

# Health Cost Containment Initiative – Medicare Benefit Modernization Proposals

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BENEFIT MODERNIZATION - THE BPC APPROACH

# • The Challenge:

- The Medicare benefit package is out-of-date and fails to provide adequate protections for enrolled seniors and people with disabilities. Largely for this reason, roughly 90 percent of Medicare beneficiaries have some source of supplemental insurance to fill in coverage gaps. At the same time, assistance for low-income beneficiaries is inadequate.
- BPC Proposal Beginning in 2016:
  - Improve, simplify, and modernize the basic traditional Medicare benefit package, providing predictable cost-sharing for beneficiaries.
  - Reform supplemental coverage to minimize cost-shifting from private plans to Medicare and to reduce beneficiary premiums.
  - Increase and improve support for low-income Medicare beneficiaries.
  - · Reduce subsidies to higher-income Medicare beneficiaries.



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### STRENGTHEN AND MODERNIZE THE MEDICARE BENEFIT

# Today's Medicare Cost-sharing

- Part A (Hospitalization) Deductible: \$1,184 per benefit period (may apply multiple times per year).
- Hospitalization Beneficiary Cost-sharing:
  - Days 1-60: none beyond the deductible
  - Days 61-90: \$296 per day
  - Days 91+: \$592 per day for up to 60 "lifetime reserve days"
  - · After lifetime reserve days are used up: All costs
- Skilled Nursing Cost-sharing:
  - Days 1-20: \$0
  - Days 21-100: \$148 per day
  - Days 101+: All costs
- Part B (Medical) Deductible: \$147 per year
  - Physician visits are subject to the deductible
- Part B Cost-sharing: Usually 20% coinsurance; preventive services and annual wellness visit have no cost-sharing.
- No Cost-sharing Limit Beneficiaries have unlimited potential cost-sharing liability.

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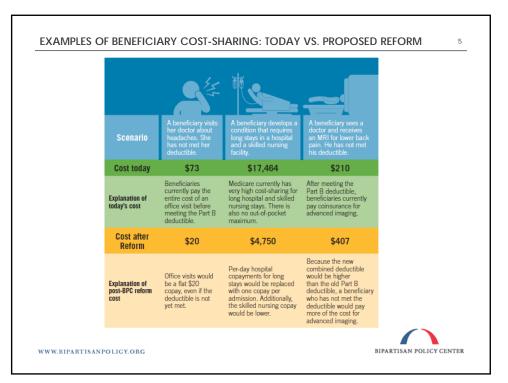
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## STRENGTHEN AND MODERNIZE THE MEDICARE BENEFIT

- Revise outdated system of deductibles and coinsurance to strengthen Medicare benefit:
  - Provide financial protection from the costs of a catastrophic illness by capping the medical and hospital cost-sharing beneficiaries can be required to pay in a given year at \$5,300.
  - Replace the current complicated array of deductibles and coinsurance rates with a single \$500 deductible and a simplified, more rational copay schedule. Examples:
    - \$20 copayment to see a primary care physician, \$40 to visit a specialist.
    - \$750 per hospital admission.
    - \$80 per day for skilled nursing
  - Deductible does not apply to physician office visits.
  - Maintain preventive services with no beneficiary cost-sharing.
  - Reduce the need for supplemental coverage, allowing many beneficiaries to save money.
  - Leave aggregate beneficiary cost-sharing amount unchanged program-wide.

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### RESTRICT 1ST-DOLLAR SUPPLEMENTAL COVERAGE TO MINIMIZE COST-SHIFTING

- Revise Medicare supplemental coverage to address incentives for over-utilization of services, while increasing assistance for low-income beneficiaries.
- Prohibits all supplemental plans (Medigap and employer plans, including TRICARE For Life and FEHB) from covering firstdollar beneficiary cost-sharing.
- Beginning in 2016, all supplemental coverage would:
  - Include a deductible of at least \$250;
  - Include an out-of-pocket maximum no lower than \$2,500 (out of the beneficiary's pocket); and
  - Cover no more than half of beneficiary copayments and coinsurance (once the deductible is met and before the out-of-pocket maximum is reached).
- The National Association of Insurance Commissioners would be asked to develop new, standard Medigap plans that meet these requirements.

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#### INCREASE AND IMPROVE SUPPORT FOR LOW-INCOME MEDICARE BENEFICIARIES 7

- Today: Help with cost-sharing is currently available for Medicare beneficiaries <100% FPL, but not for those with incomes just above the poverty level.
- BPC Proposal: Add automatic cost-sharing assistance (federally-funded, federally-administered to beneficiaries with incomes up to 150% of the federal poverty level (FPL)):

	New Cost-Sharing Assistance	Average Beneficiary Savings from Full BPC Plan	
100-135% of FPL	50% of cost-sharing	\$1,250 per year	
135-150% of FPL	25% of cost-sharing		

• Would benefit over <u>8 million</u> low-income seniors and people with disabilities starting in 2016.

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## REDUCE PREMIUM SUBSIDIES TO HIGHER-INCOME MEDICARE BENEFICIARIES

- Unlike Medicare Part A, which is funded through payroll taxes, Parts B and D of Medicare are funded through a combination of general tax revenues and beneficiary premiums.
- Beginning in 2016, establish lower federal subsidies to highincome Medicare beneficiaries (affects 17 percent of beneficiaries):

CURRENT LAW THRESHOLDS		PROPOSED THRESHOLDS			
Single	Couple	Premium	Single	Couple	Premium
<\$85,000	<\$170,000	25%	<\$60,000	<\$90,000	25%
\$85,001- \$107,000	\$170,001- \$214,000	35%	\$60,001- \$82,000	\$90,001- \$123,000	35%
\$107,001- \$160,000	\$214,001- \$320,000	50%	\$82,001- \$135,000	\$123,001- \$202,500	50%
\$160,001- \$214,000	\$320,001- \$428,000	65%	\$135,001- \$189,000	\$202,501- \$283,500	65%
>\$214,000	>\$428,000	80%	>\$189,000	>\$283,500	80%

Note: New thresholds take effect in 2016 and would be updated for inflation beginning in 2019

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