Redesigning Medicare Benefits

The NCHC Fact Sheet Series

Americans face serious health care challenges: rising costs, barriers to access and affordability, and real gaps in care quality, especially for certain chronic diseases. While these challenges affect all of us, they are most acute when we are at our most vulnerable, such as when we confront old age, face disability, weather economic hardship, or reside in communities afflicted by health disparities. Amidst the sometimes heated debates around health care and the federal deficit, ordinary citizens and health care advocates alike need to be informed and engaged. This fact sheet is one of a series examining the policy choices before us.

Background

Medicare provides a guaranteed set of health benefits and insurance coverage to seniors and Americans facing disability or end-stage renal disease, regardless of income, assets, or medical history. In 2012, 48 million beneficiaries and their families benefited from this federal entitlement program. However, with rising health care expenditures and an aging population, policymakers and thought leaders are considering changes to the structure and costs of the benefits that Medicare provides. This fact sheet examines four of the most commonly proposed changes to Medicare and analyzes their strengths and weaknesses.

Limit Supplemental Coverage

Most Medicare beneficiaries (90%) have additional health insurance that helps cover those out-of-pocket expenses that the traditional Medicare benefit does not cover. Supplemental coverage comes from a variety of sources, including employer-sponsored insurance (covers 33% of all beneficiaries), Medicare Advantage plans (24%), Medicaid (15%), and private supplemental policies, known as Medigap plans (17%). Some beneficiaries have multiple sources of coverage. [1]

The added financial protection that these policies provide can help ensure that Medicare's cost-sharing does not restrict needed care. However, by reducing or eliminating cost-sharing, supplemental coverage can also lead to unnecessary health services and higher costs for Medicare. Thus, policymakers have suggested changing the terms of supplemental coverage. The Simpson-Bowles plan[2] and proposed Congressional legislation would prohibit supplemental plans from offering "first-dollar" plans, which cover all of a patient's out-of-pocket charges, including the initial deductible and co-pays. Proposals from MedPAC and the Obama Administration[3] would allow the sale of "first-dollar" plans but would subject those sales to additional taxation. Savings range from modest ($3.6 billion in the Obama Administration's budget) to substantial ($75 billion in the Simpson-Bowles plan).

Pros

Supplemental coverage adds to Medicare's overall program costs through additional utilization—much of which may be unnecessary. And because taxpayers and Medicare beneficiaries' premiums pay for much of those costs, proponents argue that restrictions on supplemental coverage are a fair strategy for producing savings. Additionally, even the most aggressive proposals to curb supplemental plans would still allow protection from out-of-pocket costs for the lowest income Medicare beneficiaries through Medicaid or Medicare Savings Programs.

Cons

Discouraging supplemental coverage increases the out-of-pocket burden for seniors and disabled Americans. This additional cost sharing could increase the economic burden of care and discourage the use of needed services at all income levels. With 31% of Medigap purchasers earning $20,000 a year, restrictions on supplemental coverage could have a particularly serious impact on vulnerable beneficiaries.

[1] Kaiser Family Foundation. "Sources of Supplemental Coverage Among Medicare Beneficiaries, 2009." Accessed 5 May 2013 at http://kff.org/medicare/slide/sources-of-supplemental-coverage-among-medicare-beneficiaries-2009/.

[2] [3] National Commission on Fiscal Responsibility and Reform. "The Moment of Truth: Report of the National Commission on Fiscal Responsibility and Reform." 2010 December. Accessed on 5 May 2013 at http://momentoftruthproject.org/sites/default/files/TheMomentofTruth12_1_2010.pdf.

[3] The Obama Administration. Fiscal Year 2014 Budget of the U.S. Government. Office of Management and Budget. Accessed on 3 May 2013 at http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/budget.pdf.

Institute an Out-of-Pocket Cap and Unified Deductible

Unlike most other health insurance, Medicare does not provide a cap on enrollees' out-of-pocket costs. Medicare also has separate deductibles for Part B physician services and Part A hospital and post-acute services.

Recent proposals from the Medicare Payment Advisory Commission, the National Commission on Fiscal Responsbility and Reform, and members of Congress attempt to reform this structure. A common recommendation is to institute a "catastrophic cap" on the amount of out-of-pocket expenses for which Medicare beneficiaries can be held responsbile. Additionally, a single "unified deductible" would be applied to both Medicare Part A and B services.

Pros

This policy would strengthen the Medicare program by protecting beneficiaries against significant health costs. The lower deductible for Part A hospitalizations, in conjunction with the catastrophic cap, would reduce beneficiaries' exposure to out-of-pocket costs. The budgetary impact of this policy varies according to the size of the unified deductible and the level of the catastrophic cap, but CBO estimates that one variation on this approach would save $32 billion over ten years.[4]

Cons

Under a unified deductible, beneficiaries could face a higher deductible than now. This increase could deter them from seeking the care needed to treat health conditions early and less expensively. Moreover, only a fraction of enrollees would actually benefit directly from the catastrophic cap or the lower deductible for Part A services, because 90% of Medicare beneficiaries already receive supplemental coverage.[5]

Expand Means-Testing Approach

Means-testing refers to a process by which an enrollee's premiums or cost sharing is adjusted to reflect his or her income and assets. In fact, the amount that beneficiaries pay for Medicare Part B and Part D premiums already varies according to income. Under changes enacted in the Affordable Care Act, the percentage of Medicare beneficiaries who pay higher income-related premiums will increase to 10% by 2019. Members of both political parties have proposed increasing the proportion of individuals who pay higher premiums, co-pays, or deductibles.[6]

Pros

By curbing the financial value of Medicare benefits to wealthy Americans, additional means-testing could produce significant savings. Since Medicare's finances are likely to be constrained, proponents argue that the program's resources should be given first to those who need them most.

Cons

Means-testing could undermine the character of Medicare as a social insurance program for Americans of all income levels. Beneficiaries with higher incomes could be expected to disenroll at a high level of means-testing. Medicare would then increasingly become a program devoted to the poor, and might therefore lack the broad support needed for political sustainability.[7]

Implement Value-Based Insurance Design

Out-of-pocket costs for Medicare enrollees vary with each type of service (i.e. doctor's visits have a different cost-sharing arrangement than hospice care). However, with the exception of a few preventive services provided without cost-sharing, those costs do not vary based on the effectiveness of a particular treatment or a particular provider.

MedPAC, the Obama administration, and several outside experts and stakeholders have recommended allowing Medicare to implement Value-Based Insurance Design. This approach would allow Medicare to charge less for higher-value treatments or providers and to charge less for low-value treatments and providers.

Pros

Supporters argue incentivizing high-value care and disincentivizing low-value care can help ensure Americans are spending health care dollars more wisely.

Cons

Some treatments or providers may be of little value for most patients but contribute substantially to the health of other patients. Designing a value-based cost-sharing arrangement that accounts for the diversity of patients' needs could be challenging. Additionally, a recent analysis found that programs that relied on lowering cost-sharing improved adherence but generated little monetary savings.[8]

[4] See p.49 of "Reducing the Deficit: Spending and Revenue Options" from CBO. 2011 March. Accessed 5 May 2013 at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf.

[5] Kaiser Family Foundation. "Key Medicare and Medicaid Statistics." Accessed 5 May 2013 at http://kff.org/medicaid/upload/key%20Medicare%20and%20Medicaid%20Statistics.pdf.

[6] American Enterprise Institute. "Means Testing and Its Limits." 2011 September. Accessed on 3 May 2013 at http://www.aei.org/article/economics/retirement/means-testing-and-its-limits/.

Center for American Progress. Senior Protection Plan. 2012 November. Accessed 3 May 2013 at http://www.americanprogress.org/wp-content/uploads/2012/11/SeniorProtectionPlan.pdf.

[7] National Committee to Preserve Social Security and Medicare. "Medicare and Means Testing." 2013 January. Accessed 5 May 2013 at http://www.ncpssm.org/PublicPolicy/Medicare/Documents/ArticleID/212/Medicare-and-Means-Testing.

[8] Choudry NK, et. al. "Value-Based Insurance Design: Quality Improvement But No Savings." Health Affairs, Accessed 26 July 2013 at http://content.healthaffairs.org/content/32/7/1251?=right.