crown, regardless of the cost of the service).
- Discount plan: The individual pays for a discount card that entitles the individual to receive a discount on services from providers who have agreed to accept the card. This type of coverage is not insurance but can result in savings compared to the price that the provider would otherwise charge for the service without the discount card.

Other types of supplemental coverage

Other types of supplemental coverage include:

- Accident
- Disability

- Specified disease policies (e.g., cancer or critical illness policies).
- Hospital fixed indemnity and other fixed indemnity policies that pay a specified amount due to hospitalization or other specified medical event.

Unlike typical health insurance, these policies generally pay a cash benefit triggered by a covered accident or illness unrelated to the amount of expenses incurred. This cash benefit can be used for any purpose as determined by the policyholder, whether to help compensate for the out-of-pocket costs that add up even with health insurance or for other financial needs. Thus, this type of policy provides financial protection due to an accident or illness that is flexible to meet the needs of the policyholder.

Conclusion

Regardless of what changes, big or small, lie ahead for our health care system, one reality is that there will always be expenses that health insurance doesn't cover. Supplemental benefits, including dental and vision coverage, specified disease, critical illness, hospital indemnity and other fixed indemnity health excepted benefits, are one way individuals can help reduce exposure to unexpected costs.

1. The Kaiser Family Foundation (2019). An overview of Medicare. Accessed from https://www.kff.org/medicare/issue-brief/an overview-of-medicare.

2. The Kaiser Family Foundation (2019). 2019 employer health benefits survey. Accessed from https://www.kff.org/report-section/ehbs-2019-summary-of-findings.

3. Board of Governors of the Federal Reserve System (2019). Report on the economic well-being of U.S. households in 2018 – May 2019. Accessed from https://www.federalreserve.gov/publications/2019-economic-well-being-of-us-households-in-2018-dealing-with-unexpected-expenses.htm.