



Statement before the House Committee on Ways and Means,
Subcommittee on Health
On the President's and Other Bipartisan Proposals to Reform Medicare

Medicare Cost-Sharing Requirements Should Be Restructured

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Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify today before the House Committee on Ways and Means, Subcommittee on Health.

The Medicare program is on a fiscally unsustainable path. Medicare spending will nearly double over the next decade, increasing from \$586 billion this year to more than \$1 trillion in 2023.¹ The oldest members of the baby boom generation have reached age 65 and are enrolled in Medicare. Over the next two decades, some 76 million people will move out of the workforce, into retirement, and into Medicare. That will place an increasing burden on the budget and on younger generations whose taxes support the program.

In their 2012 report, the Medicare trustees project that the Hospital Insurance (HI) trust fund, which finances hospital and other institutional services provided to Medicare beneficiaries, will become depleted in 2024.² Medicare has been liquidating the HI trust fund since 2008 to cover the excess of current expenses over income. The Supplementary Medical Insurance (SMI) trust fund, which finances physician and other outpatient services as well as prescription drug coverage, is considered adequately financed. However, that trust fund automatically receives funds from general tax revenue to cover any shortfall and would otherwise not be self-sustaining. This year's trustees' report, which will be released soon, may offer a somewhat more optimistic view of Medicare financing in the short run, but the long term picture remains bleak.

Policies must be adopted to moderate the growth of Medicare spending while ensuring that beneficiaries with greater needs continue to get the necessary help with their health care costs. Although there is considerable controversy over how best to reform Medicare, there are opportunities to make incremental changes in the program.

Today's hearing focuses on three proposals in the President's 2014 budget that would modestly reduce Medicare spending over the next decade. Beginning in 2017, new enrollees in Medicare would be required to pay a higher deductible for their Part B services. New enrollees would also be subject to a \$100 per episode copayment for home health episodes lasting five or more visits. In addition, the President proposes to increase income-related premiums paid under Part B and Part D.

These proposals are estimated to yield \$54 billion in budget savings over the next decade—less than 1 percent of the \$7.9 trillion Medicare is likely to spend over the same time period. Although modest in scope, the proposals offer an opportunity for bipartisan agreement that could eventually lead to broader reforms to protect Medicare for future generations.

Reforming Medicare Cost Sharing

Traditional Medicare has long been criticized for its baffling set of cost-sharing requirements. Unlike modern insurance products, traditional Medicare requires its enrollees to

¹ Congressional Budget Office, *Medicare—May 2013 Baseline*, <http://www.cbo.gov/publication/44205>.

² Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report*, April 23, 2012, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf>.

pay greatly variable amounts in cost-sharing depending on which services are used. Because the required cost-sharing payments are difficult to know in advance, they do not provide a clear incentive to beneficiaries or their providers to select the lowest-cost approach to treatment.

Most comprehensive health insurance has a fairly simple benefit structure. A single deductible amount must be paid each year by the beneficiary before the insurer will pay its share of the cost of services. In addition, beneficiaries are responsible for either a coinsurance (a percentage of the negotiated price of each service, often 20 percent) or a copayment when they use health services.

Medicare imposes several different deductibles, requires varying amounts of coinsurance depending on the service, and places limits on coverage for certain services. In 2013, Medicare beneficiaries must pay a \$147 Part B deductible before the program begins to cover the costs of physician and other services.³ The separate hospital inpatient deductible of \$1,184 must be paid for each benefit period—possibly more than once a year. In addition, traditional Medicare does not limit the amount that beneficiaries must pay out of pocket, exposing them to potentially catastrophic costs.

Few Medicare beneficiaries actually pay these amounts directly out of pocket. About 90 percent of beneficiaries in traditional Medicare receive supplemental coverage through Medigap, retiree plans, or Medicaid. That reduces beneficiary uncertainty about how much they might be required to pay in cost-sharing during the year. It also reduces the beneficiary's awareness of the cost of their care, which leads to higher use of services and higher program spending than would otherwise be the case.

Numerous experts and bipartisan commissions have recommended policies to reform and simplify Medicare's cost-sharing structure. The Bowles-Simpson commission proposed new cost-sharing rules and limitations on Medigap coverage that would reduce Medicare spending by \$90 billion over the next decade.⁴ Similar reforms have been proposed by the Bipartisan Policy Center (estimated program savings of \$61.6 billion) and the Medicare Payment Advisory Commission (MedPAC).⁵

The President's 2014 budget proposals are much narrower in scope. The proposals increase the amount of the current Part B deductible and introduce a new cost-sharing requirement for certain home health episodes. Other cost-sharing rules would remain as they are today.

The new provisions would be phased in, and would apply only to new Medicare enrollees entering the program beginning January 2017. The Part B deductible would be increased \$25 a

³ *Medicare 2013 costs at a glance*, <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>.

⁴ The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, http://www.momentoftruthproject.org/sites/default/files/TheMomentofTruth12_1_2010.pdf.

⁵ Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, April 2013, <http://bipartisanpolicy.org/sites/default/files/BPC%20Cost%20Containment%20Report.PDF>; Medicare Payment Advisory Commission, "Reforming Medicare's benefit design," chapter 1 in *Report to Congress: Medicare and the Health Care Delivery System*, June 2012.

year in 2017, 2019, and 2021, for a total increase of \$75. The new \$100 copayment would be levied on home health episodes with 5 or more visits, and would only apply if the episode was not preceded by an inpatient stay.

Because the provisions are not effective until 2017, the savings measured in the ten-year budget window are modest. The Part B deductible would yield \$3.3 billion and the home health copayment would yield \$730 million through 2023.

These are modest proposals, but at least they are a start. The increased deductible and the new copayment are intended to promote greater cost awareness among Medicare beneficiaries. It would be reasonable to apply the new requirements to all beneficiaries, and they could be applied before 2017. There is no obvious difference between someone entering Medicare in 2016 and someone entering in 2017. A more reasonable phase-in approach would account for differences in beneficiary ability to pay and health status rather than their year of enrollment.

Critics of these proposals argue that the new cost-sharing requirements could pose a burden on beneficiaries. Since the vast majority of beneficiaries have essentially complete protection against out-of-pocket costs through Medigap and other supplemental coverage, the financial impact on seniors would be minimized. Those who receive Medicaid benefits will not pay more, and those with retiree plans are also likely to have the extra cost paid by their plan. Medigap premiums would rise modestly since insurers will cover the additional \$75 deductible (which everyone enrolling after January 2017 must pay) and the cost of the home health copayment (which will be incurred by a minority of patients). Beneficiaries without supplemental coverage risk paying higher amounts, but they already take that risk now.

The President also proposes to add a surcharge to the Part B premium paid by beneficiaries who have near-first dollar Medigap coverage. It is expected to yield \$2.9 billion in program savings through 2023. This provision would increase the costs faced by beneficiaries with high-end Medigap plans, but would not significantly discourage the purchase of such plans and would do little to increase cost-awareness among seniors. Rather than adding to the tax burden of seniors, we should restructure Medicare to reflect the innovations that have occurred in benefit design over the past five decades.

Increasing Income-Related Premiums

Medicare provides generous subsidies to seniors at all income levels.⁶ Imposing premiums that increase with the income of a beneficiary reduces those subsidies and makes the program more progressive. In that way, seniors who are better able to pay shoulder a larger share of the cost of the program.

⁶ The Medicare benefits that high earners can expect in their lifetimes more than make up for the additional Medicare taxes they pay during their working careers. A two-earner couple with a combined income of \$116,000 who turn 65 in 2010 can expect an average of \$387,000 in Medicare benefits but only paid \$156,000 in Medicare payroll taxes, both measured in present value terms. See C. Eugene Steuerle and Caleb Quakenbush, *Social Security and Medicare Taxes and Benefits over a Lifetime: 2012 Update*, October 2012, <http://www.urban.org/UploadedPDF/412660-Social-Security-and-Medicare-Taxes-and-Benefits-Over-a-Lifetime.pdf>.

This is not a new policy principle for Medicare. The Medicare Modernization Act of 2003 established income-related premiums for Part B. The Affordable Care Act established income-related premiums for Part D. But even before those policies were enacted, higher wage earners have contributed more to Medicare than those with less income. During their working lives, high wage earners pay higher payroll and income taxes than low wage earners.

The President proposes to increase income-related premiums under Part B and Part D by five percentage points, beginning in 2017. In addition, the income threshold (currently \$85,000 for an individual or \$170,000 for a family filing a joint tax return) would be frozen until 25 percent of Medicare beneficiaries are subject to such premiums. This proposal is expected to yield \$50 billion in program savings through 2023.

The Bowles-Simpson Commission supported a similar proposal, increasing premium levels and setting the income threshold to make 15 percent of seniors subject to income-related premiums (\$65 billion in program savings). The Bipartisan Policy Center recommended setting the income threshold to make 17 percent of seniors subject to the premiums (\$66.3 billion in program savings).

The Heritage Foundation took this policy to its logical conclusion. If the budget resources are not available to maintain an adequate level of Medicare benefits for every senior, then we should care first for those who cannot afford to cover the costs themselves. Under their proposal, Medicare subsidies would be phased out completely for individuals with income of \$110,000 and couples with income of \$165,000.⁷ That was expected to save \$514 billion over ten years.

Increasing premiums reduces the fiscal pressure Medicare places on the rest of the budget, but it does not address the fundamental defects that drive up program costs. Higher premiums do not change the financial incentives of fee-for-service Medicare. They do not change the way beneficiaries use services or the way those services are delivered. Although this policy may be a useful short-term measure, more fundamental reforms that address Medicare's cost drivers are needed.

Conclusion

The President's budget is one possible starting point for developing bipartisan legislation that can begin to slow Medicare spending while protecting the interests of seniors. Although it is far preferable to restructure Medicare's cost-sharing requirements, we can start with targeted changes such as raising the Part B deductible or introducing a new copayment for home health services. Raising premiums will not slow program spending, but could buy some time to implement effective measures to reform the program.

Any significant Medicare reform will take time to develop and implement. It is better to act now than to delay until the fiscal crisis is upon us. Abrupt actions forced by crisis harm

⁷ Robert E. Moffit and Rea S. Hederman Jr., *Medicare Savings: 5 Steps to a Downpayment on Structural Reform*, April 12, 2013, <http://www.heritage.org/research/reports/2013/04/medicare-savings-5-steps-to-a-downpayment-on-structural-reform>.

seniors and risk the long-term stability of the program. Proposals advanced by the President, as well as proposals from independent commissions, provide a basis for bipartisan agreement and the start of a process that can preserve and improve Medicare for future generations.

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