# Re-Designing Medicare

## Findings from the California Medicare CHAT Collaborative

*September 2014*

## *Executive Summary*

Financial concern about Medicare is a topic of national attention. To encourage public engagement and input on the Medicare debate, the Center for Healthcare Decisions (CHCD) in partnership with LeadingAge California developed the California Medicare CHAT Collaborative ("MedCHAT"). More than 20 organizations became MedCHAT partners to help bring this civic engagement and research project to their communities.

Over the past year, 82 three-hour MedCHAT sessions were conducted in California with 810 participants: seniors, younger adults, healthcare professionals, and community and senior services leaders. The task was to review the benefits currently provided with Original Medicare and decide if an alternative design would be better for future generations.

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when there are no easy answers.

***The photos used in this report are those of participants from various MedCHAT sessions.***

# *Executive Summary*

## THE MEDCHAT TOOL

Using an interactive, computer-based simulation, participants create a benefits package where coverage options exceed current Medicare funding. Displayed on a pie chart, there are 12 categories of coverage and 1–3 tiers within each; the higher the tier, the more extensive and expensive the benefit. Each person has 100 markers to spend, representing the current amount that Medicare spends per person. The MedCHAT pie chart has 130 spaces available to reflect several new benefits to consider. The actuarial value of each category and tier was calculated by Milliman to be as representative as possible to current costs.

MedCHAT uses principles of public deliberation, where priority-setting and trade-offs are explicit, and group discussions help illuminate individual and societal values. Since any new Medicare benefit has to be balanced by reducing others, participants debate the pros and cons of the benefits that will best meet the needs of all Medicare users.

Since most people have little knowledge about the details of Medicare coverage, those tiers which represent existing coverage are identified as "current." This label helps participants recognize when they choose benefits that are more or less than existing coverage. A participant who places all 100 markers only on "current" tiers has selected the existing Medicare coverage and nothing more.

## RESULTS

The results below are based on round 4, the last decisions made in the MedCHAT process. In most of the 12 MedCHAT categories, the combined decisions of the participants reveal a Medicare design that is significantly different from current Medicare coverage.

### New coverage

There are five categories where most participants increase Medicare coverage:

1. **Long-term care.** To provide extended non-medical care to those with physical or mental impairment, 77% supported at least one year coverage in a nursing home, supportive housing or person's home.
2. **Dental, Vision and Hearing.** 85% supported modest coverage of all three as new Medicare benefits.
3. **Transportation.** For those who are unable to drive or use public transportation, 81% supported coverage to and from medical appointments as a new Medicare benefit.
4. **Mental Health.** To address the needs of those with less severe mental health problems, 69% increased coverage from short-term to long-term with a lower co-insurance than current coverage provides.
5. **Medicare's longevity.** To assure that Medicare lasts at least another 50 years, 85% were willing to reduce Medicare spending on current and future beneficiaries.

To add these benefits, participants had to eliminate existing benefits or impose new restrictions on current coverage.

## The structure of a 3-hour MedCHAT session:

**Led by trained facilitators, each session includes 8–15 people in a computer lab or with individual laptops. Participants complete a pre-CHAT survey, hear a short introduction to Medicare, and are instructed on using the computer program. MedCHAT consists of four rounds.**

- ***Round 1:*** Individually, participants design a Medicare plan for themselves or a senior family member; the needs of other seniors are not considered.
- ***Round 2:*** In groups of 2–3, participants work on one computer to agree on a Medicare plan for the whole country.
- ***Round 3:*** Facilitators lead the entire group through an extended discussion to create one uniform plan for the country; participants give their rationale for their choices and debate the reasoning they use to justify trade-offs.
- ***Round 4:*** On individual computers, participants make their final decisions on what Medicare should be for the country, and they complete a post-CHAT survey.

### New restrictions

Participants did not eliminate benefits, but they accept stricter criteria or new limitations:

1. **Require enrollment in a provider network.** Rather than the freedom of choice guaranteed now in Original Medicare, 82% supported the use of defined networks. Yet most included the proviso that a referral outside the network would be covered with approval of the primary care provider.
2. **Reduce coverage of low-value care.** Pertaining to patients with complex chronic conditions, 88% supported value-based coverage: if research showed that the benefit of a treatment was small, unlikely or more expensive than an equivalent treatment, patients would pay at least half the cost.
3. **Change coverage of end-of-life care.** For care of those with incurable and terminal illnesses, 65% supported coverage of palliative care/hospice but not for treatments unlikely to make a meaningful difference; 31% supported coverage of those treatments. 97% eliminated ICU coverage for dying patients.
4. **Apply penalties and rewards to urge patients' compliance.** For controlling early chronic conditions like high blood pressure and obesity, 48% supported using incentives — both penalties and rewards — to encourage compliance with medical advice. Another 36% supported using penalties only.
5. **Charge higher-income seniors more for Part B premium.** 79% thought that Part B premiums should be increased for higher-income seniors, especially those earning $85K and more.

## DISCUSSION

These choices differ significantly from Original Medicare and several correspond to topics that are foremost in today's healthcare policy discussions.

### Using provider networks

Californians' general acceptance of provider networks in MedCHAT may be because they are accustomed to this model within employer-based coverage. MedCHAT's actuarial model also shows that the cost of unrestricted choice was substantial, convincing many to re-think their commitment to this feature. This category may be viewed differently in states less accustomed to the network approach. Regardless, the cost of unrestricted choice has prompted national concern about fee-for-service payments on which Original Medicare is based. Efforts to reduce fee-for-service medicine may impact the unlimited choice now at the heart of Original Medicare.

### Setting boundaries on low-value care

While participants strongly supported reducing low-value care in Complex Chronic, less than 50% supported it in the categories of Catastrophic and Routine Care. The rationale was that for those who were otherwise healthy but struck by a major catastrophic event, even "long-shot" treatments should be tried. This willingness to cover marginal care was not supported for long-standing chronic conditions where the outcome was less likely to be changed. For Routine Care, many participants did not readily accept the fact that some preventive services could be low-value. These differing perspectives are important considerations as healthcare leaders consider fair and reasonable ways to use "value" as a coverage criterion.

### Connecting end-of-life and long-term care

Group discussions about the end-of-life category ("Final Phase") showed greater unanimity of viewpoint than any other category. Participants did not believe that doctors should offer life-sustaining treatment when the likelihood of failure is great and suffering is likely. They also believed there were better ways to use Medicare dollars.

There was not an explicit connection between saving money on end-of-life care and investing those dollars in long-term care services, but at times discussions linked the two issues. Despite controversial aspects of end-of-life treatment, some visionaries have proposed a new arrangement: if patients agree to use palliative care instead of further treatment that will offer little meaningful benefit, in exchange they receive expanded community and home-based services.

## ADDITIONAL INFORMATION

The full MedCHAT report contains detailed qualitative and quantitative findings, as well as the definitions of the categories and tiers; how participants' beliefs and attitudes changed in pre/post surveys; where there were demographic differences in MedCHAT decisions; more discussion about the implications of the results; the project limitations that are important in considering these findings; and a complete listing of MedCHAT session sponsors. To download the full report, go to www.chcd.org. Or contact Marge Ginsburg at CHCD (916) 333-5046.

## PROJECT PARTNERS

The organizations listed below joined CHCD and LeadingAge CA in contributing their time and resources to making MedCHAT a success.

- ACC Senior Services*^
- Alzheimer's Association, Northern California/ Northern Nevada Chapter
- American Society on Aging*
- California Department of Aging
- California Health Advocates
- Episcopal Communities & Services^
- Episcopal Senior Communities^
- Eskaton
- Huntington Hospital Senior Care Network*^
- Institute on Aging*^
- Keiro Senior HealthCare*^
- Legal Assistance for Seniors/Alameda HICAP^
- Navigage*
- Northern California Presbyterian Homes and Services*
- Partners in Care Foundation*^
- Plymouth Village Retirement Community*^
- SCAN Health Plan^
- Tim Schwab Healthcare Solutions*
- TELACU^

*Keiro Senior HealthCare merits particular recognition for bringing MedCHAT to so many of its communities.*

* Leaders of these organizations were members of the MedCHAT Steering Committee.
^ One or more staff were facilitators of MedCHAT sessions.

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- Blue Shield of California
- Dignity Health
- LeadingAge California
- Sutter Health

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