Perspectives

REFORMING MEDICARE

Option: Redesign Medicare's Copays and Deductibles

Medicare Part A pays for inpatient hospital, skilled nursing facility, hospice and home health care. Part B pays for physician and outpatient services (excluding prescription drugs). Part A and Part B have different cost-sharing and deductibles. Under Part A, beneficiaries who receive inpatient hospital services pay a deductible ($1,156 in 2012) in each benefit period, and there is no initial cost-sharing for hospital stays under 60 days. In contrast, the annual deductible for Part B services is $140, and beneficiaries must pay 20 percent of their costs after meeting their deductible. Some proposals would combine the Part A and Part B programs to have only one deductible (for example, $550) and one coinsurance (for example, 20 percent) for all Part A and Part B services. Currently, there is no annual upper limit on out-of-pocket expenses for Part A or Part B. Some proposals would set an out-of-pocket limit.

Prepared for the Public Policy Institute by: Avalere Health, LLC

Argument for:

Redesigning Medicare copayments and deductibles could simplify and streamline Medicare benefits for beneficiaries. It can be confusing to track the various deductibles and cost-sharing requirements across the different parts of the Medicare program. More uniform cost-sharing will give beneficiaries a coverage program that works more like the private health insurance plans that many had prior to enrolling in Medicare.

If an annual out-of-pocket spending cap were included in this redesign, Medicare beneficiaries—particularly those with high utilization—would have more financial protection from expenses caused by severe and often unexpected illnesses. This could also reduce the need for supplemental insurance, such as Medigap. While most beneficiaries likely will not reach the out-of-pocket limit in a given year, knowing that the limit exists could give them a greater sense of financial security.

Redesigning Medicare cost-sharing could also create savings for the federal government. One study estimated that the federal government could save up to $110 billion over a 10-year period if the Part A and Part B programs had a combined annual deductible of $550, a uniform 20 percent coinsurance rate for all services (reduced to 5 percent after beneficiary out-of-pocket costs exceeded $5,500), and an annual out-of-pocket cap of $7,500. In addition, increased cost-sharing could make beneficiaries more price-sensitive in using health care services, resulting in lower utilization and greater Medicare savings. These savings would improve the long-term stability of the Medicare program for both current and future beneficiaries.

Argument against:

Many Medicare beneficiaries would end up paying more out of their own pocket if Medicare cost-sharing were combined across Parts A and B. Beneficiaries who use few services or primarily physician services could be particularly affected by a combined deductible that is greater than the current Part B deductible and the new coinsurance requirements for certain services. Similarly, beneficiaries with higher hospital utilization could be adversely affected by proposals that apply coinsurance to the first 60 days of a hospital stay.

In addition, Medicare beneficiaries, especially those with modest incomes or no supplemental coverage, could find it difficult to afford these cost-sharing requirements. These beneficiaries may decide not to get the medical care that they need in order to avoid paying coinsurance or deductible amounts, which could lead to poorer health outcomes and higher Medicare costs in the long run. Providers, not patients, know what services and tests are appropriate—patients are in no position to second-guess their health care providers.

Supplemental plans are expected to help enrollees pay for the new cost-sharing requirements under the alternative benefit design. However, under some proposals, supplemental plans could pass some of these new expenses on to enrollees in the form of higher premiums, which would affect even the relatively few Medicare beneficiaries who do not use any Medicare-covered services in a given year.

Avalere Health, LLC *is a leading advisory company focused on health care business strategy and public policy.*

Perspectives 9, June, 2012

AARP Public Policy Institute,
601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
202-434-3890, ppi@aarp.org
© 2012, AARP.
Reprinting with permission only.

The views expressed herein are for information, debate and discussion,
and do not necessarily represent official policies of AARP.

Perspectives