

Modernizing the Medicare Benefit: A Closer Look at Reforming Medicare Cost-Sharing Rules

Marc Goldwein, Ed Lorenzen and Jessica Stone

June 24, 2013



Moment of Truth
PROJECT



CHAIRMEN

Erskine Bowles
Senator Alan Simpson

EXECUTIVE DIRECTOR

Ed Lorenzen

ADVISORY BOARD

Dave Cote
Ann Fudge
Honorable Alice Rivlin
Honorable John Spratt

About the Moment of Truth Project

In its final report, “The Moment of Truth,” the President’s bipartisan National Commission on Fiscal Responsibility and Reform (“Fiscal Commission”) declared that the era of deficit denial is over. The debt crisis in Europe, the sobering election results, and the work of the Fiscal Commission have transformed the debate from a question of if we will reduce long-term deficits, to a matter of when and how we will do so. Fiscal responsibility will be the dominant national issue of the next two years, and we have the rare opportunity to enact a broad bipartisan plan to reduce the deficit and bring the debt under control. We must not let that opportunity pass.

The Moment of Truth project will spearhead a sustained, coordinated effort to capitalize and expand on the momentum generated by the Fiscal Commission. Though the Fiscal Commission did not have all the answers, it showed that broad bipartisan support for an ambitious deficit reduction plan is possible – as demonstrated by the bipartisan 11 out of 18 supermajority vote in favor of the plan, which included five Democrats, five Republicans, and one Independent.

The Moment of Truth project will build on this effort, working with Congress, the Administration, and the public at large. The project will be co-chaired by Erskine Bowles and Senator Alan Simpson and staffed by several senior members of the Fiscal Commission staff. It will focus primarily on public education, Congressional outreach, and technical and policy analysis.

To contact the Moment of Truth project, or for media and other inquiries, please email Lawrence Kluttz at kluttz@crfb.org.

The Moment of Truth (MOT) project is a non-profit, non-partisan 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.

www.momentoftruthproject.org

Modernizing the Medicare Benefit: A Closer Look at Reforming Medicare Cost-Sharing Rules

June 24, 2013

Growing Medicare spending represents the single biggest long-term fiscal challenge facing this country. Even with the recent slowdown in health care cost growth, Medicare spending (net of offsetting receipts) will grow from roughly \$500 billion this year to over \$900 billion by 2023 under current policies. Beyond this decade, Medicare spending is projected to continue to increase substantially and consume a growing portion of the federal budget as the influx of baby boomers entering Medicare rolls get older and health care cost growth continues to outpace growth of the economy.

As lawmakers consider options to address the fiscal shortfalls and growing debt over the long term, it is essential that they address growing Medicare costs, and 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 to receive less and individuals to contribute more in order to reduce the *level* of health care spending, policymakers must first do everything they can to reduce the *growth* in health spending by changing incentives to promote more efficient and cost effective delivery and use of health care services. There are many policies which have the potential to slow cost growth by changing incentives for providers and beneficiaries. One of the most straight forward ways to do so on the beneficiary side is to modernize Medicare cost-sharing rules to encourage better and more cost-effective utilization of health care services.

The current Medicare benefit has a complex and disjointed set of cost-sharing rules – separate deductibles for out-patient and in-patient services, a hodge-podge of varying copays and coinsurance, and no out-of-pocket spending cap. Today’s insurance norms have changed from the bifurcated private insurance model of the 1960s, with a single deductible being more common. The current Medicare cost-sharing rules mask costs, lead to over- and mis-utilization of care, and drive up spending. At the same time, the lack of an out-of-pocket limit leaves beneficiaries vulnerable to financial hardship from catastrophic health care costs unless they purchase private supplemental coverage, such as Medigap, for protection.

Modernizing the Medicare benefit and reforming cost sharing rules would not only strengthen the financial state of Medicare, but would also improve Medicare’s value for beneficiaries and make it easier to navigate and understand. Designed properly, cost-sharing reforms can achieve significant savings for the Medicare program and reduce Medicare premiums by limiting overutilization of care while providing greater protection from risk of catastrophic health care costs and reducing total out-of-pocket spending over their lifetime for most seniors.

The final report of the National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, recommended four basic reforms to help address projected cost growth in Medicare and modernize the Medicare benefit: replacing the separate deductibles for inpatient and outpatient services with a single combined deductible, establishing uniform coinsurance requirements for all services, providing an out-of-pocket limit for catastrophic health costs, and restricting supplemental Medigap coverage.

The Fiscal Commission's proposals represent a comprehensive approach to redesigning Medicare's cost-sharing rules. An alternative approach would be for policymakers to make piecemeal reforms to the existing benefit design. For example, President Obama has proposed increasing cost-sharing for home health services and the Medicare Payment Advisory Commission (MedPAC) has made several other provider-specific recommendations.

Since the release of the Commission's report in late 2010, bipartisan support for cost-sharing reforms has increased, and there is a growing consensus that these reforms can streamline the Medicare benefit, offer catastrophic protection, and more efficiently target Medicare dollars.¹ Numerous proposals to reform Medicare's cost-sharing rules have been put forth by experts across the spectrum, including: MedPAC, the Urban Institute, Center for American Progress, National Coalition on Health Care, American Enterprise Institute, Heritage Foundation, Brookings Institution, and the Commonwealth Fund.

In their latest report, *A Bipartisan Path Forward to Securing America's Future*, Fiscal Commission co-chairs former Senator Alan Simpson and Erskine Bowles proposed a modified version of the cost sharing reforms in the Commission report by incorporating elements from these proposals and other feedback on their original proposal. In particular, the new cost-sharing reforms proposed in *A Bipartisan Path Forward* provide greater protections for low-income beneficiaries while still encouraging more efficient spending and bending the health care cost curve.

The cost sharing reforms in *A Bipartisan Path Forward* include:

- Replacing current Medicare cost-sharing rules with a unified deductible, uniform coinsurance, and an out-of-pocket maximum, while varying the deductible and out-of-pocket limit with income and allowing value-based adjustments in coinsurance amounts for certain low or high value services.
- Restricting supplemental "Medigap" plans from covering near first-dollar coverage of cost-sharing liabilities.
- Limiting near first-dollar coverage of supplemental TRICARE for Life plans

¹Calmes, Jackie, and Robert Pear. "Talk of Medicare Changes Could Open Way to Budget Pact." New York Times. 28 Mar. 2013. http://www.nytimes.com/2013/03/29/us/politics/common-ground-in-washington-for-medicare-changes.html?pagewanted=all&_r=2&

- Requiring a reformed Federal Employees Health Benefits Program (FEHBP) to subsidize retirees' premiums rather than their cost-sharing
- Imposing a surcharge on Medicare premiums for those with employer-sponsored retiree plans while offering an option for seniors to "cash out" and instead use the value to subsidize their Medicare premium.

A Bipartisan Path Forward noted the exact parameters would need to be developed based on Congressional Budget Office estimates, but set a goal of achieving total savings of \$90 billion over ten years from cost-sharing reforms, while holding average out-of-pocket costs (including premiums) for beneficiaries constant so that seniors are no worse off in a given year and giving them more protection from risk over their lifetime, particularly at lower-income levels. These reforms would modernize the Medicare benefit to improve the value for seniors and reducing premiums by promoting more efficient utilization of Medicare services, while achieving savings for the Medicare program.

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.

The Logic of Cost-Sharing

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

Though the moral hazard and the resulting welfare loss is to some extent an unavoidable consequence of insurance – which is meant to protect against the risk of high health costs – it can be mitigated through certain forms of cost-sharing rules that give health care consumers more “skin in the game.” Behind benefit design, there are a number of tradeoffs that can be made. Premiums, the monthly payments made to an insurer for coverage, can be altered to make cost-sharing rules in a package more or less generous. Altering the premium, however, would spread the cost equally among all beneficiaries, whereas cost-sharing reforms would spread the cost by beneficiaries’ use of services, thereby making them more cost-conscious. Beyond premiums, there are three ways Medicare and private insurance companies require cost-sharing: (1) deductibles require individuals to pay a certain amount out-of-pocket before insurance kicks in; (2) copayments require individuals to pay a fixed dollar amount for every service used; and (3) coinsurance requires individuals to bear some proportion of the cost of each service.

In Medicare, some cost-sharing rules already exist. However, the lack of a coherent cost-sharing system significantly contributes to overutilization and misuse of care. Medicare 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. Additionally, because many seniors purchase Medigap wrap-around plans, they are often unexposed to what cost-sharing rules Medicare does have. At the same time, this system also fails to protect beneficiaries against potentially catastrophic health care costs in the event of a serious injury, illness, or a prolonged period of medical care.

Overutilization of health care services, resulting in part from insufficient cost-sharing, drives up costs and places an increased financial burden on the Medicare program. While it is impossible to always differentiate between good and bad health services, a substantial amount of care adds little or nothing to a patient’s overall health.² Estimates for the amount of unnecessary care

² 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 (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.

provided are difficult to measure, but can range from 10 to 30 percent of total health care costs.³ Meanwhile, overutilization of care leads to thousands of unnecessary deaths each year.⁴ System-wide, the Institute of Medicine recently estimated that of the \$750-760 billion in wasteful health care spending in 2009, \$210 billion was spent on unnecessary services beyond evidence-based levels and higher-cost care.⁵

While there are other drivers of unnecessary spending in the system, such as fraud and abuse, Medicare cost-sharing reforms are one way lawmakers can help reduce future spending on unnecessary 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.⁶ Moreover, a better supply of information and use of comparative effectiveness research, both on beneficiaries and providers, could help make the costs of services more transparent to beneficiaries and lessen the impact of cost-sharing reforms on utilization of necessary health care services.

A more efficient use of resources from cost-sharing reforms, leading beneficiaries to spend less on some unnecessary medical services in exchange for more productive uses, can substantially reduce and control health spending growth over the long term and would be better for society as a whole. Compared to other policies that achieve savings in Medicare primarily through cost shifting, such as higher premiums, cost-sharing reforms can change the incentives and behavior of patients to reduce costs, for beneficiaries as well as the government, and improve outcomes.

The Fiscal Commission Approach to Reforming Medicare Cost-Sharing Rules

Reform Medicare Cost-Sharing Rules

The current Medicare cost-sharing system features a jumble of various deductibles, copayments, and other rules. Medicare Part A (Hospital Insurance), for example, has a \$1,184 deductible per spell of illness along with a variety of copayments, while Medicare Part B has a \$147 per year deductible with a variety of co-insurance rates.

³Kolata, 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>.

⁴Brownlee, Shannon. *Overtreated*. Bloomsbury, 2007.

⁵"Best Care at Lower Cost: The Path to Continuously Learning Health Care in America," Institute of Medicine, September 2012. http://books.nap.edu/catalog.php?record_id=13444

⁶Beeuwkes Buntin M, Havil and 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, Stroebl 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 different 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 encourages 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.

The Congressional Budget Office (CBO) has studied the effect of an illustrative reform option that would overhaul the entire Part A and B cost-sharing system by replacing the current cost sharing rules 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 2010 Fiscal Commission proposed a reform with similar parameters except that beneficiaries would pay a smaller 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 accounts for nearly all of their savings. In 2011, the CBO estimated their illustrative option would have saved \$32 billion over ten years *without* increasing net out-of-pocket costs for beneficiaries. While beneficiaries would pay more for first-dollar coverage, they would pay less for catastrophic costs and use fewer services, resulting in savings for them (through the form of lower Part B premiums) and the government. Additionally, it is 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 these benefits would not be affected by cost-sharing changes. 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 reduced utilization.

Beyond reducing utilization and encouraging more rational decision making, these reform options would offer sweeping new protections. According to a Kaiser Family Foundation report which studied the CBO option, 71 percent of Medicare beneficiaries would see their out-of-pocket costs go up by about \$180 per person, nearly a quarter would see little or no change, while 5 percent with the highest costs each year would see an average *reduction* of \$1,570.

Box 1: Value-Based Cost Sharing

Another approach to modifying Medicare cost sharing rules that has been proposed on its own or in combination with an overhaul of cost sharing rules is value-based insurance design (VBID). Under a VBID, cost-sharing rules are designed to encourage beneficiaries to pursue high-value services through a combination of lower (or no) cost sharing requirements on those services and higher cost sharing requirements on low value services. In *A Bipartisan Path Forward*, Simpson and Bowles recommend giving the Center for Medicare and Medicaid Services (CMS) the authority to make value-based adjustments to coinsurance rates for certain very high or very low value procedures on a budget neutral basis, with lower cost sharing requirements for high value services offset by higher cost sharing on low value services.

MedPAC has also suggested a version of this approach by recommending more service- and provider-specific coinsurance or copayments that account for value. Options of this nature range from introducing cost-sharing to services which are currently cost-sharing free, such as home health or clinical labs, to increasing or altering the type of coinsurance for services, such as skilled nursing homes or outpatient drugs. Proponents argue that VBID would recognize the challenge of a one-size fits all approach to cost-sharing reforms and bring greater sophistication to the benefit design.

Implementing value-based cost sharing presents many practical challenges in determining how certain services or providers would be defined as high value and choosing the data to measure quality outcomes. Some services may be universally high-value for all beneficiaries, while others may depend on factors such as a beneficiary's health and socioeconomic background. Additionally, very specific cost-sharing rules could create added complication to an already fragmented and confusing benefit design.

Policymakers will also face pressure to provide lower cost sharing requirements for services which advocates assert are high value and resistance to proposals increasing cost sharing for low-value services, which could increase spending and undercut the effectiveness of the value based approach. Recently, several national organizations representing medical specialists looked at this issue of measuring quality with a new initiative called "Choosing Wisely."⁷ The initiative had these provider organizations identify five tests or procedures commonly used in their field, whose necessity should be questioned and discussed. However, more data and consensus on these metrics would be required under VBID.

⁷ Choosing Wisely Initiative: <http://www.choosingwisely.org/>

Similarly, when CBO analyzed this option in 2008, they estimated out-of-pocket cost would rise modestly by about \$500 on average for more than three-fourths of beneficiaries, stay the same for another 13 percent, and fall by an average of about \$4,500 for the remaining 9 percent.⁸ Although this reduction in out-of-pocket costs would be somewhat less under 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 with only modest increased costs for other beneficiaries, even while it reduced and slowed the growth of overall health care costs by making beneficiaries more cost conscious about routine health care services.

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, Medicare Advantage, an employer retiree health plan, or a private Medigap plan.⁹ 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.¹⁰ The plans cover most of the cost-sharing required by Medicare, and 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 seniors themselves. Medicare spends, on average, about 33 percent more on services for beneficiaries with Medigap and 17 percent more than those with retiree health plans than it does for Medicare enrollees with no supplemental coverage.¹¹

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. However, using a third party for pre-payment means paying for administrative expenses, risk premiums, and profits. In the end, the average Medigap beneficiary pays almost \$2,000 per year in premiums, but receives only \$1,500 in benefits – more than a \$450 annual loss. Although this additional cost might be warranted to reduce the risk of high costs, it does not make sense in the context predictable costs with limits on exposure to catastrophic health care expenses.

⁸ “Budget Options Volume 1 Health Care.” CBO, December 2008.

<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>

⁹ “Report to the Congress: Medicare and the Health Care Delivery System.” MedPAC, June 2012.

http://www.medpac.gov/documents/Jun12_EntireReport.pdf

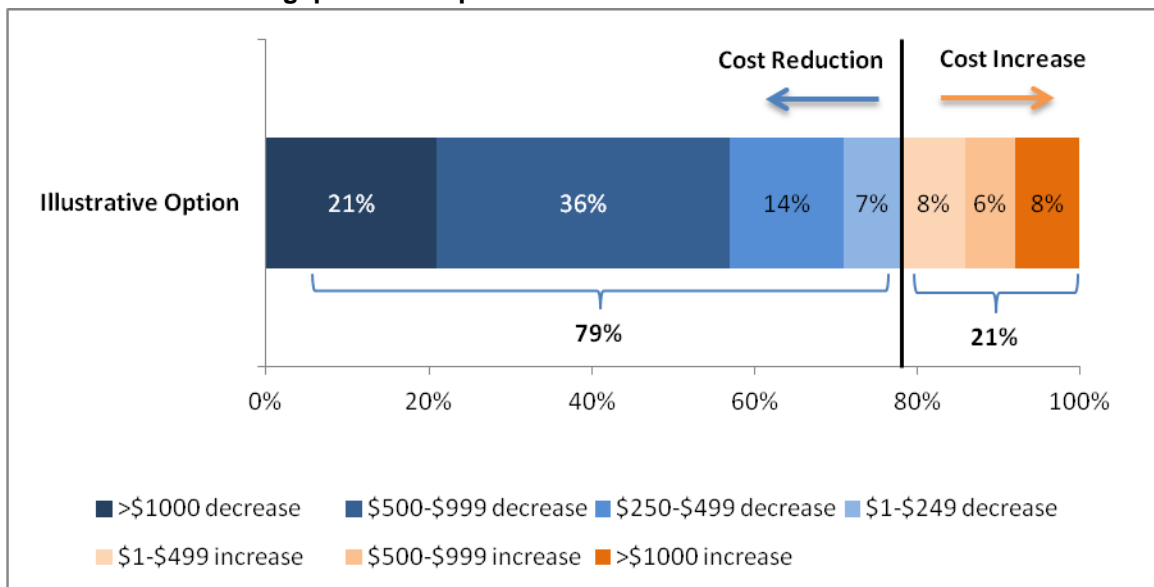
¹⁰ Ibid.

¹¹ Ibid.

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 the CBO's 2011 estimate, this policy alone would have saved \$53 billion by itself and \$93 billion from 2012-2021 when combined with the CBO cost-sharing reform option. In combination with the Fiscal Commission cost-sharing option, it would save even more. These two reforms would work together to reduce overutilization of health care services and Medicare costs by aligning the level of beneficiary spending where the Medigap policy's cap on out-of-pocket costs reaches the level at which the Medicare program's cap is reached. Between the deductible and the out-of-pocket cap, Medigap policyholders would face the uniform coinsurance rate.

Fig. 1: Share of Medigap Enrollees, by Change in Expected Premium and Out-of-Pocket Costs under an Illustrative Medigap Reform Option



Source: Kaiser Family Foundation.

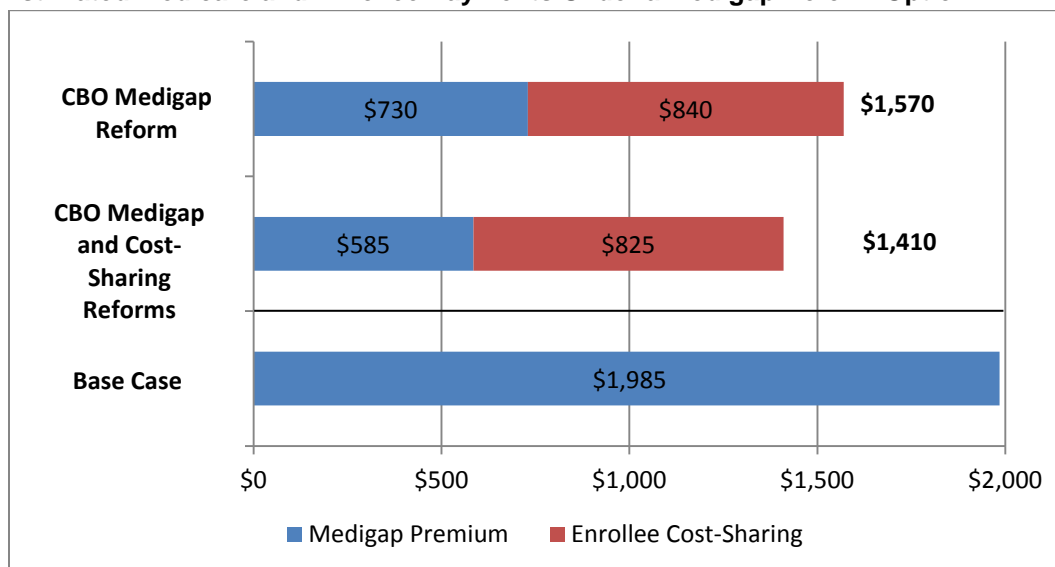
*Under this illustrative option, enrollees would pay first \$550 in cost-sharing for covered A/B services and 50 percent of required cost sharing up to \$3,025 out-of-pocket limit.

In addition to reducing the deficit, this proposal will reduce costs for most enrollees because it would reduce the need to purchase catastrophic coverage – especially when combined with other Medicare cost-sharing reforms. A study commissioned by the Kaiser Family Foundation on a package of changes to Medicare cost-sharing rules and Medigap restrictions similar to the CBO option 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 of beneficiaries who will see a reduction of more than \$1,000 per year and another third who will see a reduction between \$500 and \$1,000. Only 21 percent of individuals would see any cost

increase in any given year– and only 8 percent would see a cost increase of more than \$1,000. When looking over a lifetime rather than a single year, it is likely that a much higher proportion would 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 the combination of this Medigap reform with the CBO cost-sharing option would further reduce cost-sharing by \$15 and Medigap premiums by almost \$150 – for a net reduction of about **\$575 per person**.¹² The proposal recommended by the Fiscal Commission would likely have a similar, but somewhat less net reduction per person.

Fig. 2: Estimated Medicare and Enrollee Payments Under a Medigap Reform Option



Source: Kaiser Family Foundation. Under this illustrative option, enrollees would pay first \$550 in cost-sharing for covered A/B services and 50 percent of required cost sharing up to \$3,025 out-of-pocket limit.

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

Some concerns have been raised about imposing a federal restriction on a private insurance product. However, federal regulation of Medigap policies is justified because the market for private Medigap plans is based entirely on the existence of the federal Medicare program, and

¹² Estimates based off Kaiser data and elasticities, authors computations from the CBO Budget Option, along with conversations with author Mark Merlis and authors' assumptions and calculations. Estimate assumes no change in Medigap coverage as a result of reform.

these plans create a negative externality on public programs by contributing to higher utilization of health services paid for by Medicare.

While the Fiscal Commission recommended the regulatory approach of restricting Medigap's coverage, an alternative approach would be to impose a surcharge on Medigap plans to offset the externality of higher Medicare spending due to Medigap plans. A surcharge could be set to offset some or all of the higher Medicare spending for beneficiaries with Medigap coverage, and vary depending on desired revenue and how it might affect beneficiary choices when combined with other cost-sharing reforms. The surcharge could be applied either to the premium for the plan itself or to a beneficiary's Part B premium. However, relying on a surcharge to discourage the purchase of Medigap policies and offset the externality cost of Medigap plans would increase costs for some seniors relative to the approach of restricting Medigap plans, which would reduce costs for seniors as well as achieving savings for the Medicare program.

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 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 are not even indirectly exposed to the increased costs from this benefit.

Applying the Fiscal Commission's Medigap reforms to TRICARE for Life – that is, restricting 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 through 2021 (according to a 2011 CBO estimate). 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.

Alternatively, policymakers could decide to apply a surcharge on Medicare premiums for beneficiaries with TRICARE for Life coverage or convert the value of the TRICARE for Life benefit into a subsidy to cover a portion of Medicare premiums instead of shielding beneficiaries from cost-sharing requirements. Another approach would be to charge a premium for the Tricare for Life benefit, but this would not have any of the behavioral effects on utilization of health care services that the other approaches would achieve.

Reform FEHBP

The Fiscal Commission recommended reforming the Federal Employee Health Benefits Program (FEHBP) to change how federal retirees in FEHBP who are eligible for Medicare are affected by cost-sharing rules. Under current law, FEHBP can serve as Medigap-like

wraparound coverage to cover some of Medicare's cost-sharing rules. Under the Fiscal Commission plan, however, seniors would no longer be allowed to use the FEHBP subsidy to buy supplemental insurance, instead they could use it to help pay for the cost of their Medicare premium.

The Fiscal Commission achieved a total of \$22 billion in savings over ten years from a combination of other changes to the formula for FEHBP subsidies and the change in how the subsidy could be used. Of the \$22 billion in savings, roughly half would come from lower Medicare costs due to the change in the retiree coverage from a wrap-around benefit to a premium subsidy. Thus, without changing the formula for FEHBP subsidies, adopting the policy of applying the FEHBP subsidy to the Medicare premium (instead of covering Medicare cost-sharing requirements) could achieve in excess of \$10 billion over ten years in savings from lower utilization without increasing the net out-of-pocket costs for the average beneficiary.

Employer-sponsored Retiree Supplemental Plans

Some employers also provide private supplemental coverage to retirees, further contributing to overutilization and increased costs to Medicare. MedPAC's June 2012 report to Congress found that beneficiaries with employer-sponsored supplemental coverage had Medicare spending that was 17 percent higher than spending for beneficiaries without supplemental coverage.

However, applying Medigap-style reforms that limit these supplemental plans from providing wraparound coverage to Medicare would be unfair to retirees who have generally paid for or were promised retiree health benefits as part of their compensation over their working lives. Instead, the increased costs to the Medicare program could be offset by imposing a surcharge on the retiree health plan or the Part B premium for beneficiaries who have retiree health plans that offer wraparound coverage. A surcharge could be combined with an option for employees to "cash out" the value of their health plan in the form of a Part B premium subsidy instead of receiving wraparound coverage and being subject to a surcharge on their Part B premium

One policy challenge in implementing any of these reforms is determining whether to apply the changes to new beneficiaries or all beneficiaries. Some proposals would only apply reforms to new beneficiaries while preserving existing rules for current beneficiaries. Although this would ultimately result in the new rules applying to all beneficiaries in the future, it would be two decades or more before the policy is in effect for all beneficiaries, with significantly less savings from the policy over that period as a result. Moreover, this approach would create considerable complexity and inequities, with new beneficiaries responsible for higher deductibles and coinsurance than those currently in Medicare, while current beneficiaries would not benefit from catastrophic protections available to new beneficiaries. If policymakers are concerned

about the impact of making abrupt changes in cost sharing requirements for current beneficiaries, a more rational solution would be to gradually phase-in changes in cost sharing requirements and out-of-pocket limits for all beneficiaries.

Other Cost-Sharing Reform Proposals

Since the Fiscal Commission released its report in late 2010, many other proposals to overhaul Medicare's cost-sharing rules have come to light. Meanwhile, support for cost-sharing proposals continues to grow among lawmakers on both sides of the aisle, and news reports have indicated that such reforms have been on the table in recent budget negotiations.¹³

While the Commission's cost-sharing reforms would substantially slow health care cost growth by reducing overutilization and providing important protections to seniors, some concern was raised regarding the impact on seniors who would face increased costs in a given year, particularly those with limited means (though those below the poverty line would still be protected under Medicaid). Several recent cost-sharing proposals have been developed by various experts to address this issue along with other innovations in cost-sharing rules.

The Seniors' Choice Act

In 2012, Senators Tom Coburn (R-OK) and Richard Burr (R-NC) introduced the Seniors' Choice Act which included a cost-sharing overhaul that mirrored that of the Fiscal Commission's with the addition of higher out-of-pocket limits and deductibles for high-income beneficiaries. Specifically, it adopted part of an earlier Lieberman-Coburn Medicare proposal which would apply higher out-of-pocket limits for beneficiaries with incomes greater than \$85,000 per individual (\$170,000 per couple). The Coburn-Burr proposal would also prohibit Medigap plans from covering the first \$500 of beneficiaries' cost-sharing and limit coverage above \$500 to 50 percent of the next \$5,000 of Medicare cost-sharing.

Urban Institute Proposal

Earlier this year, Robert Berenson, John Holahan, and Stephen Zuckerman of the Urban Institute authored a cost-sharing proposal similar to the policy in the Fiscal Commission report, but recommended varying the unified deductible for Parts A and B based on income. The deductible would be higher than current deductibles for beneficiaries over 400 percent of the poverty line, about the same for those between 300 and 400 percent, and lower for beneficiaries below 300 percent. Further, they proposed an out-of-pocket cap on total cost-sharing that would be based on income. They suggested that cap could be \$6,000 for beneficiaries at 400 percent of the poverty line or higher, gradually reducing to zero for people at or below 133 percent. They

¹³ Radnofsky, Louise and Janet Hook. "Common Ground on Medicare Emerges." Wall Street Journal. April 4, 2013. <http://online.wsj.com/article/SB10001424127887323916304578403043420917884.html>

also proposed limiting Medigap supplemental coverage of cost-sharing by, for example, prohibiting Medigap from covering the first \$500 and 50 percent of the next \$4,950.

Gruber Proposal

In the same vein, MIT economist Jonathan Gruber proposed basing out-of-pocket costs on income level while also offering a lower \$250 deductible for beneficiaries with incomes below 200 percent of the poverty line.¹⁴ Instead of a \$5,250 out-of-pocket (OOP) maximum, Gruber proposed a sliding scale OOP limit ranging from one-third of the Health Savings Account (HSA) limit (\$1,983) for those between 100 and 200 percent of the poverty line to the full HSA limit (\$5,950 in 2012) for those over 400 percent. To address the supplemental insurance issue, he proposed an excise tax of up to 45 percent on premiums for Medigap plans and employer-sponsored retiree coverage (for those over 65). Gruber roughly estimates the proposal would save about \$125 billion over ten years, though he acknowledges this depends on the exact level of the excise tax and other uncertainties.

A Bipartisan Path Forward

As a result of these recent policy developments, Fiscal Commission co-chairs former Senator Al Simpson and Erskine Bowles proposed a modified version of the cost-sharing reforms in their report *A Bipartisan Path Forward to Securing America's Future*, which incorporated several modifications to the Commission's original cost-sharing reforms that specifically address concerns regarding the impact of cost-sharing reforms on vulnerable and low-income beneficiaries. *A Bipartisan Path Forward* calls for a net reduction in spending of \$90 billion over ten years, while holding average out-of-pocket costs and providing more protection from risk over a beneficiary's lifetime.

While many vulnerable seniors would be better off over their lifetimes under the Fiscal Commission proposal approach, most would face modestly higher costs in a given year (though those below the poverty line would be protected under current law by Medicaid). *A Bipartisan Path Forward* would mitigate the impact of cost-sharing reforms on low-income beneficiaries and provide even stronger protections for the most vulnerable seniors. It would do so by modifying the Fiscal Commission reforms to incorporate elements of the Urban Institute and Gruber proposals, including an income-adjusted out-of-pocket maximum and lower deductible for low-income beneficiaries, while retaining the 5 percent coinsurance above the first out-of-pocket threshold. Additionally, the plan proposes giving the Centers for Medicare and Medicaid Services (CMS) the authority to make certain value-based adjustments to coinsurance rates for certain very high or very low value procedures, on a budget neutral basis.

¹⁴ Gruber, Jonathan. "Restructuring Cost Sharing and Supplemental Insurance for Medicare." The Hamilton Project, 27 Feb. 2013.
http://www.brookings.edu/~media/research/files/papers/2013/02/thp%20budget%20papers/thp_15waysfedbudget_rop3.pdf

The policy on supplemental coverage in *A Bipartisan Path Forward* is largely the same as the Fiscal Commission plan – with plans being restricted from offering first-dollar coverage within the deductible and no more than half of the base Medicare coinsurance. Likewise, the plan would apply this restriction to TRICARE for Life plans. As an interim step, the plan does suggest that there should be a surcharge applied to the Part B premium for beneficiaries with Medigap policies to provide time for the restrictions on Medigap plans to be developed and implemented. As an alternative, Bowles and Simpson suggest policymakers could apply the first-dollar coverage limits to new Medigap policies only and apply a surcharge to existing plans.

In addition, the plan incorporates a variation on Gruber’s proposal to tax the externality of increased Medicare spending for beneficiaries with employer-sponsored retiree health plans. It proposes a Part B premium surcharge for beneficiaries with retiree health plans providing wraparound coverage, while giving those retirees the opportunity to “cash out” the actuarial value of their retiree health coverage into a subsidy to cover their Part B premium instead. A similar cash out would be mandated for retiree health coverage under the Federal Employee Health Benefits Program, as the Fiscal Commission proposed.

While the exact parameters will need to be determined, *A Bipartisan Path Forward’s* reforms would be designed to hold constant average out-of-pocket costs (including premiums) so that seniors are not worse off in a given year, and that they have more protection from risk over their lifetime (particularly at lower income levels). The net savings target in *A Bipartisan Plan Forward* is approximately 25 percent lower than would be achieved by the policies in the Fiscal Commission. The smaller savings target and savings from the surcharge on beneficiaries with employer-sponsored retiree health would allow for lower deductibles and out-of-pocket limits for low and moderate income beneficiaries. The exact savings to beneficiaries would depend on design details, but should have similar results to the CBO option analyzed by the Kaiser Family Foundation (discussed earlier in this report). More importantly, it would provide greater protection than current law for the most vulnerable seniors with lower incomes and greater health needs. Designed properly, this proposal would not only improve Medicare’s value for beneficiaries, but would strengthen the financial state of Medicare by reducing overutilization of care.

Bowles and Simpson also highlight alternatives to their approach. For example, the stair-step coinsurance model could be replaced with a single coinsurance and a single (but still income-related) out-of-pocket limit – perhaps at the HSA limit (\$6,250 for 2013) like Gruber’s proposal. Another approach offered in the report is to make greater subsidies available for low-income beneficiaries instead of income relating changes in cost-sharing rules. This method is already used in Medicare Part D under the Low-Income Subsidy (LIS) program.

Bipartisan Policy Center

The Bipartisan Policy Center's (BPC) latest health plan combines some of the larger cost-sharing reforms in other proposals with a more value-based approach. BPC's plan would replace the deductibles for Part A and B with a combined \$500 deductible, a cost-sharing limit of \$5,315, and new value-based copayments. BPC's value-based and provider-specific approach is integrated with their broader plan to create new "Medicare Networks" of high-value providers. Traditional Medicare beneficiaries who enroll in these alternative Medicare Networks would have lower in-network cost sharing, but pay higher cost-sharing if they receive services from out-of-network Medicare providers. This would encourage beneficiaries to higher value and efficient providers. In a recent Congressional hearing, Dr. Alice Rivlin, one of the authors of the report, testified about their approach and explained:

*"I want to note that our recommendations are structured as an integrated package. We believe that a comprehensive approach, rather than breaking out individual recommendations for implementation, is critical to achieving successful health care system transformation."*¹⁵

Additionally, the BPC recommends reforming supplemental coverage (both Medigap plans and employer-provided plans, including Tricare-for-Life and the Federal Employees Health Benefits Program) by requiring that these programs include a \$250 deductible, have an out-of-pocket maximum no lower than \$2,500, and cover no more than half of an enrollee's coinsurance or copayments. While most of these cost-sharing reforms would yield savings, BPC recommends using some of the gross savings from the reforms to increase spending by \$75 billion to expand cost-sharing assistance for beneficiaries below 150 percent of poverty, resulting in no net savings from the overall policy.

Alternative Approaches to a Cost-Sharing Reform Overhaul

While the aforementioned proposals all provide a comprehensive approach to reforming Medicare cost-sharing rules, other experts and policymakers have proffered reforms to improve individual pieces of the existing cost-sharing regime. Most notably, President Obama has included cost-sharing reforms in his recent budget proposals. His FY2014 budget proposal would introduce a \$100 home health copayment for certain episodes, a surcharge on Part B premiums for new beneficiaries who purchase Medigap policies with low cost-sharing requirements, and lower copayments for generic drugs for lower-income beneficiaries.

The independent MedPAC Commission also recommended a number of changes to Medicare's current cost-sharing rules. In their June 2012 report, MedPAC proposed replacing coinsurance with copayments that may vary by type of service and provider, and would give the Secretary

¹⁵ Rivlin, Alice M. Testimony before the U.S. House of Representatives Committee on Ways and Means Subcommittee on Health. 21 May 2013. <http://docs.house.gov/meetings/WM/WM02/20130521/100874/HHRG-113-WM02-Wstate-RivlinPhDA-20130521.pdf>

of Health and Human Services authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached an out-of-pocket maximum. MedPAC supports a surcharge on supplemental coverage as well in order to recover some of the additional costs borne by Medicare.

Box 2: Copayments vs. Coinsurance

As MedPAC's proposal demonstrates, reforms can also be made to the type of cost sharing. This could include changing the 20 percent coinsurance for physician office visits to a flat copayment amount. A copayment has the benefit of being very easy for beneficiaries to remember and understand, thereby reducing some of the complexity in the current system. A copayment would also be less financially cumbersome than coinsurance for some beneficiaries who require higher-cost health care services.

However, copayments may not give beneficiaries enough price-sensitivity as an incentive to consider cost effectiveness of health care services. Coinsurance makes beneficiaries more sensitive to the cost of a service and therefore more judicious in their usage. That is why the cost sharing reforms in *A Bipartisan Path Forward* and most other proposals to reform cost sharing that seek to reduce overutilization of health care services adopt the coinsurance approach. Coinsurance requirements also increase automatically with the cost of health care services, whereas copayments may require periodic adjustments to keep pace with the cost of specific health care services.

Conclusion

While there are many different approaches toward implementing cost-sharing reforms, it is clear that experts and policymakers across the spectrum agree our current benefit structure is costly and inefficient. There is also much agreement on a basic framework that includes a combined deductible with some level of out-of-pocket protection and restrictions to supplemental coverage. By enacting a set of reforms to rationalize Medicare cost-sharing rules and limit supplemental insurance plans, policymakers can improve the Medicare benefit for beneficiaries and lower costs for the Medicare program and beneficiaries by reducing the use of unnecessary care, while providing new catastrophic protections. As growing numbers of baby boomers enter Medicare rolls and federal health spending over the next several decades is projected to increase, reforming Medicare's cost-sharing rules will be an important part of the discussion on serious entitlement reform that could forge a bipartisan agreement.

Additional Resources

Bipartisan Policy Center: “A Bipartisan Rx for Patient-Centered Care and System-wide Cost Containment”

<http://bipartisanpolicy.org/sites/default/files/BPC%20Cost%20Containment%20Report.PDF>

Congressional Budget Office: Reducing the Deficit: Spending and Revenue Options (March 2011)

<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf>

Gruber, Jonathan: “Restructuring Cost Sharing and Supplemental Insurance for Medicare”

http://www.brookings.edu/~media/research/files/papers/2013/02/thp%20budget%20papers/thp_15waysfedbudget_prop3.pdf

MedPAC: Report to Congress (June 2012)

http://www.medpac.gov/documents/Jun12_EntireReport.pdf

Moment of Truth Project: “A Bipartisan Path Forward to Securing America’s Future”

<http://www.momentoftruthproject.org/publications/bipartisan-path-forward-securing-america-future-0>

President Obama’s FY2014 HHS Budget Proposal

<http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>

Senator Tom Coburn and Senator Richard Burr: “The Senior’s Choice Act”

http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=dd0753e9-e62b-4640-9659-75099f9bd1a9

Urban Institute: “Can Medicare Be Preserved While Reducing the Deficit?”

<http://www.urban.org/publications/412759.html>

Appendix: Comparison of Medicare Cost-Sharing Proposals

	Current Law		Reform Options						
	Part A	Part B	Fiscal Commission	A Bipartisan Path Forward*	Bipartisan Policy Center^	Urban Institute	Gruber Proposal	Coburn-Burr	President Obama FY14 Budget
Deductible	\$1,184 per Benefit Period	\$147 per year	\$550 per year	\$550 per year; lower on sliding scale between 100% and 250% of FPL	\$500 per year; Expand premium and cost-sharing assistance for beneficiaries below 150% of FPL	Combined income-related deductible similar to cost-sharing under the ACA exchanges	\$525 per year above 200% of FPL, \$250 below 200% of FPL	\$550 per year	Apply a \$25 increase to Part B deductible beginning in 2017, 2019, and 2021 for new beneficiaries
Hospital Care	Free for First 60 Days, \$296 per day for Days 61-90, \$592 per day after Day 90 (up to a maximum of 60 days)	20% Coinsurance	20% uniform coinsurance on all Part A & B services up to \$5,500 in OOP costs	20% uniform coinsurance on all Part A & B services up to \$5,500 in OOP costs; Give CMS authority to make value-based adjustments	\$750	Coinsurance would apply to all services but could also vary by income	20% uniform coinsurance on all Part A & B services up to catastrophic limit on out-of-pocket costs; revisit based on value-based benchmarks so it does not raise total costs	20% uniform coinsurance on all Part A & B services up to \$5,500 in OOP costs	N/A
Skilled Nursing Facility	Free for First 20 Days, \$148/Day for Next 80, No Coverage After	N/A			\$80 per day				N/A
Home Health	Free	Free			\$150 per episode				\$100 copayment per episode for new beneficiaries starting in 2017
Hospice Care	Generally Free; \$5 Copay for Drugs & 5% Coinsurance for Inpatient Respite Care	N/A			Free				N/A
Physician Services	N/A	Generally 20% Coinsurance			\$20 primary care/\$40 specialist per visit				N/A
Ambulatory Surgical Services	N/A	20% Coinsurance			N/A				N/A
Diagnostic Tests, X-rays,	N/A	20% Coinsurance for diagnostic tests			N/A				N/A

& Lab Services		and X-rays; Free clinical laboratory services							
Durable Medical Equipment	N/A	20% Coinsurance			20%				N/A
Physical, Occupational, & Speech Therapy	N/A	Generally 20% Coinsurance			N/A				N/A
Mental/ Psychiatric Health	Free for 190 Days over Lifetime	20-40% Coinsurance			N/A				N/A
Preventive Services	N/A	Free, some exceptions a 20% Coinsurance			Free				N/A
Outpatient Drugs		20% Coinsurance on some Physician-Administered Drugs	Continuation of Medicare Part D	Continuation of Medicare Part D As an alternative, suggests modifying cost-sharing in the low income subsidy (LIS) program to encourage the use of generic drugs	20% coinsurance For LIS beneficiaries, eliminate copays for generics and set copay for brand-name drug at \$6.00	Continuation of Medicare Part D Eliminate copays for generics and set copay for brand-name drug at \$6.00 for LIS beneficiaries	Continuation of Medicare Part D	Continuation of Medicare Part D	Lower copayments for generic drugs by 15 percent for low-income beneficiaries
Catastrophic Coinsurance			5% coinsurance between \$5,500-\$7,500	5% coinsurance between \$5,500-\$7,500		N/A	N/A	5% coinsurance between \$5,500-\$7,500	N/A
Out-of-Pocket Cap (OOP)	None	None	\$7,500 Limit	\$7,500 Limit, but lower income-related cap for lower-income beneficiaries	\$5,315 Limit	Income-related cap on Part A, B, and D cost-sharing; Illustrative: \$6,000 for those above 400% FPL, lower for those below 400% FPL, and \$0 OOP expenses for those below 133% of FPL	Income-related cap: sliding scale ranging from one-third of the HSA limit (\$1,983) for 100-200% of FPL to the full HSA limit (\$5,950) over 400% of FPL	\$7,500 Limit; higher limits based on income for those above \$85,000 (individual)/ \$170,000 (couples)	N/A

Medigap Limits	None	None	No first-dollar coverage below \$500; only half of cost-sharing up to \$5,000	No first-dollar coverage below \$550; only half of cost-sharing up to \$5,500; interim surcharge applied to the Part B premium for beneficiaries with Medigap policies	Require a \$250 deductible, an OOP maximum no lower than \$2,500, and cover no more than half of an enrollee's coinsurance/co-payments	Illustrative: Prohibit Medigap from covering the first \$500 and no more than 50% of the next \$4,950	Excise tax of up to 45% on premiums for Medigap plans	Prohibit coverage of the first \$500 of beneficiaries' cost-sharing and limit coverage above \$500 to 50 percent of the next \$5,000 of Medicare cost-sharing	Surcharge on Part B premium equal to 15 percent of average Medigap premium for new beneficiaries beginning in 2017
TRICARE	N/A	N/A	Apply above Medigap reform	Apply above Medigap reform	Apply above Medigap reform	N/A	N/A	N/A	N/A
FEHBP and Retiree Coverage	N/A	N/A	Restrict beneficiaries from using FEHB subsidy to buy supplemental insurance; Use subsidy to help pay for Medicare premium	Impose surcharge on Part B premium for beneficiaries with retiree health plan; Give option to "cash out" the value of their health plan in the form of a Part B premium subsidy; A similar cash out would be mandated for FEHB plans	Apply above Medigap reform	N/A	Apply 45% excise tax on employer-sponsored retiree coverage	N/A	N/A

*A Bipartisan Path Forward proposes lower OOP limits for those beneficiaries with lower incomes, both for the catastrophic coinsurance rate (less than \$5,500) and for the overall OOP cap (less than \$7,500). The proposal seeks to hold constant average OOP costs.

^The Bipartisan Policy Center recommends replacing coinsurance on most covered services with copayments similar to those recommended by MedPAC, illustrated in this chart. They also recommend exempting physician office visits from the \$500 combined deductible.