NATIONAL HEALTH POLICY
FORUM

FORUM SESSION

Rethinking Medicare's Cost Sharing and Supplemental Coverage:

Options and Implications

APRIL 12, 2013

Beneficiaries' cost-sharing requirements under Medicare Parts A and B have remained largely unchanged since the program's inception in 1965 and are unlike the design of many contemporary health insurance products. As shown in Table 1 (next page), Medicare Part A has a relatively high deductible ($1,184 in 2013) for inpatient stays for each spell of illness and daily copayments that vary for extended hospital or skilled nursing facility stays—services that are generally perceived as less discretionary. Part B has a relatively low annual deductible ($147 in 2013), but has 20 percent copayment on physician visits and most other Part B services—services typically regarded as more discretionary.

In addition, Medicare has no upper limit on beneficiaries' out-of-pocket costs. This leaves beneficiaries at risk for high out-of-pocket spending if they use a lot of services or very expensive services. In 2009, almost one-quarter were liable for more than $2,000, and 6 percent were liable for more than $5,000 (as shown in Figure 1, page 3). To protect against some or all of their liability for cost-sharing, about 93 percent of beneficiaries participate in a Medicare managed care plan or have some kind of supplemental coverage such as Medigap or employer-sponsored retiree health benefits (Figure 2, page 4). Supplemental coverage protects beneficiaries from unexpected costs. Such protection can be especially valuable for those living on low and fixed retirement incomes. Critics argue that first-dollar or near-first-dollar coverage, a feature of some supplemental coverage polices which shields beneficiaries from all cost sharing for a service, eliminates the incentive for beneficiaries to be judicious users of health care services. Reducing first-dollar coverage would, however, create a risk that some individuals may forgo necessary services, exacerbating

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

TABLE 1
Medicare Cost Sharing for Select Services Under Parts A and B, 2013

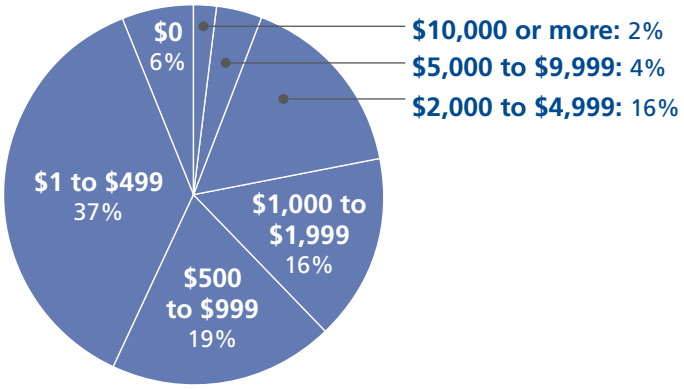
SERVICES	BENEFICIARY LIABILITY
Part A	
Inpatient Hospital Stay	• $1,184 deductible per benefit period • $0 for the first 60 days of each benefit period • $296 per day for days 61-90 of each benefit period • $592 per each lifetime reserve day after day 90 of each benefit period (up to 60 days over a lifetime) • All costs beyond lifetime reserve days
Skilled Nursing Facility	• $0 for the first 20 days each benefit period • $148 per day for days 21-100 each benefit period • All costs for each day after day 100 in a benefit period
Home Health Care	• $0 for home health care services • 20% of the Medicare-approved amount for durable medical equipment
Hospice Care	• $0 for hospice care. • Copayment of no more than $5 for each prescription drug for pain relief and symptom control • 5% of the Medicare-approved amount for inpatient respite care (may range from $5-$12 per day)
Part B	
Part B Premium	• $104.90 per month • Beneficiaries pay more if their incomes are over $85,000 per year for individual tax filers or $170,000 per year for joint tax filers.
Part B Deductible	$147 per year
Medical and Other Services	• 20% of the Medicare-approved amount for most doctor services, drugs covered under part B, outpatient therapy, and durable medical equipment • Some screenings and preventive services are exempt from beneficiary cost sharing
Outpatient Hospital Services	• Coinsurance (for doctor services) or copayment amounts for most outpatient hospital services vary by service and are being phased down to 20% over time • Copayment for a single service cannot exceed the amount of the inpatient hospital deductible
Outpatient Mental Health Services	• 20% of the Medicare-approved amount for visits to a doctor or other health care provider for diagnosis, monitoring or changing prescriptions • An additional copayment or coinsurance for treatment in a hospital outpatient clinic or hospital outpatient department. This amount will vary depending on the service provided, but will be between 20 to 40% of the Medicare-approved amount • 35% of the Medicare-approved amount for outpatient treatment (like individual or group psychotherapy) in a doctor or other health provider's office or hospital outpatient department
Clinical Laboratory Services	$0 for Medicare-approved services

Source: Medicare.gov, "Medicare Costs at a Glance," U.S. Department of Health and Human Services, available at www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html#collapse-4631.

their health care needs. (For additional information see the Forum's Issue Brief No. 845, "Recent Proposals to Limit Medigap Coverage and Modify Medicare Cost Sharing."[1])

Several recent proposals would alter Medicare's cost-sharing requirements, for example, by combining and changing the deductible for Parts A and B, altering the amount and form of cost sharing for covered services, and adding a cap on beneficiaries' out-of-pocket spending. Some options for cost-sharing restructuring would combine these changes with limits or penalties on supplemental coverage. Some of these proposals, such as that from the National Commission on Fiscal Responsibility and Reform (also known as Simpson-Bowles), have the explicit goal of reducing the rate of growth in Medicare spending, while others, such as the Medicare Payment Advisory Commission's (MedPAC's) June 2012 recommendation, seek to protect beneficiaries against high out-of-pocket spending and mitigate the need for supplemental insurance. These and other proposals vary in the amount, if any, they are expected to save the Medicare program, the aggregate amount of Medicare spending that is shifted to beneficiaries, and the redistribution of beneficiary spending across Medicare enrollees depending on their service use.

FIGURE 1
Cost-Sharing Liability for Medicare Fee-for-Service Beneficiaries, 2009



Note: Amounts reflect cost sharing under fee-for-service Medicare—not what beneficiaries paid out of pocket. Most beneficiaries have secondary insurance that covers some or all of their Medicare cost sharing. Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year and not enrolled in private Medicare plans.

Source: Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare and the Health Care Delivery System, *June 2012, p. 8, available at* www.medpac.gov/chapters/Jun12_Ch01.pdf.

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

Judith Miller Jones
Director

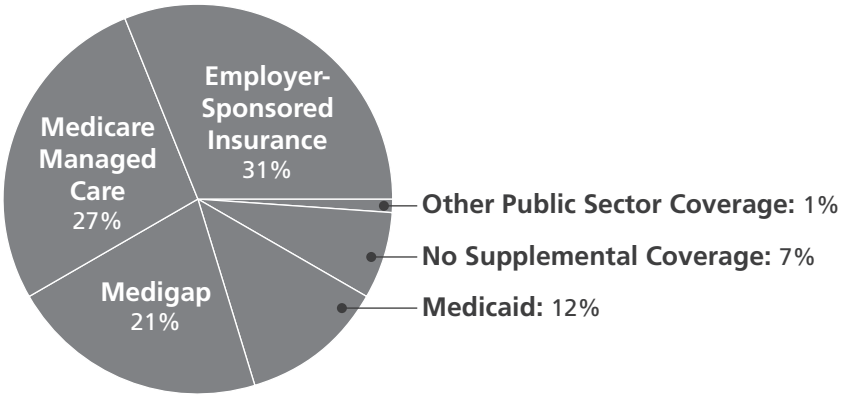
Sally Coberly, PhD
Deputy Director

Monique Martineau
Director, Publications and Online Communications

Forum Session Manager

Kathryn Linehan
Principal Policy Analyst

FIGURE 2
Sources of Supplemental Coverage for Non-institutionalized Medicare Beneficiaries



Note: Beneficiaries could have had coverage in more than one category in 2009 but were assigned to the supplemental coverage category that applied for the most time in 2009. "Other public sector" includes federal and state programs not included in other categories. Analysis includes only beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in Parts A and B throughout 2009, or who had Medicare as a secondary payer.

Source: MedPAC, A Databook: Healthcare Spending and the Medicare Program, *June 2012, p. 51, available at* www.medpac.gov/chapters/Jun12DataBookSec5.pdf

SESSION

This session explored recent recommendations for restructuring Medicare's cost sharing and policies to limit supplemental coverage. **Tricia Neuman, ScD**, vice president and director with the Medicare Policy Project at the Henry J. Kaiser Family Foundation, discussed other recent proposals and options to change Medicare's benefit design and supplemental coverage, implications of these policies for beneficiaries, and policies to strengthen protections for low-income beneficiaries. **Mark Miller, PhD,** executive director of MedPAC, provided key background information on Medicare's benefit design and supplemental coverage and discussed MedPAC's June 2012 recommendation to reform Medicare's benefit design. **Dale Yamamoto**, founder and president of Red Quill Consulting, fellow of the Conference of Consulting Actuaries, member of the American Academy of Actuaries, member of the National Academy of Social Insurance, and fellow of the Society of Actuaries (1980-2012), has over 30 years of experience providing employers with actuarial and strategic consulting to support their employee benefit programs. He discussed retiree health benefits for Medicare-eligible retirees, including typical retiree coverage benefit design, and how changes in Medicare cost-sharing requirements and restrictions or penalties on supplemental coverage would affect current and future retirees and employers.

KEY QUESTIONS

- What are the goals of different proposals/options to restructure Medicare's cost-sharing requirements and limit or discourage supplemental coverage? How would a catastrophic limit on out-of-pocket spending reduce the need for supplemental coverage?

- What is the evidence on the effect of first-dollar and near-first dollar coverage on Medicare beneficiaries' use of services? How does current Medicare cost sharing and the presence of first-dollar coverage affect the program's ability to help beneficiaries distinguish high-value services?

- How are beneficiaries affected by different proposals/options to restructure Medicare's cost-sharing requirements? How do the effects vary depending on service use, income, type of supplemental coverage, etc.? How does coverage of preventive services with no cost sharing affect the value of first-dollar coverage? What are the options for protecting low-income beneficiaries from increases in cost sharing? How would this affect program spending?

- Are beneficiaries who buy Medigap policies getting good value for their premium dollar? How much are beneficiaries willing to pay for predictability of the monthly Medigap premium versus the unpredictability of Medicare cost sharing?

- How should employer-sponsored benefits be considered in discussions of supplemental coverage reform? What do typical retiree health benefits cover? What do covered beneficiaries pay out of pocket? What are the difficulties of regulating employer-based supplemental coverage?

ENDNOTES

1. Kathryn Linehan, "Recent Proposals to Limit Medigap Coverage and Modify Medicare Cost Sharing," National Health Policy Forum, Issue Brief No. 845, February 24, 2012, available at www.nhpf.org/library/details.cfm/2885.