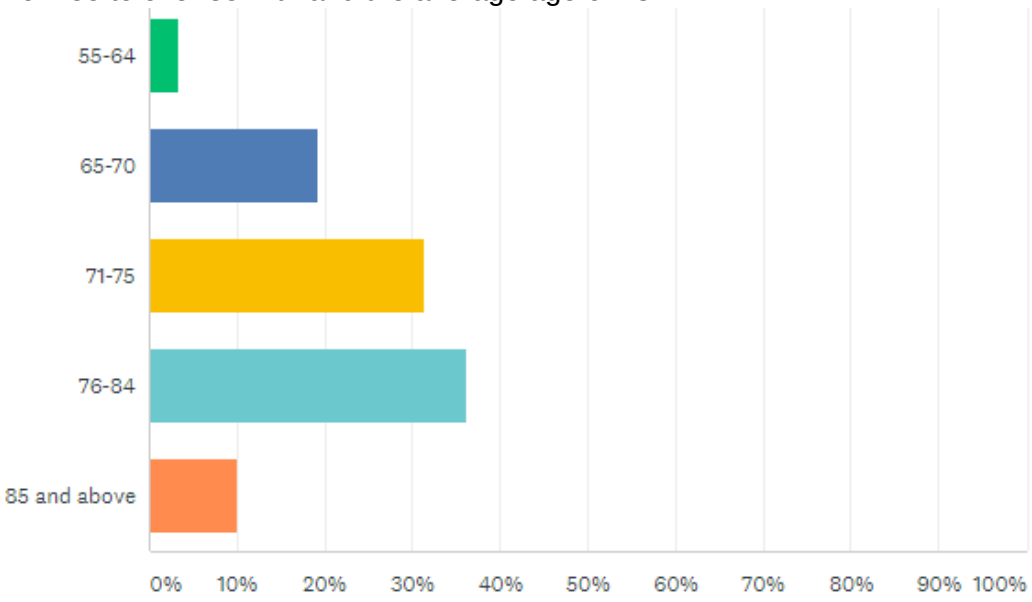
Medicare Out-of-Pocket Cap Survey Results Narrative

The National Retiree Legislative Network (NRLN) hosted a survey from July 13 to August 25, 2021, in which 3,312 NRLN members' responses to questions showed they mainly rely on original Medicare and a private supplement plan (Medigap) for healthcare, but costs are eating way their fixed income. The participants in the survey were from all 50 states. They retired from 161 companies or public entities. Ages of responders ranged from 55 to over 85 with and the average age of 78.

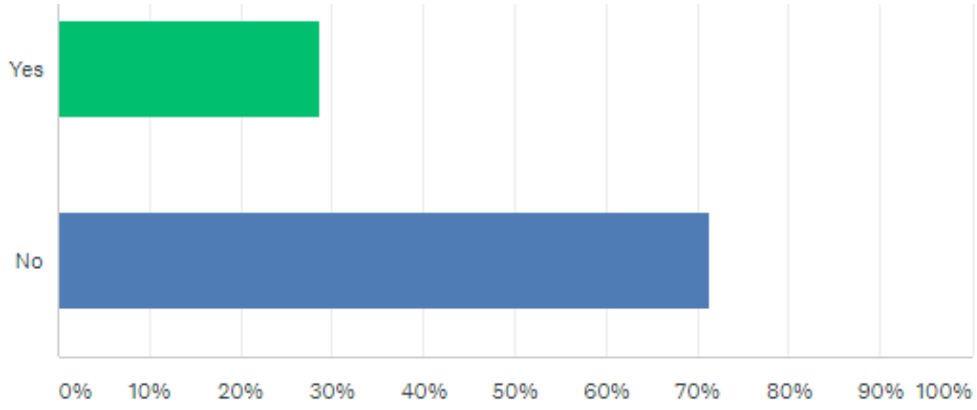


The purpose of the survey was to collect information on what NRLN senior members over age 65 pay for healthcare under the coverages of their various insurance plan types, how healthcare costs affect their economic stability and to assess their interest in adding an out-of-pocket cap to Medicare - would it help them meet financial obligations. Their overall response to the question on adding out-of-pocket coverage was:

Eighty-eight percent of the responders to the survey said **they think adding an out-of-pocket cap to original Medicare sounds reasonable** so that they would have financial protection and another choice to compete with Medicare Advantage and supplemental coverage. Ninety percent said they think Medicare should have **an out-of-pocket cap for everyone**, whether they are in original Medicare or Medicare Advantage.

The first ten survey questions were common - every respondent was asked to answer all ten. The first three questions collected information on respondents ages, geographic location and organizations from which they retired (see findings above).

Question four asked: **Are you aware that if you enroll in a Medicare Advantage plan and then switch from it to Original Medicare within 12 months from your enrollment date that you could also buy a Medigap plan without having to meet pre-existing conditions requirements?** Seventy-one percent of the 3,274 who answered the question said "No".



Questions five through ten were intended to identify their cost of healthcare, including policy premiums, copays and coinsurance and the financial impact of these outlays on their livelihood - regardless of the plan type they were covered by and coverage or cost consequences of plan switching after initial enrollment:

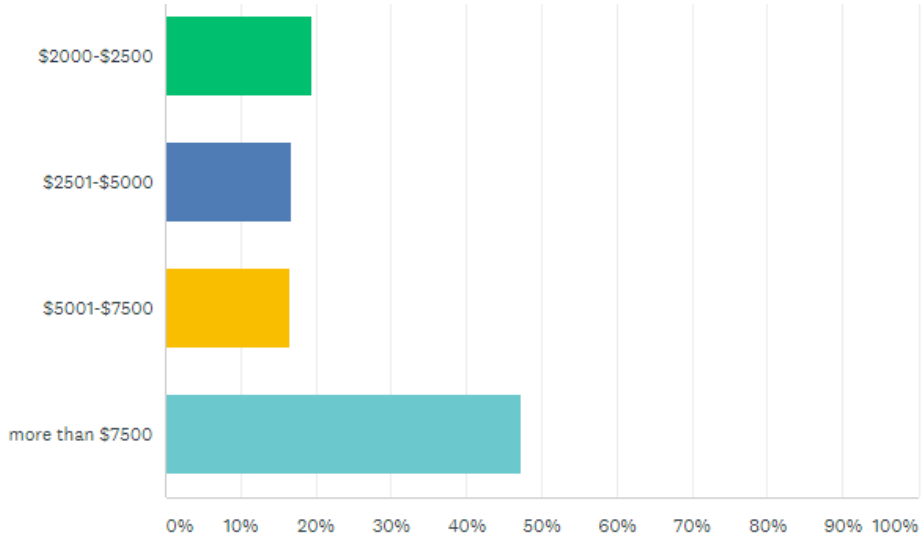
What is your monthly premium for healthcare insurance, not counting Medicare? Nineteen percent of those responding had zero monthly premium. Twenty-five percent $1-$150. Sixteen percent $151-$200. Thirteen percent $201-$250. Ten percent $251-$300. Seventeen percent over $300.

If you pay an annual deductible amount, how much are you required to pay? Thirty-one percent of those responding had zero annual deductible. Twenty-one percent $1-$250. Eighteen percent $251-$500. Eight percent $501-$1000. Nineteen percent $1001-$5000 Three percent over $5000.

With your current healthcare plan, if you have ever paid more than $2,000 a year for your care out of pocket, how much did you pay? Twelve percent $2000-$2500. Sixteen percent $2501-$5000. Five percent $5001-$7500. Four percent over $7500. Sixty-three percent never paid more than $2000.

If you spent over $2000, what percent of your annual income did that sum represent? Seventy-one percent 0-10%. Twenty-one percent 11-20%. Six percent 21-30%. Two percent over 30%.

Did or would having to pay the following amounts in a year cause you to borrow money to make ends meet? Twenty percent $2000-$2500. Seventeen percent $2501-$5000. Sixteen percent $5001-$7500. Forty-seven percent more than $7500.



Please provide a limited version of your personal story on how medical expenses caused you to spend more than $2,000 a year on healthcare.

The leading expenses that caused responders to spend more than $2,000 a year on healthcare were: heart surgeries and heart attacks, cancer treatments (chemotherapy and radiation), strokes, knee and hip surgeries and rehab, high priced prescription drugs, cataract and lens implants surgery, hearing aids, dental surgery, crowns and implants, diseases that required hospitalization, multiple illnesses within the same year.

The following are some quotes from survey participants that quantify what caused them to spend in excess of $2000 to more than $7,500 a year on healthcare.

“We owe $41,000 in deductibles and copays for the past 5 years medical bills not covered by Medicare and Medigap. All we can do is tell multiple collection agencies to stand in line. We will likely never be able to pay these bills.”

“Cost of prostate cancer surgery and 9 weeks of radiation, including out-of-network charges resulted in $11,000 out-of-pocket costs.”

For my wife and I to have the health coverage we need that addresses our medical needs (prostate and skin cancer, a faulty heart valve, bad knees, hips and feet, etc.) we pay over $6,000 a year out of pocket just for our Medigap coverage.

“We pay $167 a month for supplemental insurance for both me and my wife. It started out at $135 only 5 years ago and keeps increasing annually! That's now $4008 a year for us!”

“Lost all medical coverage from Kodak. Operations caused extra costs. I’m spending over $10,000 on medical expenses for my wife and I. I didn’t plan on these costs because I thought Kodak would be covering us.”

“Husband had bypass surgery and the out of pocket was $3,000.”

““Have $3250 out of pocket max for medical expenses. In 2020 I did have several hospital expenses so I did pay the max out of pocket.”

“I pay the annual Medicare deductible of $203 and $1850 for a supplemental medical policy. My wife pays the same. Total annual healthcare cost us $8328 + dental & vision.”

“Wife and I have heart issues. Additionally, my wife has dementia and the out-of-pocket expenses leave us with very little left to make ends meet. My daughter helps us financially but is limited on her pension also.”

“I need to take Forteo for osteoporosis; but cost is $994.00 per month WITH insurance. So, I’m not able to take it.”

“Deductibles, premiums, vital doctor treatments not covered by Medicare, prescriptions not covered by Medicare easily add up to over $4,500 a year, and I do not go to the dentist anymore because that is not covered.”

“I take a maintenance drug to keep my cancer from returning it cost me $9,000 a year Medicare covers the other $150,000 that I would have to pay if I did not have insurance.”

“Because of uncovered medical expenses, we are in collection with collection agencies for approximately $100,000.00 over the past two years. My wife is now completely without any insurance coverage because of her medical disability, but not yet 65.”

“I have a rare blood disorder. The drug I need is called Jakafi and the cost is $8,000 PER MONTH just for that drug.”

“We are living on my Social Security and a small pension. If we had to spend more than $2000 out-of-pocket, it would be a huge problem.”

“Thyroidectomy, CKD Stage 3, Hypertension, Prostate Cancer, checkups, pharmaceuticals, blood tests cause me to exceed my $3290 max out of pocket annually.”

“Over $34K I spent last year for Lyme treatments with doctors who do not take insurance. Most good Lyme Literate doctors don't take insurance.”

“A cancer diagnosis 3 years ago. Zeroed out my FSA on treatment copays and deductible (over $8000). Yearly drug expense is around $7000.

“Medicare $1648.00. Medicare Supplemental Insurance $4924.00. Dental Insurance $1024.80. Doctors $1112.71. Prescriptions $3031.49. Total. $11,951.88”

““Had to have my gall bladder removed and had to pay $3,500 out of pocket. Had to put it on my credit card.”

“I was hospitalized 3 times in 2020 for spinal surgery, pulmonary emboli, and chest pains. Total bills were $150,000, Medicare allowed $15,000, and I had to pay 20% of that ($3,000).”

“My wife has MS and her medicine used to cost around $2000 per month but last year it was closer $3500 a month. This year would have been closer to $10,000 a month, but luckily her doctor took her off that medication.”

“Health Savings Account tracks all of my out-o- pocket healthcare expenses. It's on track at a rate to spend $5,600 in 2021. The biggest part of that is drugs.”

“Hip issues. Heart issues and heart drugs going into donut hole. Drugs not covered by Medicare advantage due to 3 pills a day instead of limit of 2 pills a day limit, so they covered zero pills. Dental crown and normal cleanings. Vision exams, specialists, contacts and glasses. I have to pay a lot more then Medicare $148.50/Mo.”

“COPD drug cost is $700 per day for IPF of my lungs. It is not a formulary drug.”

“Hip replacement and physical therapy caused me to Reach my annual $995 out-of-pocked max. All expenses were covered after a reached the max.”

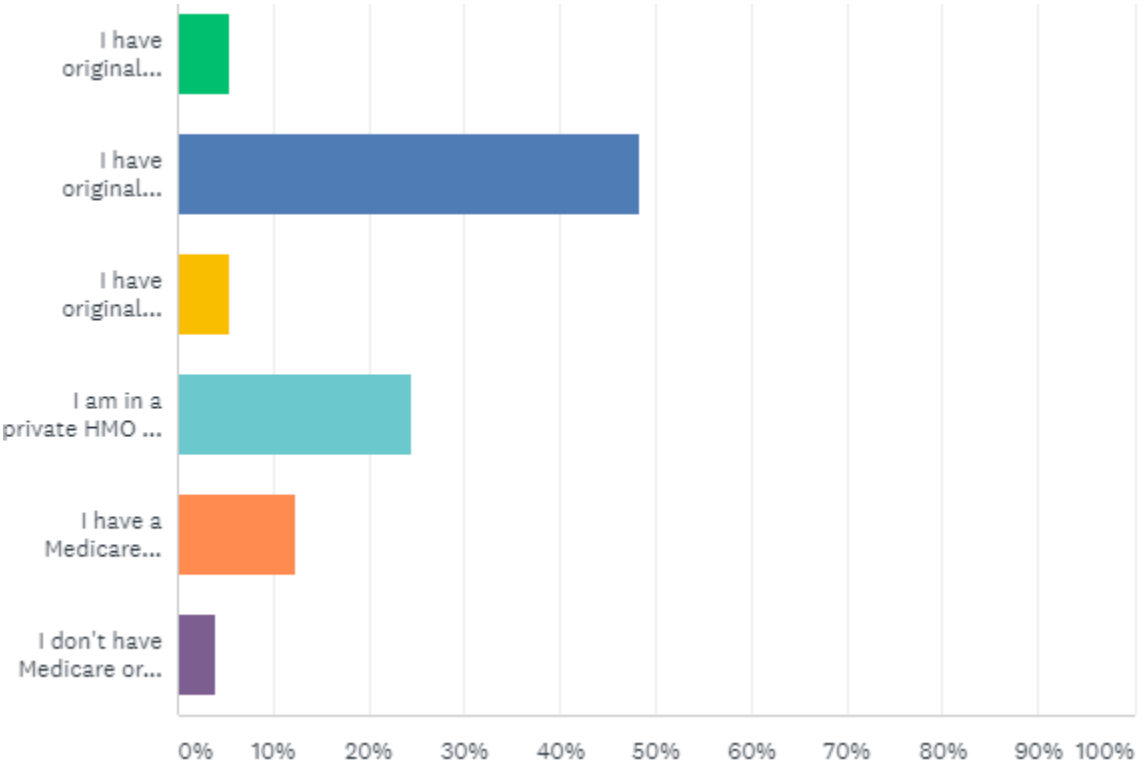
“I had numerous blood tests, over 15 scans (about $7500 each), and 6 chemo treatments (about $10000 each)”

“I passed Gaul stones and two got stuck. It took three ERCP's to get them removed. Eleven days in the hospital. $116,000 total bill. I paid $3900.”

“Macular degeneration monthly injections - approximately $2400/month for the injection & medicine.”

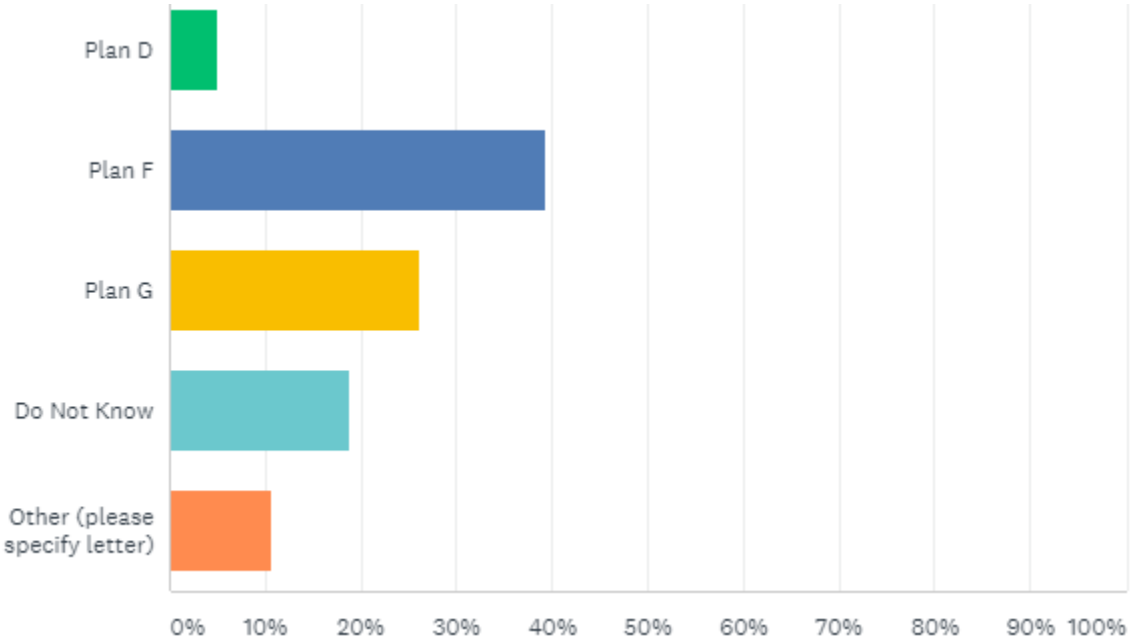
“My wife has mucous membrane pemphigoid (known as MMP) regarded as an autoimmune disorder. Only doctor with significant knowledge of this disease is on staff at the University of Washington Medical Center. She saw him twice, but now Kaiser Permanente's contract with UWMC has expired and they have informed us that they won't pay for any additional treatments which might be quite expensive.”

Beginning with survey question eleven, we asked them to answer questions that were aimed at their particular coverages in one of the six (6) types of Medicare and other private plans they might be covered by and then asked a series of questions about these specific plans:



1) 49% - Nearly half of the responders (49%) have **original Medicare Part A and B, pay the Medicare Part B $148.50 monthly premium and pay for a Medigap plan**.
2) 24% - Twenty-four percent (24%) are in a private insurer Medicare Advantage (Medicare Part C) plan and if they are on Social Security the $148.50 premium is deducted from their monthly check.
3) 12% **- Some employers provide their workers and retirees a Medicare Advantage Plan** and (12%) of the responders have this benefit and also pay the $148.50 monthly Medicare Part B premium.
4) 6% - Nearly 6% of the responders have Original Medicare A & B only – no supplemental coverage.
5) 5% - Results showed that 5% of the responders **have original Medicare Part A and B from a union, former employer or another organization** and pay the $148.50 monthly Medicare Part B premium.
6) 4% - Only 4% said they do not have original Medicare or Medicare Advantage and rely on other private insurance or Medicaid.

The 49% of responders who **have original Medicare and a Medigap plan**, 39% have Plan F; 26% Plan G; 5% Plan D; 11% had other Medigap plans (many were Plan N) and 19% were not sure which Medigap plan they had.



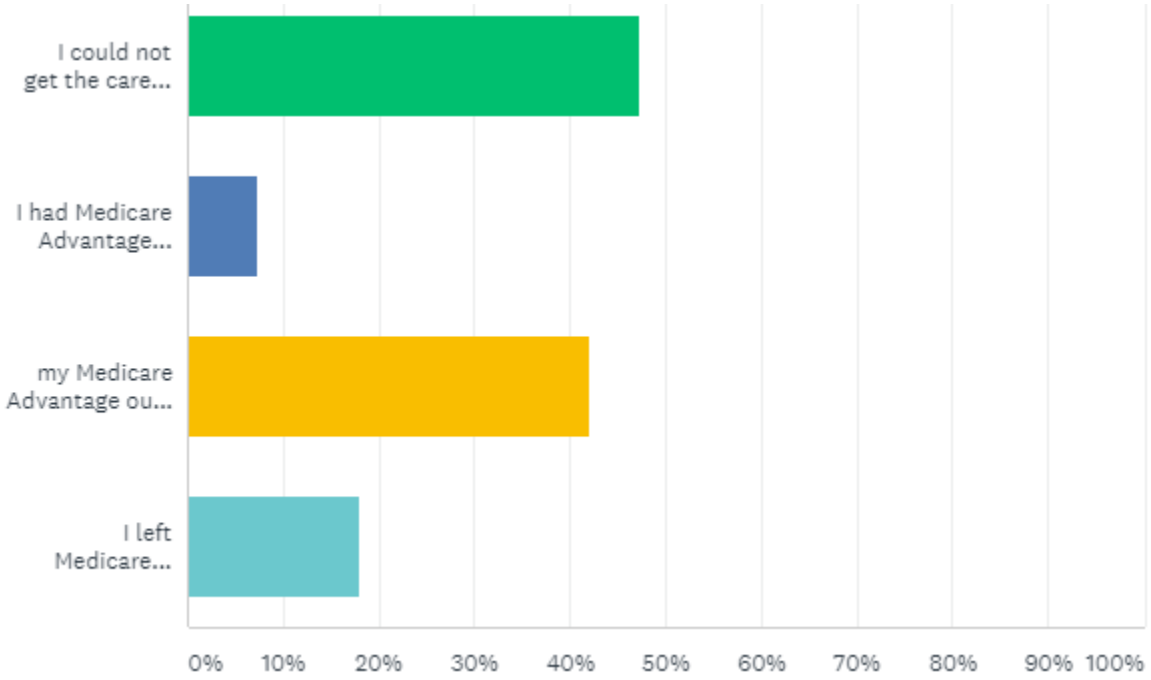
Survey respondents covered by all six plans were then asked a series of questions about their ability to switch (change plans) from one of the six plans to another and if they did, what happened. Specific questions about private Medicare Advantage plan switching consequences, services networks, and out-of-pocket limits were included in this section of the survey:

Eighty-eight percent said “No” **that they had never tried to purchase another Medigap plan**. Six percent were denied the purchase of another Medigap plan because of a pre-existing condition and 3% **attempted to purchase another Medigap plan but didn’t because the premium and/or deductible was too high**. Another 3% had various answers to the question.

Survey participants who had a **company group plan** were asked whether it pays for original Medicare A and B and some of their Medigap coverage by paying them **a monthly stipend to help buy supplemental coverage**? Sixty percent said “No”. In addition, 83% said they do not pay added premiums to their employer for any other coverages.

Ninety-six percent of those responding to the survey **said they had never switched from a Medicare Advantage plan to original Medicare** with or without addition of a Medigap plan. The 4% who had switched had two predominate reasons for switching. Forty-eight percent said they **could not get the care they needed from a Medicare Advantage** provider. The reason that 41% switched was their **Medicare Advantage out-of-pocket cost was too high**. The third main reason was they left Medicare Advantage before the 12-month protection period expired **so their pre-existing condition could not be used to increase the Medigap plan**

premium or outright deny their application. A few said they switched because their **Medicare Advantage plan had denied their claims**.



When they switched varied. Fifty-seven percent switched from a Medicare Advantage Plan to original Medicare **before the Medicare 12-month deadline expired so they could guarantee being accepted by a Medigap plan without having to meet pre-existing requirements**. Ten percent who had a pre-existing condition switched after the 12-month deadline but **were accepted conditionally or permanently without having to pay a higher premium**. Others with a pre-existing condition switched after the 12-month deadline and were **accepted for a Medigap plan but had to pay a higher premium**. However, some who applied for a Medigap plan after the 12-month deadline **were denied coverage**.

In response to, **has your Medicare Advantage plan ever refused to pay for medical care that your doctor said was needed**, “No” was the response from 88%. Ninety-two percent said they **have never chosen to go without care** in order to avoid having to pay a Medicare Advantage plan out-of-pocket amount. Eighty-eight percent said they had **never had delays getting their Medicare Advantage plan to pay for needed care**. Seventy-seven percent said they have **never had to go out of network to get the care** their doctor said they needed.

“No” was the answer from 79% (company plan respondents) to the question **have your out-of-pocket payments reached or exceeded your plan’s maximum level in any for the last three years?** However, 14% said they had **exceeded their Medicare Advantage plan’s out-of-pocket** in 2020; 14% in 2019 and 12% in 2018. Seventy five percent responded that they do not pay added premiums to their employer for any other coverages.

The survey did not request participants name or contact information, only their city, state zip code and company or public entity from which you retired. However, responders were invited to provide their name, email address and/or phone number if they were willing to be contacted for more information. There were 1,138 individuals who provided their contact information.