The Moment of Truth Project

The era of deficit denial is over.

A Closer Look at the Fiscal Commission's Cost-Sharing Recommendations
November 16, 2011

Growing Medicare costs represent the single biggest long-term fiscal challenge facing this country. Under current law, Medicare spending (net of offsetting receipts) will grow from 3.2 percent of GDP in FY 2011 to 4.4 percent by 2030, 6.3 percent by 2050, and 9.8 percent by 2080. Under the Congressional Budget Office's (CBO) Alternative Fiscal Scenario, which assumes policymakers will continue to waive scheduled reductions to Medicare physician's payments and that the cost controls from the Affordable Care Act will not continue to slow cost growth beyond this decade, Medicare costs will increase to 5.0 percent of GDP by 2030, 7.2 percent in 2050, and 11.0 percent by 2080.

As the Joint Select Committee on Deficit Reduction ("Super Committee") deliberates over how to reduce deficits and debt, it is important that they address growing Medicare costs, and that they do so with a special focus on "bending" the health care cost curve. In other words, while it will indeed be necessary to ask providers and individuals to contribute more in order to reduce the *level* of health care spending, policymakers must first do everything they can do reduce the *growth* in health spending. Although there are many approaches to slowing cost growth, one of the most straightforward ways to do so is to reform cost-sharing rules so that they no longer serve as an incentive to over-utilize health care services.

To help address projected growth in Medicare and other federal health care costs, the Simpson-Bowles Fiscal Commission recommended four basic changes designed to improve cost-sharing rules and reduce federal health spending.

The Moment of Truth (MOT) project is a non-profit effort that seeks to foster honest discussion about the nation's fiscal challenges, the difficult choices that must be made to solve them, and the potential for bipartisan compromise that can move the debate forward and set our country on a sustainable path.

These reforms include:

- Restricting supplemental "Medigap" plans from offering near first-dollar coverage of cost-sharing liabilities *(ten-year savings: $53 billion).*
- Replacing Medicare Part A and B cost-sharing rules with a unified deduction, a uniform co-insurance rate, a special catastrophic co-insurance rate, and an out-of-pocket limit *(ten-year savings, including interaction with Medigap reform: $74 billion).*
- Limiting near first-dollar coverage of supplemental TRICARE for Life plans *(ten-year savings: $43 billion).*
- Requiring a reformed Federal Employees Health Benefits Program (FEHB) to subsidize retirees' premiums rather than their cost-sharing *(ten-year savings, though about half would come from change to premium support model: $22 billion).*

The Logic of Cost-Sharing

Most economists agree that one of the many drivers of growing health care costs is overutilization of care, caused by so-called "moral hazard." Essentially, because a third party (the insurer) bears most of the costs of health services, individuals are not as price sensitive as they otherwise would be. Often, individuals will demand services that would not ordinarily pass a cost-benefit analysis, resulting in a deadweight or welfare loss.

Though the moral hazard and the resulting welfare loss is to some extent an unavoidable consequence of insurance – which is meant to provide against the risk of high health costs – it can be mitigated through certain forms of cost-sharing which puts "skin in the game" for health care consumers. There are three ways insurance companies require cost-sharing: deductibles require individuals to pay a certain amount out-of-pocket before insurance kicks in; copays require individuals to pay a fixed dollar amount for every service used; and coinsurance requires individuals to bear some proportion of the cost of each service.

In the case of Medicare, some cost-sharing already exists. Within Medicare, the lack of a coherent cost-sharing system is a significant contributor to over- and mis-utilization of care. The program includes a hodge-podge of deductibles, copays, and coinsurance which asks for a lot in some areas and very little, or nothing at all, in others. Because many seniors purchase Medigap wrap-around plans, moreover, they are often unexposed to what cost-sharing rules Medicare does have. At the same time, this system also fails to protect beneficiaries against potential catastrophic health care costs in the event of a serious injury or a prolonged period of medical care.

The over-utilization of health care services, resulting in part from insufficient cost-sharing, drives up costs and places an increased financial burden on the Medicare program. And though

it is impossible to always differentiate between good and bad health services,[1] a substantial amount of care adds little or nothing to a patient's overall health. Estimates for the amount of unnecessary care provided are difficult to measure but can range from 10 to 30 percent of total health care costs,[2] and meanwhile the over-utilization of care leads to thousands of unnecessary deaths each year.[3] Even much of the care which does improve the quality of health would not pass a regular cost-benefit analysis. Better supply of information and use of comparative effectiveness research, both by beneficiaries and providers, could help make the costs of services more available and reduce the impact of cost-sharing reforms on reducing necessary health care services.

Effective cost-sharing rules can significantly strengthen the incentives both to use health care services prudently and to weigh benefits against costs. According to numerous studies, even modest amounts of cost-sharing can help to reduce overall utilization of health care.[4]

A more efficient use of resources from cost-sharing reforms, leading beneficiaries to spend less on some unneeded medical services in exchange for more productive uses, can substantially reduce and control health spending growth over the longer-term and would be better for society as a whole and in many cases for beneficiaries. Compared to other health care reforms that would rely more on cost shifting, such as higher premiums, cost-sharing reforms can change the incentives and behavior of patients to reduce costs and improve outcomes.

Policies to Reform Cost-Sharing

Reform Medicare Cost-Sharing Rules

The current Medicare cost-sharing system features a hodge-podge of various deductibles, co-payments, and other rules. Medicare Part A (Hospital Insurance), for example, has a $1,132 deductible per spell of illness along with a variety of copayments, while Medicare Part B has a $162 per year deductible with a variety of co-insurance rates.

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[1] One major concern about increased cost-sharing is that some evidence suggests the result will be a reduction of effective and ineffective health services alike or a delay of needed care. (Rice, Thomas and Matsuoka, Karen M. "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors," Medical Care Research and Review, Vol. 61 No. 4. December 2004.). Although the substantial amount of low-value care currently provided suggests the result of this reduction would still be beneficial to society as a whole, it may in some cases harm the beneficiary. Better comparative effectiveness research and more transparency of information can help to mitigate these concerns.

[2] Kolata, Gina. "Law May Do Little to Curb Unnecessary Care." *New York Times*, March 29, 2010. http://www.nytimes.com/2010/03/30/health/30use.html.

[3] Brownlee, Shannon. *Overtreated*. Bloomsbury, 2007.

[4] Beeuwkes Buntin M, Haviland AM, McDevitt R, and Sood N, "Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans," American Journal of Managed Care, Vol. 17, No. 3, March 2011, pp. 222–230; Shah ND, Naessens JM, Wood DL, Stroebel RJ, Litchy W, Wagie A, Fan J, and Nesse R, "Mayo Clinic Employees Responded To New Requirements For Cost Sharing By Reducing Possibly Unneeded Health Services Use," Health Affairs, Vol. 20 No.11, November 2011, pp. 2134-2141.

All the variations in cost-sharing rules across various services fail to provide clear and consistent incentives for beneficiaries to weigh relative costs and benefits when considering options for treatment. This is particularly true in some areas – such as home health and clinical laboratories – where there is no cost-sharing at all. This leads the current system to encourage the overutilization of care. At the same time neither program includes out-of-pocket limitations to protect against catastrophic risk.

Reforming the current disarray of cost-sharing rules can generate significant health care savings by improving and rationalizing cost-consciousness, and can do so even while offering new protections against catastrophic costs.

Fig. 1: Current Cost-Sharing Rules Compared to Potential Reform Options

	Current Law		Reform Options	
	Part A	Part B	CBO	Bowles-Simpson
Deductible	$1,132 per Benefit Period	$162 per Year	$550 per Year	$550 per Year
Hospital Care	Free for First 2 Months, $283-$566 per Day for Next 3 Months, No Coverage After	20% Coinsurance	20% Uniform Coinsurance On All Part A & B Services up to Catastrophic Limit of $5,500 in out-of-Pocket Costs	20% Uniform Coinsurance On All Part A & B Services up to $5,500 Catastrophic Limit 5% Coinsurance Above $5,500 in out-of-Pocket Costs up to a Limit of $7,500
Skilled Nursing Facility	Free for First 20 Days, $141.50/Day for Next 80, No Coverage After	N/A		
Home Health	Free	Free		
Hospice Care	Generally Free; $5 Copay for Drugs & 5% Coinsurance for Inpatient Respite Care	N/A		
Physician Services	N/A	Generally 20% Coinsurance		
Ambulatory Surgical Services	N/A	20% Coinsurance		
Diagnostic Tests, X-rays, & Lab Services	N/A	20% Coinsurance		
Durable Medical Equipment	N/A	20% Coinsurance		
Physical, Occupational, & Speech Therapy	N/A	Generally 20% Coinsurance		
Mental/ Psychiatric Health	Free for 190 Days over Lifetime	45% Coinsurance		
Preventative Services	N/A	20% Coinsurance w/ Certain Waivers		

The Congressional Budget Office has studied the effect of an illustrative reform option that would overhaul the entire Part A and B cost-sharing system, replace it with a unified $550 deductible, a uniform 20 percent coinsurance rate on all services, and a $5,500 per year out-of-

pocket cap above which all services would be covered. The Simpson-Bowles Fiscal Commission proposed a similar reform whereby beneficiaries would continue to pay a 5 percent coinsurance rate beyond the $5,500 threshold, up to a limit of $7,500 in out-of-pocket costs.

Both of these options would result in reduced utilization, which account for nearly all of the savings in these options. The CBO option, in fact, would save $32 billion over ten years *without* increasing net out of pocket costs for beneficiaries. The Fiscal Commission option would save $50 to $60 billion, though some of this would come through higher net out of pocket costs in addition to reduce utilization.

In addition to reducing utilization and encouraging more rational decision making, these reform options would offer sweeping new protections. While three quarters of individuals would see their out of pocket costs go up under the CBO option – by about $500 per person – the tenth of the population with the highest costs each year would see an average reduction of *$4,500*. Although this reduction in out of pockets costs would be somewhat less in the Fiscal Commission option given the higher out-of-pocket limit, unhealthy individuals with higher costs would continue to see large reductions in their cost-sharing.

In other words, this reform would protect those with the most risk in catastrophic health care costs even while it reduced and slowed the growth of overall health care costs. It is also important to note that Medicaid covers the cost-sharing responsibilities of about 18 percent of Part B enrollees with lower incomes and limited assets, and would thus be protected from cost-sharing changes.

Restrict First-Dollar Coverage in Medigap

Currently, about 90 percent of seniors with fee-for-service Medicare have some type of supplemental coverage – whether through Medicaid, an employer, or a private plan. About 30 percent of fee-for-service Medicare enrollees also hold Medigap policies, or private insurance plans that seniors can buy to "wrap around" their Medicare policies in order to provide extra insurance.

The plans tend to cover most of the cost-sharing required by Medicare, and in fact the most popular plans, plans C and F (plans are standardized to have a letter between A and N), cover essentially all deductibles and coinsurance.

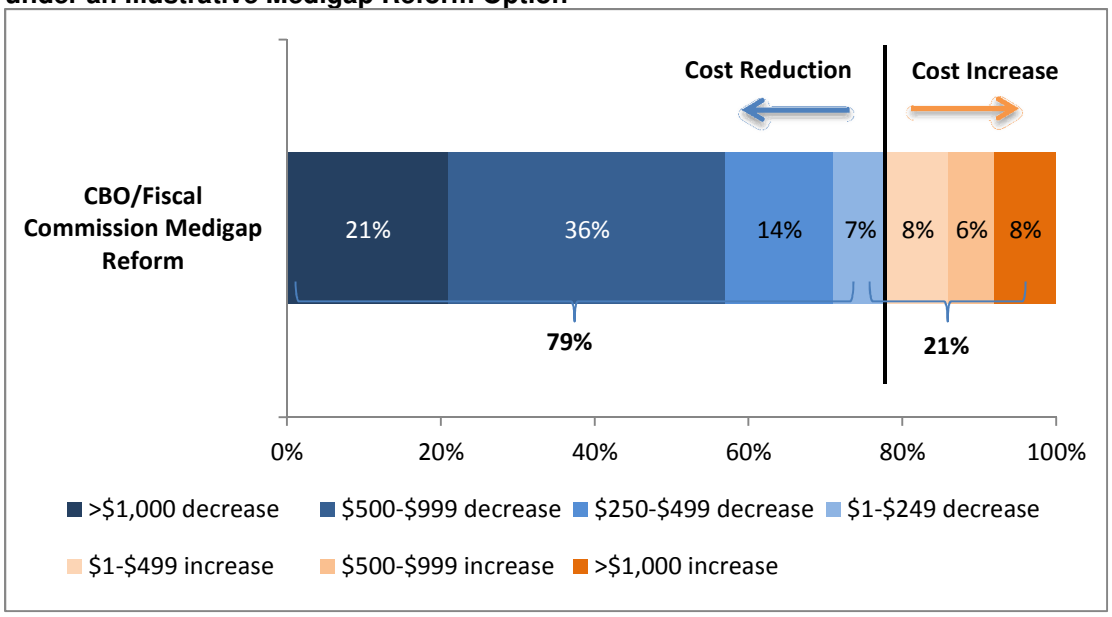
Unfortunately, this level of coverage generally makes Medigap plans a bad deal for the taxpayer as well as the seniors themselves. Medigap beneficiaries, on average, use about 25 percent more services than Medicare enrollees with no supplemental coverage and 10 percent more than those with retiree health plans. This leads to substantial additional Medicare spending.

At the same time, seniors are not coming out ahead either. Because Medigap plans largely help with first-dollar coverage, they mainly cover the types of regular and easily anticipated medical expenses which could be more easily paid out-of-pocket. In this sense, much of Medigap is closer to a "prepayment plan" than insurance. The problem is, using a third party for pre-payment means paying for administrative expenses, risk premia, profits, etc. In the end, the average Medigap beneficiary pays almost $2,000 per year in premiums but receives over $1,500 in benefits – more than a $450 loss. Though this additional cost might be warranted to reduce the risk of high costs, it does not make sense in the context of low and predictable costs.

To remedy this, the Fiscal Commission and others have recommended restricting Medigap's ability to cover first-dollar or near first-dollar coverage. In particular, Medigap plans would not be allowed to pay for the first $550 per year in cost-sharing and could only cover half of cost-sharing up to $5,500.

According to CBO, this policy alone would save $53 billion by itself and $60 billion when combined with the CBO cost-sharing reform option. When combined with the Fiscal Commission cost-sharing option, it would save even more.

Fig. 2: Share of Medigap Enrollees, by Change in Expected Premium and Out-of-Pocket Costs under an Illustrative Medigap Reform Option



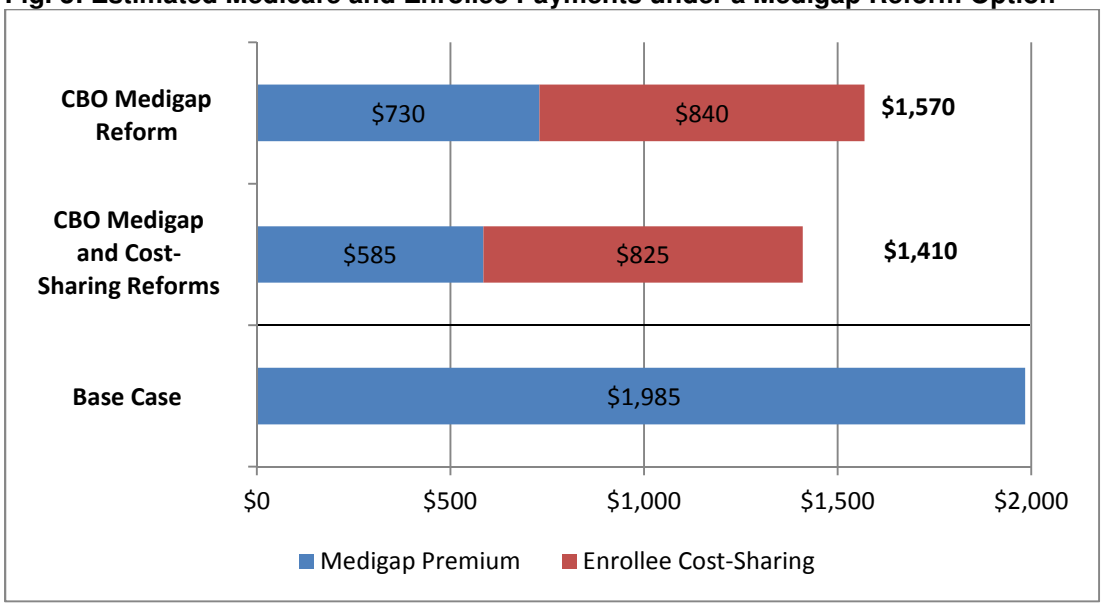
Source: Kaiser Family Foundation.

But in addition to reducing the deficit, this proposal will reduce costs for most enrollees. The Kaiser Family Foundation commissioned a study which found that nearly 80 percent of Medigap enrollees would see a reduction in their combined Medigap premium and out-of-pocket costs. That includes nearly one fifth who will see a reduction of more than $1,000 per year and another third who will see a reduction of between $500 and $1,000. On the other side, only 21 percent of individuals see any cost increase – and only 8 percent would see a cost

increase of more than $1,000. When looking over a life time rather than a single year, it is likely that a much higher proportion see an overall reduction in their costs.

This reduction, of course, is the net effect of higher cost-sharing expenses and lower Medigap premiums. The Kaiser study finds that the average cost-sharing would increase by about $840 per person. At the same time, though, Medigap premiums would drop by about $1,250 – for a net reduction of **$415 per person**. Very roughly, we estimate that combination of this Medigap reform and the CBO cost-sharing option would further reduce cost-sharing by $15 (see the above section) and Medigap premiums by almost $150 – for a net reduction of about **$575 per person**.[5] It isn't clear what impact the Fiscal Commission option would have.

Fig. 3: Estimated Medicare and Enrollee Payments under a Medigap Reform Option



Source: Kaiser Family Foundation and authors' calculations.
Note: Numbers rounded to nearest $5 billion.

These estimates show the impact of implementing Medigap restrictions right away and across-the-board for all future and current beneficiaries with supplemental coverage. For those currently holding a Medigap plan, these changes could be phased-in to give people time to adjust, or a new premium surcharge could be applied to existing policies plans that offer first-dollar or near-first dollar coverage with the prohibition only applying to new policies.

Reform TRICARE for Life Cost Sharing

TRICARE for Life is a health insurance program that was established in 2002 to provide military retirees and their families free Medigap-style plans to cover Medicare cost-sharing. Like most

[5] Rough estimates based off Kaiser data and elasticities, authors computations from the CBO Budget Option, along with conversations with the author of the Kaiser study, Mark Merlis, and authors' assumptions and calculations. Estimate assumes no change in Medigap coverage as a result of reform.

Medigap plans, TRICARE for Life covers virtually all deductibles and copays faced by its beneficiaries and in doing so helps to drive up utilization and costs. However, the program is even less effective at controlling costs since enrollees never need to pay for the insurance and therefore never decide whether it is worth it in the first place.

Applying the Medigap reforms described above to TRICARE for Life – that is, restrict it from covering the first $550 in cost-sharing and allowing it to only cover half of additional cost-sharing up to $5,500 – would save $43 billion over ten years. Of that, nearly $10 billion would come from lower Medicare costs as a result of lower utilization, with the remainder coming from lower costs borne by the TRICARE program covering Medicare cost sharing requirements.

Reform FEHB

The Fiscal Commission recommended replacing the Federal Employee Health Benefits (FEHB) plan with a premium support plan whereby subsidies grow by GDP+1 percent per year. Importantly, though, this reform included an important cost-sharing provision for those in FEHB who are eligible for Medicare.

Under current law, FEHB can serve as a Medigap-like wraparound to cover some of Medicare's cost-sharing rules. Under the Fiscal Commission plan, however, seniors would no longer use the FEHB subsidy for supplemental insurance and would instead use it to help pay for the cost of their Medicare premiums. Of the $22 billion in savings from the Commission's FEHB reform, we estimate about half of it comes from lower Medicare costs due to this change. Thus, adopting the policy of applying the FEHB subsidy to the Medicare premium instead of covering Medicare cost-sharing requirements on its own without changing the formula for FEHB subsidies could achieve in excess of $10 billion in savings from lower utilization without increasing the net out of pocket costs for the average beneficiary.

Conclusion

Currently, Medicare and its supplements offer a confusing and unequal set of cost-sharing rules, which offer little incentive to weigh the financial costs of treatment against expected benefits. This contributes to overutilization of health care services. By enacting a set of reforms to rationalize cost-sharing rules and limit these supplements, policymakers can reduce the use of unnecessary care, provide new catastrophic protections, and even reduce costs for many seniors.

Of course, the Fiscal Commission does not offer the only potential set of options. The President's recent submission, for example, calls for increasing the Medicare Part B deductible, introducing copayments for home health, and implementing a premium surcharge for those with Medigap plans.

Whatever the outcome of the Super Committee is, failure to address cost-sharing rules would be a missed opportunity to not only reduce Medicare costs but to bend the cost curve downward and help rein in the unsustainable growth in health care spending.