Leadership Council of Aging Organizations

ISSUE BRIEF

MARCH 2016

Medicare "Redesign" Proposals Could Harm Many Beneficiaries

Background:

The Medicare program provides vital health coverage to approximately 54 million seniors and people with disabilities. While traditional Medicare guarantees coverage for a range of health care services, it is neither comprehensive in scope nor is it without cost to beneficiaries. Cost-sharing under traditional Medicare (including deductibles, copayments and coinsurance) can be both significant and complicated, especially for those who lack retiree insurance or other supplemental coverage.

In order to both achieve federal savings and seemingly simplify the program, some policymakers have suggested redesigning the traditional Medicare benefit. While details vary, most proposals would combine the Part A and B deductibles, implement a single coinsurance rate for health care services (including new home health cost-sharing), limit first dollar coverage in Medigap plans, and create an out-of-pocket spending cap for beneficiaries.

Our Position:

Congress should tread carefully with respect to redesigning the Medicare benefit. While we welcome a discussion about expanding Medicare benefits and reducing all beneficiaries' out-of-pocket costs, the Leadership Council of Aging Organizations (LCAO) opposes redesigning or restructuring benefits for the purpose of achieving savings for the federal government by shifting even higher health care costs on to beneficiaries. As long as redesigning the Medicare program is approached with the aim of securing federal savings, such efforts are likely to unfairly redistribute costs to beneficiaries, including those with fixed incomes, and limit access to needed health care.

Our Rationale:

- **Many redesign proposals would increase the costs on the majority of Medicare beneficiaries.** For example, one typical cost-sharing proposal examined by the Kaiser Family Foundation includes a combined Part A and Part B deductible of $550, 20% coinsurance rates for health care services, and a $5,500 out-of-pocket cap. Under this proposal, 71% of people with Medicare would pay more for health coverage and only 5% would pay less. Further, for the 5 million people who would experience annual increased costs greater than $250, the average increase total would be $660 each in 2013.[i]

- **Most people with Medicare cannot afford to pay more.** In 2014, half of Medicare beneficiaries—more than 25 million seniors and people with disabilities—lived on incomes at or below $24,150. One quarter of Medicare beneficiaries had annual incomes at or below $14,350.[ii] On average, Medicare households already spend 14 percent of their income on health care costs, about three times as much as non-Medicare households.[iii]

- **Low-income beneficiaries are not protected against Medicare cost-sharing.** Eligibility for assistance with Medicare cost-sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100% of poverty (plus $20 a month, totaling $12,012 for singles and $16,176 for couples in 2015) and non-housing assets below just $7,280 for singles and $10,930 for couples. This is far less generous than cost-sharing protections available to those under age 65, with eligibility at 138% of poverty and no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third are actually enrolled in the program.[iv] Changing Medicare cost-sharing in the manner suggested by many redesign proposals would redistribute the burden of health care costs onto the most vulnerable, including those with moderate incomes and those with persistent and chronic health needs.[v]

- **As cost-sharing goes up, utilization of services—*both* necessary and unnecessary—goes down.** Many Medicare redesign proposals would increase costs on beneficiaries by either increasing cost-sharing amounts or

imposing cost-sharing for services that currently do not require them. Often, the justification for such proposals is based on the flawed assumption that charging beneficiaries more in upfront out-of-pocket costs will deter them from using unnecessary medical care, will steer them towards "higher-value" services, and therefore save the program money. Conversely, decades of empirical research confirm that higher cost-sharing deters access to both needed and unneeded care indiscriminately, and most notably for those living on modest incomes.[vi]

- **Beneficiary cost-sharing does not get at the real cost drivers.** It is health care providers—not beneficiaries—who determine the necessity of health care services, yet many proposals would increase cost-sharing, essentially forcing beneficiaries to self-ration their care. Research illustrates that once an individual enters the health care system, it is their providers that dictate treatments and services.[vii]

- **Home health copayments would harm the most vulnerable and likely increase program costs.** This proposal would primarily impact lower income, chronically ill women over age 75, and would deter many vulnerable beneficiaries from accessing needed care. Forgoing Medicare home health services may increase the incidence of premature nursing home placement, as well as hospitalizations and other more costly acute care. As a result, this could increase hospital inpatient spending by $6 to $13 billion over 10 years, in addition to significantly increasing Medicaid spending on long-term care.[viii]

- **Medigap proposals would shift additional costs onto beneficiaries.** Nearly one in four Medicare beneficiaries pay for and rely on Medigap plans to provide financial security and protection from high, unexpected out-of-pocket costs due to unforeseen medical care. Yet, some lawmakers suggest shifting additional costs onto people with Medigap policies by increasing deductibles or other cost-sharing, or by adding a surcharge or tax on plans offering "first-dollar" coverage. Most Medigap enrollees (86%) have incomes below $40,000 per year and nearly half (47%) have incomes below $20,000 per year.[ix] Increasing cost-sharing for or adding surcharges to Medigap plans will harm those who can least afford it—those who are sick or chronically ill and those with low or moderate incomes.[x]

---

[i] Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8256.pdf.

[ii] Kaiser Family Foundation, " Income and Assets of Medicare Beneficiaries, 2014 – 2030" (September 2015), available at: http://files.kff.org/attachment/issue-brief-income-and-assets-of-medicare-beneficiaries-2014-2030.

[iii] Kaiser Family Foundation, "Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households" (January 2014) available at: http://kff.org/medicare/issue-brief/health-care-on-a-budget-the-financial-burden-of-health-spending-by-medicare-households/; also see LCAO Issue Brief "Medicare Beneficiary Characteristics and Out-of-Pocket Costs" (June 2014), available at: http://www.lcao.org/files/2014/07/LCAO-issue-brief-bene-characteristics-updated-June-2014-7.8.14.pdf.

[iv] Government Accountability Office, "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment," GAO-12-871 (September 2012), available at http://www.gao.gov/assets/650/648370.pdf.

[v] Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8256.pdf.

[vi] See, e.g., National Association of Insurance Commissioners (NAIC), Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper" (October 2011), available at: http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.

[vii] See, e.g., Rand and other studies cited in National Association of Insurance Commissioners, *ibid*.

[viii] Avalere Health LLC, "Potential Impact of a Home Health Co-Payment on Other Medicare Spending" (July 2011); also see LCAO Issue Brief "Medicare Home Health Copayments: Harmful for Beneficiaries" (February 2015), available at: http://www.lcao.org/files/2015/02/LCAO-Copay-Issue-Brief-Feb-2015.pdf.

[ix] Kaiser Family Foundation, "Medigap Reform: Setting the Context for Understanding Recent Proposals" (January 2014), available at: http://kff.org/medicare/issue-brief/medigap-reform-setting-the-context/.

[x] *Ibid. Also see* LCAO Issue Brief "Reforming Medigap Plans by Shifting Costs onto Beneficiaries: A Flawed Approach to Medicare Savings" (July 2014), available at: http://www.lcao.org/files/2014/07/LCAO-IB-Medigap-July-2014-Update-7.8.14.pdf.