

What's Happening to My Medicare?

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As debt reduction talks continue in Washington, changes to Medicare to save federal dollars have gained widespread support from the Medicare Payment Advisory Commission (MedPac), policymakers and Congressional representatives. Many of the proposed changes would affect both current and future Medicare beneficiaries, but in significantly different ways, depending on which changes are adopted. Savings to the Medicare program in “Washington speak” usually mean reducing the number or amount of services beneficiaries receive which translates to beneficiaries paying more of their own health care costs.

Besides reducing the deficit, Congress is also challenged with slowing the growth of future spending. This is where the rising costs of Medicare poses a problem. Medicare costs have been increasing because beneficiaries are living longer and needing more services as they get older. In addition, more people are becoming eligible for Medicare benefits as baby boomers turn 65. Each of these trends increases Medicare's costs.

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Apart from those two trends, Medicare expenditures *are* increasing, although at a lower rate than the private health insurance market. For instance, from 2002 to 2009 Medicare costs increased 4.6% per person compared with 6.1% per person for similar benefits in the private market because the cost of medical care services remains uncontrolled. In addition, Medicare has often led the way in pioneering new payment methods and systems at an administrative cost much lower than the private insurance market.

Many in Washington believe Medicare's rising costs are, in part, a result of Medicare beneficiaries not having enough “skin in the game.” If they did, they would be more cautious about using health care services since they would have to pay more of the cost of their own care. This view point assumes that beneficiaries currently use health care services whether they need them or not, and if they had to pay more, they would use only the services they really need. However, there is no evidence that Medicare beneficiaries over utilize health care services, or that the services they use are unnecessary. Most beneficiaries have legitimate health care needs, either because they are older or because they are disabled. Nearly half of this population has 3 or more chronic health conditions, while 1/3 have cognitive or mental impairments. Medicare beneficiaries already spend on average 15% of their annual fixed income on health care expenses, many of which are not covered by Medicare such as dental, hearing, glasses and long-term care. Moreover, Medicare only covers and pays for services that are medically reasonable and necessary, and a beneficiary who uses services that are not medically necessary would have to pay for them.

Half of all Medicare beneficiaries have incomes of \$22,000 or less, and can ill afford additional costs to use health care services. The risk of adding additional cost-sharing is that beneficiaries may delay or forego necessary services because they cannot afford those costs. If beneficiaries delay important and necessary care they may need more care later when they are sicker, and care is more expensive.

Described below are a few of the proposals that would most directly impact Medicare beneficiaries.

Voucher or premium support

A popular notion in Washington would limit the amount of money the federal government spends each year for a Medicare beneficiary. Instead of covering a required set of benefits for every beneficiary under the system today, this proposal would give a certain amount of money, a defined contribution, to each beneficiary to buy his or her own insurance. The federal contribution, also referred to as premium support or voucher, would increase each year but by less than the rate of medical inflation, resulting in beneficiaries paying a larger portion of their own premium cost each year. Over time, Medicare beneficiaries would pay an increasingly larger share of the premium for their Medicare benefits and would have higher out-of-pocket costs. The federal government's Medicare costs would still increase, but would do so more slowly than today.

This proposal is usually combined with another one that would require beneficiaries to buy Medicare benefits in the private insurance market, much like they do today in the Medicare Advantage and Part D programs. Beneficiaries would be responsible for paying the premiums of the plan they select and for any other costs the plan imposes on them. These proposals neither contain any restrictions for premiums based on age, nor require consumer protections that would be critical for this population. In addition to premiums, Medicare beneficiaries could be faced with higher out-of-pocket spending for deductibles and copayments in the plan they select.

Restructure Medicare to add more cost-sharing

Another popular idea is to restructure Medicare by creating a single annual deductible amount for Parts A and B (\$500 up to \$750 per individual) combined with an annual out-of-pocket limit (\$5,000 up to \$7,500 per individual). While this would be simpler than the separate deductibles for Part A and Part B today, it would shift a significant amount of the cost to beneficiaries. Under this proposal, new copayments would be required for all Medicare covered services, including hospital inpatient services, skilled nursing facility care and home health care.

In addition, this and other proposals would prohibit retiree plans, Medigap policies, the Federal Employees Health Benefit program and TriCare-for-Life from paying any annual deductible that becomes law, and at least half of any out-of-pocket costs. The thinking behind these proposals is that Medicare beneficiaries would use fewer medical services if they have to pay a significant amount of the cost for those services at the time of use, and hence, federal Medicare dollars would be saved. However, if beneficiaries have to pay copayments when they need care, they

may delay or do without care, including preventive care services which have no copayment but are accessed through other services that do have a copayment. Some studies show this would result in beneficiaries waiting until they are sicker and need more expensive care. Thus any savings projected by these proposals could be wiped out by more costly care received later.

Discourage benefits that supplement Medicare

In addition to the restrictions on benefits discussed above, several proposals would penalize Medicare beneficiaries in a variety of ways if they purchase or have supplemental benefits that pay their out-of-pocket expenses. Some proposals would tax the Medigap insurers who offer these Medicare supplement plans. Insurers would likely pass on the tax to consumers in higher premiums for those products.

Other proposals would reduce employers' tax benefits as a way to discourage them from providing generous retiree benefits that supplement Medicare. Several also include a provision to impose premiums and copayments for military retirees with TriCare-for-Life benefits.

Another proposal would impose higher Part B premiums on anyone who had existing supplemental benefits that cover deductibles and copayments.

Each of these proposals is intended to save Medicare dollars by requiring beneficiaries to pay more and to discourage them from using health care services.

Higher income beneficiaries

Several proposals would require higher income beneficiaries to pay a higher Medicare premium, and some would require higher income beneficiaries to pay a higher deductible amount than other Medicare beneficiaries. Individuals with annual incomes over \$85,000 or couples with incomes over \$170,000 already pay higher premiums for both Part B and Part D, and in general paid higher Medicare taxes while working. Several proposals would increase the amount of premium this group pays, while other proposals would freeze or remove an inflation adjustment until at least 25% of Medicare beneficiaries are in this category. Some proposals would tie premiums to people's individual income, converting Medicare to a means-tested program.

Increase the age of eligibility for Medicare

One proposal increases the Medicare eligibility age from 65 to 67, and another increases it to 70. However, delaying eligibility until 67 or 70 would cost Medicare more, as well as increase costs for employers and individuals age 65 to 70. Compared to people in their 70s and 80s, those who are 65 to 70 are generally healthier and need fewer health care services. If the Medicare eligibility were delayed, Medicare could collect premiums only from these older beneficiaries who generally need more services thereby increasing Medicare's costs.

Conversely, compared to the younger working population, younger seniors are older workers, and their health insurance premiums tend to be higher and their claims costs greater than much

younger employees. More of these seniors would remain in the workforce or take advantage of retiree coverage driving up the cost to employers.

Younger seniors without employer health coverage would have to buy insurance from the private individual market paying higher premiums based on their age.

What can we do?

While we at California Health Advocates appreciate the need to reduce the federal deficit, we do not believe proposals that cut spending by increasing beneficiary out-of-pocket costs will solve the problem. Instead, the rising cost of health care services must be brought under control by focusing on wellness and prevention, bundling payments, reducing waste, encouraging efficiency such as coordinating care and using electronic health records, and giving providers incentives to hold down costs. We need to change the health care system to aim for better health care that results in better health outcomes.

The new health law, the Affordable Care Act, introduced initiatives to control costs as well as pay for value instead of volume. Instead of focusing on cutting Medicare spending by shifting the cost to beneficiaries, lawmakers should build on the initiatives in the Affordable Care Act and address the challenge of taking care of a growing Medicare population without adding to the federal deficit.