



Health Policy Brief

JUNE 20, 2013

Restructuring Medicare. To reduce federal spending, advance entitlement reform, and simplify benefits, policy makers have proposed redesigning Medicare cost sharing.

WHAT'S THE ISSUE?

Policy makers in Washington have been debating the role that entitlement programs, such as Medicare, should play in reducing federal deficits. Proposals to restructure Medicare's benefit design have been suggested as a means to reduce Medicare spending by the federal government.

Some policy makers have recommended redesigning the program to protect beneficiaries from high out-of-pocket spending, better align incentives to reduce overuse of services, and potentially lower costs for the federal government. Opponents of such reform efforts fear that, in trying to reduce federal spending, reforms will shift costs onto beneficiaries and could make them less likely to seek needed care.

This brief explores the options that have been discussed for redesigning Medicare cost sharing and the potential impact on beneficiaries.

WHAT'S THE BACKGROUND?

With the exception of the addition of prescription drug coverage in 2006, Medicare's general benefit design is largely unchanged since the program was created in 1965. Its complex design is different from other insurance plans available today. Part A covers inpatient services and postacute care. Most people ages 65 and older are entitled to Part

A benefits based on their work history and do not pay a premium for Part A coverage. Part B covers outpatient services, including doctor's visits, such as doctor's services provided during an inpatient stay; hospital outpatient care; and durable medical equipment, such as canes, walkers, and hospital beds. Beneficiaries can choose whether or not to receive Part B coverage, and most pay a premium that is 25 percent of the average cost of Part B services for older enrollees (\$104.90 in 2013). Beneficiaries with income greater than \$85,000 pay a higher Part B premium. Some low-income beneficiaries receive help from Medicaid paying the Medicare premium.

Medicare Parts A and B are together referred to as traditional "fee-for-service" Medicare because they generally pay for care based on the individual services (or bundle of service) provided—although this may change as Medicare continues to implement value-based purchasing and tests innovative payment models. Beneficiaries can choose to get Medicare through this traditional approach, or they can choose to receive benefits through a private health care plan by enrolling in Medicare Part C, called Medicare Advantage (MA).

Medicare Part D offers voluntary prescription drug coverage through private plans for beneficiaries in both traditional Medicare and MA plans. Beneficiaries who choose to enroll in Part D pay an additional premium. Low-income beneficiaries are eligible to receive additional financial assistance from the federal

government that pays all or a portion of this premium. High-income beneficiaries pay an additional amount for Medicare Part D.

The Medicare structure becomes even more complicated when beneficiary cost sharing is taken into consideration. In addition to the Part B and Part D premiums, Medicare beneficiaries are also responsible for paying a portion of their care before Medicare starts paying—called the deductible—as well as coinsurance, or share of the covered expenses. The deductible and cost sharing vary depending on the type of service the beneficiary receives (Exhibit 1). Inpatient services under Part A are measured by benefit period, which begins with the day of admission to the hospital or skilled nursing facility and ends when the beneficiary has not received any inpatient care for 60 days. There is a relatively high deductible per benefit period, and a beneficiary can have more than one benefit period each year. Beneficiaries do not pay any additional amount beyond the deductible for the first part of an inpatient stay but are responsible for a per day copay for stays beyond a certain length.

For most Part B services, beneficiaries pay a relatively low annual deductible and then 20 percent of the Medicare payment amount for most services. The exceptions are clinical laboratory services; home health services; and certain preventive services, such as recommended cancer screenings for which Medicare pays the full amount, and the beneficiary pays nothing. Part B cost sharing is particularly difficult to predict because it is a percentage of the payment for services received. These costs

can vary depending on where the service is provided and how it is reported on the claim.

Beneficiary cost sharing for prescription drugs under Part D also varies according to the plan. The Part D benefit includes catastrophic coverage, which helps people with extremely high drug spending. There is no similar assistance with high medical costs under traditional Medicare.

Medicare's structure no longer resembles the insurance that people receive when they are working. In testimony before the US House Ways and Means Health Subcommittee, the Kaiser Family Foundation's Tricia Neuman described the current Medicare benefit structure—with separate deductibles for Parts A, B, and D, and cost-sharing requirements that vary by type of service—as more complex than a typical large employer-sponsored plan. Further, unlike typical large-employer plans, Medicare does not have a limit on out-of-pocket spending. The American Academy of Actuaries notes that typical private health plans have an integrated benefit design that allows for management of hospital and nonhospital care in a coordinated manner.

In part to deal with the expense and uncertainty of the Medicare cost sharing, most beneficiaries in traditional Medicare have help covering out-of-pocket costs from some form of supplemental insurance. The Medicare Payment Advisory Commission (MedPAC) reports that fewer than 10 percent of Medicare beneficiaries have traditional Medicare alone. About 27 percent of Medicare beneficiaries enroll in MA plans; 31 percent have additional employer-sponsored coverage; 12 percent receive help from Medicaid to pay Medicare cost sharing; and another 21 percent purchase a Medigap plan.

Medigap is private insurance that, for an additional premium, covers Medicare cost sharing and certain benefits not covered by Medicare. The most popular Medigap plans pay all of the Medicare deductible and coinsurance. With this so-called first-dollar coverage, beneficiaries do not pay a fee for each Medicare service they receive because the cost sharing is built into the premiums for their supplemental insurance.

Some research indicates that beneficiaries with supplemental coverage use more services than beneficiaries with traditional Medicare alone. A recent study published in *Health Affairs* by Ezra Golberstein and coauthors found

EXHIBIT 1

Fee-for-Service Medicare Cost Sharing, 2013

Medicare part	Deductible	Covered service	Cost to beneficiary
Part A	\$1,184 per benefit period	Inpatient hospital	Days 1–60: \$0 Days 61–90: \$296 per day Days 91–120: \$592 per day Days 121+: all costs
		Skilled nursing facility	Days 1–20: \$0 Days 21–100: \$148 per day Days 101+: all costs
Part B	147 per year	Most Part B services	20 percent of Medicare payment amount
		Clinical laboratory, home health, and certain preventive services such as recommended cancer screenings	\$0

SOURCE Medicare.gov, "Medicare 2013 Costs at a Glance," cited 2013 Jun 18.

that overall health care spending grew more rapidly between 1992 and 2005 for beneficiaries with supplemental coverage than those with Medicare alone, although there was less difference when examining just Medicare spending growth. The available research cannot determine whether those additional services represent appropriate treatment or unnecessary care.

10%

Of Medicare beneficiaries

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WHAT'S THE PROPOSAL?

Different groups have explored reforms to traditional Medicare's benefit structure that do not include changes to MA or Part D. The Bowles-Simpson Commission, the Bipartisan Policy Center's Debt Reduction Task Force, key members of Congress, and MedPAC have all proposed redesigning Medicare's traditional benefit structure. The proposals have many similar elements: a combined deductible for both Parts A and B and a maximum on out-of-pocket spending.

The level of the deductible and out-of-pocket limit varies in the different proposals as do other details, such as the cost-sharing requirements and associated reforms to Medigap and other supplemental insurance plans. For example, some proposals include 20 percent cost sharing for all services, including both inpatient and outpatient. In contrast, MedPAC recommends copays set at a certain dollar amount that varies by the type of service and provider.

An even more comprehensive proposal put forth by Karen Davis and colleagues at the Commonwealth Fund would create a new option called Medicare Essential that combines Medicare Parts A, B, and D with a single deductible (\$250) and modest copays for physician visits (\$20 for primary care and \$40 for specialist) and a ceiling on out-of-pocket costs (\$3,400). It also includes incentives to encourage use of certain high-value services, such as registering and receiving care with a primary care provider or using providers within an accountable care organization.

The specific parameters of a particular proposal affect the impact of the changes on both beneficiaries and federal spending—in general, the higher the deductible or out-of-pocket cap, or both, the more likely the proposal will increase spending by beneficiaries and decrease spending by the federal government. For example, a proposal with a single deductible of \$550 for Parts A and B; uniform coinsurance of 20 percent for all services; and an

out-of-pocket spending limit of \$5,500, which was described in the Congressional Budget Office (CBO) budget options 2011 report and subsequently analyzed by the Kaiser Family Foundation, would result in lower spending for some but higher spending for most in any given year. Compared to the current design, for beneficiaries who use physician services but who are not hospitalized, this model would most likely increase beneficiaries' out-of-pocket spending on Part B services, largely because the combined deductible is greater than the current Part B deductible. Under this model, beneficiaries with inpatient stays are the ones most likely to see a reduction in spending.

Under this design, the Part B premium would increase slightly because Medicare would pay 100 percent for services that exceed the \$5,500 cap, primarily hospital outpatient services. Therefore, even beneficiaries who receive no Medicare services would pay more in premiums under this proposal than under the current design, although the effect will likely be modest. The Kaiser Family Foundation found that this model would increase spending for almost three-quarters of beneficiaries with an average increase in spending of \$180 per year. Many of the beneficiaries expected to see the highest increases (\$250 or more a year) are in fair or poor health and have incomes of 100–200 percent of the federal poverty level, which is generally too high to qualify for Medicaid coverage.

The effect on the federal budget of the redesign proposal alone would be relatively modest as a share of Medicare spending. CBO estimated that if such design were implemented January 1, 2013, federal spending on Medicare benefits between 2013 and 2016 would be \$13 billion, or roughly 0.5 percent less than it would have been under the current design. Other proposals with different deductibles, copays, and limits will have a different—sometimes substantially different—impact on both beneficiary spending and the federal budget.

When combined with other reforms, the impact on the federal budget is more substantial. Many redesign proposals include changes to limit first-dollar coverage under Medigap or charge an additional premium on such coverage. For example, MedPAC recommends adding a surcharge for supplemental plans that offer first-dollar coverage, including both Medigap and employer-sponsored plans. Alternatively, Davis and colleagues would require Medigap plans to have a minimum \$250

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deductible and offer a lower-cost comprehensive benefit through Medicare to eliminate the need to purchase a separate Medigap plan.

These proposed changes are expected either to reduce consumption of Medicare services by preventing beneficiaries from obtaining first-dollar coverage (proposals to prevent plans from offering first-dollar coverage) or to offset the higher government expenditures that result from such coverage (surcharge proposals). CBO estimated that if, in addition to the benefit redesign, Medigap plans were prohibited from paying the combined Part A and B deductibles and could only pay up to 50 percent of the Medicare cost sharing above the deductible, federal spending would be reduced by \$35 billion between 2013 and 2016.

WHAT'S THE DEBATE?

Medicare's current structure is widely recognized as being outdated, lacking predictability and protections for the beneficiary, such as a cap on out-of-pocket spending. It also gives beneficiaries little incentive to seek the highest-value care or avoid unneeded care. Although some advocates of Medicare redesign seek to improve the benefit structure, others view these reforms as a means of reducing federal spending chiefly by shifting costs onto beneficiaries.

Efforts to restructure Medicare are seen by many as a middle path between the current program and other reforms, such as Rep. Paul Ryan's (R-WI) premium-support proposal that would more fundamentally alter the nature of Medicare. Redesign has been touted as a potential breakthrough in the ongoing budget stalemate between the White House and Congress, because it would provide entitlement reform advocated by Republicans with beneficiary protections that might appeal to Democrats. House Majority Leader Eric Cantor (R-VA) endorsed the concept of combining A and B deductibles and capping out-of-pocket costs, and President Barack Obama has been reported as telling House Republicans that he is open to the idea.

Supporters of redesign believe that cost sharing under a redesigned Medicare program will be more predictable and simpler for beneficiaries to understand and better align incentives to reduce any overuse of services. Others fear that, if designed to reduce federal spending, restructuring the benefit design would likely shift costs onto many Medicare beneficiaries. Critics note that Medicare bene-

ficiaries already spend three times as much of their income on health care as do people under age 65. Critics believe most beneficiaries cannot afford to pay more for their health care and are particularly concerned about proposals that include even higher deductibles or out-of-pocket caps than that studied by CBO and the Kaiser Family Foundation. Such proposals, including for example, the Lieberman-Coburn proposal from 2011, with spending limits that would range from \$7,500 to \$22,500 depending on income, would have a greater impact on federal spending but would further shift costs onto Medicare beneficiaries.

Reforms of supplemental coverage, particularly efforts to limit first-dollar coverage, are also controversial. Opponents particularly question the wisdom of Medigap reforms that would likely reduce beneficiaries' use of both necessary as well as unnecessary services. Studies in the *New England Journal of Medicine* and the *American Economic Review* suggest that eliminating first-dollar coverage of Part B services may reduce use of outpatient services but increase hospitalizations, which could increase overall Medicare spending in some instances.

The National Association of Insurance Commissioners (NAIC) recently recommended that the Department of Health and Human Services not add cost sharing to Medigap plans. NAIC noted that supplemental plans have little ability to change what care Medicare beneficiaries seek as well as how effective it is: The Medicare program determines what services are covered or not covered, and physicians guide individual beneficiaries on what particular care they need. NAIC expects that beneficiaries are unlikely to disagree with physicians about whether specific care is necessary, regardless of financial incentives.

It is also possible that redesigning the traditional Medicare package to reduce variability in costs and limit total liability might make Medigap policies less attractive. If restructuring reforms enables beneficiaries to give up Medigap, beneficiaries may pay more in Medicare deductibles and cost sharing but could ultimately save more money overall without the Medigap premium.

However, experience suggests that beneficiaries prefer to avoid the uncertainty associated with deductibles and coinsurance and does not provide clear answers as to how beneficiaries may respond to these new incentives. In 1988 the Medicare Catastrophic Cov-

\$1.3 billion

Less in federal spending

One proposal was estimated to save \$13 billion in federal spending on Medicare benefits between 2013 and 2016.

erage Act added both catastrophic coverage and a prescription drug benefit to Medicare. The law was highly unpopular with seniors, in part because of the new taxes used to pay for the additional coverage, and was quickly repealed. Analysis by Thomas Rice and colleagues of surveys conducted at the time found that beneficiaries were highly risk averse and preferred coverage with no deductibles or copays, even though that coverage required additional premiums.

WHAT'S NEXT?

President Obama's budget proposal for fiscal year 2014 includes pieces of suggested reforms, such as instituting a surcharge on the most generous Medigap plans, increasing the Part B deductible for new beneficiaries, and imposing a copay on home health services, but it does not include comprehensive reform. However, Medicare redesign remains a topic of interest on Capitol Hill. The House Ways and Means and Energy and Commerce

Health Subcommittees held hearings on this subject on February 26 and April 11, respectively. Ways and Means Subcommittee Chair Kevin Brady (R-TX) indicated that he expected to hold more hearings on the future of Medicare and hoped to forge a bipartisan approach to reforming the program.

Although out-of-pocket spending limits and combined deductibles are something that both sides seem open to at least considering, the question is whether they can reach agreement on the specifics of a redesigned program, including the appropriate levels for the combined deductible and the out-of-pocket maximum. Medicare restructuring is often raised as part of a broader ideological debate over the need for entitlement reform and whether Medicare beneficiaries should be asked to pay more to reduce federal spending. In addition, there is also a larger question as to whether such reform could realistically be adopted in a political environment in which passing any legislation has proved daunting. ■

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