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# Double Coverage: How It Drives Up Medicare Costs for Patients and Taxpayers

*Robert E. Moffit, PhD, and Drew Gonshorowski*

**Abstract**

*Traditional Medicare's cost-sharing structure has remained virtually unchanged since 1965, and seniors face unlimited out-of-pocket costs. In sharp contrast to private insurance, the greater Medicare patients' medical needs and the longer the duration of their care, the more they pay. Structurally, traditional Medicare is not only generating excessive costs for seniors and taxpayers alike, it is also failing as a health insurance program. While a Medicare defined-contribution ("premium support") system of financing would vastly improve the program—enabling seniors to choose fully integrated health plans—Congress can make short-term changes that would not only reduce Medicare's excess costs, but would also lay the groundwork for comprehensive market-based reform. One such change would be rationalizing cost sharing in Medicare Parts A and B.*

Structurally, traditional Medicare is not only generating excessive costs for seniors and taxpayers alike, it is also failing as a health insurance program.[1] While a Medicare defined-contribution ("premium support") system of financing would vastly improve the program—enabling seniors to choose fully integrated health plans—Congress can make short-term changes that would not only reduce Medicare's excess costs, but would also lay the groundwork for comprehensive market-based reform. One such change would be rationalizing cost sharing in Medicare Parts A and B.

## Key Points

- Structurally, traditional Medicare is not only generating excessive costs for seniors and taxpayers alike, it is also failing as a health insurance program because it subjects seniors to unlimited out-of-pocket costs.
- Thus, nearly all seniors purchase supplemental insurance to fill in Medicare's coverage gaps.
- Supplemental coverage, particularly Medigap, incentivizes excessive utilization and results in a hidden cost shift to seniors. A recent analysis of the MedPAC data by the Center for Data Analysis estimates that the higher spending generated by Medigap's "first dollar" coverage, will cost beneficiaries an extra $70.1 billion by 2023.
- Structural Medicare reform based on defined-contribution ("premium support") financing would enable seniors to choose fully integrated health plans. In the short term, Congress could create a single deductible for Parts A and B, and add a catastrophic benefit.

This paper, in its entirety, can be found at **http://report.heritage.org/bg2805**

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**The Heritage Foundation**
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

## Big Gaps in Cost Sharing

Traditional Medicare's cost-sharing structure has remained virtually unchanged since 1965, and seniors face unlimited out-of-pocket costs. In sharp contrast to private insurance, the greater Medicare patients' medical needs and the longer the duration of their care, the more they pay. For example, Medicare Part A's hospital deductible is very high: $1,184 for each "spell of illness" (60 days) in a hospital. Beyond this initial deductible, Medicare patients also pay a "co-insurance" of $296 per day for hospital days 61 to 90, which is increased to $592 per day for hospital days 91 to 150. For skilled nursing care, Medicare patients must pay $148 per day for days 21 to 100. While Medicare Part B, the part of the program that pays physicians and outpatient Medicare costs, is subject to a modest annual deductible of $147, most Part B services require a 20 percent co-insurance.

**Insurance Overkill.** These complex payment arrangements, plus gaps in coverage—particularly the lack of catastrophic protection—encourage millions of seniors, more than nine out of 10, to enroll in supplemental coverage. Among Medicare beneficiaries, 31.3 percent have employer-sponsored supplemental coverage; 21.3 percent are enrolled in Medigap plans; and Medicaid, which is a welfare program, accounts for 12 percent.[2] Employer-based retiree coverage is declining: between 1997 and 2010, such coverage for persons over the age of 65 fell from 20 percent to 16 percent.[3]

Beyond providing the missing catastrophic protection, these plans plug other gaps in coverage. More important, many cover Medicare's co-payments, ensuring "first dollar" coverage, and making Medicare "free" or "nearly free" at the point of service. This drives up utilization. As the Medicare Payment Advisory Commission (MedPAC), the panel that advises Congress on Medicare reimbursement, observes, "By effectively eliminating FFS [fee for service], Medicare's price signals at the point of service, supplemental coverage generally masks the financial consequences of beneficiaries' choices about whether to seek care and which types of providers and therapies to use."[4] Writing in 2009, Walton Francis, a prominent Washington health care economist, summarized the state of the research at that time:

> The literature on the effects of Medigap on Medicare spending generally agrees that excess utilization of medical care is on the order of 15 to 25 percent, or at today's per capita spending levels, from $1,500 to perhaps over $2,500 a year per enrollee in costs to original Medicare, and (as a "ballpark" estimate) in the range of $45 billion to $75 billion a year in total original Medicare spending.[5]

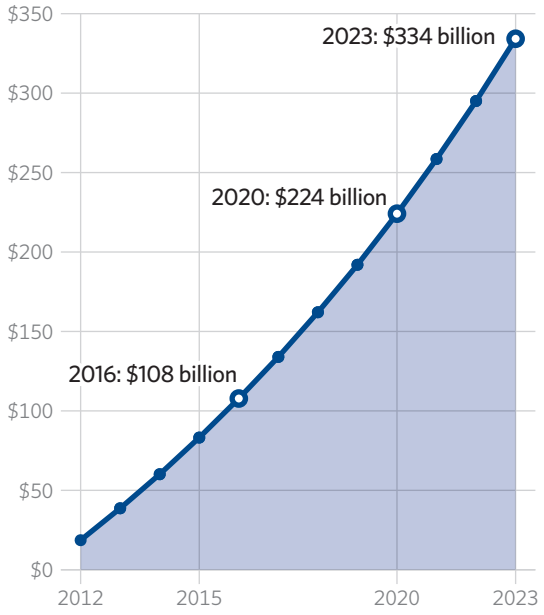
**More Spending and Higher Premiums.** While such coverage appeals to seniors, it guarantees higher costs for both them and the taxpayers. While effectively insulating Medicare enrollees from bearing the direct cost of their care, the systemic result is higher overall Medicare spending, which contributes directly to higher Medicare beneficiary premiums. Recent research confirms the relationship between supplemental coverage and higher Medicare spending growth. Researchers found that between 1992 and 2005 Medicare beneficiaries without supplemental coverage experienced an average annual spending growth of 6.08 percent, compared to an average annual rate of 7.17 percent for beneficiaries with employer-sponsored supplemental plans, and 7.18 percent with individually purchased coverage.[6]

1. For a discussion of these structural weaknesses of the traditional Medicare program, see Robert E. Moffit and Alyene Senger, "Medicare's Outdated Structure—and the Urgent Need for Reform," Heritage Foundation *Backgrounder* No. 2777, March 22, 2013, http://www.heritage.org/research/reports/2013/03/medicares-outdated-structureand-the-urgent-need-for-reform.
2. Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, June 2012, p. 51.
3. Paul Frontsin and Nevin Adams, "Employment-Based Retiree Health Benefits: Trends in Access and Coverage, 1997–2010," Employee Benefit Research Institute *Issue Brief* No. 377, October 2012, p. 1.
4. Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System* (Washington, DC: June 2012), p. 17.
5. Walton J. Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, DC: AEI Press, 2009), p. 27.
6. Ezra Golberstein, Kayo Walsh, Yulei He, and Michael Chernew, "Supplemental Coverage Associated with More Rapid Spending Growth for Medicare Beneficiaries," *Health Affairs*, Vol. 32, No. 5 (May 2013), pp. 873–881.

CHART 1

## Projected Cumulative Costs for Premium Medigap Coverage

IN BILLIONS OF DOLLARS




**Source:** Center for Data Analysis calculations based on data from Medicare Payment Advisory Commission (MedPAC), "Health Care Spending and the Medicare Program," June 2012, http://medpac.gov/documents/Jun12DataBookEntireReport.pdf (accessed May 7, 2013).

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Likewise, MedPAC reports that total Medicare spending was 17 percent higher for beneficiaries enrolled in employer-sponsored coverage, and was 33 percent higher for beneficiaries with Medigap than those with no supplemental coverage.[7] A major study, commissioned by MedPAC, concludes that "[a]ll of the available evidence suggests that secondary insurance raises Medicare spending substantially."[8] Medicare beneficiaries' premiums are inflated primarily as a result of higher Part B spending. This increased spending, according to MedPAC, is almost solely from beneficiaries with supplemental coverage who pay less than 5 percent of Part B costs out of pocket.

Supplemental coverage, particularly Medigap, thus results in a hidden cost shift to seniors. Part B premiums (fixed at 25 percent of the total premium cost for beneficiaries) are designed to cover the cost of Part B benefits. But the excess utilization also contributes to a higher dollar amount for those premiums. A recent analysis of the MedPAC data by The Heritage Foundation's Center for Data Analysis (CDA) estimates that all beneficiaries pay roughly 5 percent more in higher Part B premiums because of the higher spending generated by Medigap's "first dollar" coverage. This amounts to a total increase of beneficiaries' out-of-pocket Part B spending of $70.1 billion by 2023, according to CDA estimates.[9]

Beyond its impact on total Part B spending, Medigap enrollees' presumed insulation from cost is less than it appears. Says Glenn Hackbarth, chairman of MedPAC, "For most beneficiaries who purchase Medigap policies, the amount they pay in premiums is often well above the amount they would have incurred in cost sharing in the absence of supplemental coverage."[10] Medigap insurance itself is not a cheap product for beneficiaries.[11] Beneficiaries who have a Medigap plan will pay a total of $334 billion in premiums by 2023, according to CDA estimates.

## A Better Policy

With the enactment of the Medicare Modernization Act of 2003, Congress created the

7. Glenn M. Hackbarth, chairman, Medicare Payment Advisory Commission, "Reforming Medicare's Benefit Design," statement before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 26, 2013, p. 9.
8. Christopher Hogan, "Exploring the Effects of Secondary Coverage on Medical Spending for the Elderly," Medicare Payment Advisory Commission, 2009, p. 41, http://www.medpac.gov/documents/Jun09_SecondaryInsurance_CONTRACTOR_RS_REVISED.pdf (accessed May 29, 2013).
9. This calculation is conducted using the results of the Hogan 2009 study and applying them to the populations of individuals using Medigap from MedPAC data. Once this estimation is applied to the first year, populations and premiums are grown as outlined by the Congressional Budget Office baseline to calculate the long-term projection.
10. Hackbarth, "Reforming Medicare's Benefit Design," p. 3.
11. "The administrative costs and other expenses for this insurance are very high, and when added to the actuarial costs of the benefits, Medigap may actually increase beneficiaries' overall out of pocket burdens." Marilyn Moon, "Modernizing Medicare's Benefit Structure," *Washington and Lee University Law Review*, Vol. 60, No. 4 (Fall 2003), p. 1210.

Medicare Advantage program of competing private health plans. While the Medicare Advantage payment system is flawed precisely because it is rooted in Medicare's administrative payment system rather than real market-based competitive bidding, patients are nonetheless protected from unlimited out-of-pocket costs.

Following Medicare Advantage, all major Medicare reform ("premium support") proposals—ranging from the Heritage plan to the bipartisan 2011 Wyden–Ryan plan[12]—would require catastrophic coverage. Likewise, in a true competitive market, there would be a variety of premiums and deductibles, reflecting different levels of coverage of the enrollees' choice. As a first step toward a comprehensive reform of Medicare, Congress should do two things:

First, rationalize traditional Medicare's complex and perverse co-payment arrangements. Congress should create a single deductible for Parts A and B, and provide uniform co-insurance and limit supplemental coverage of Medicare's cost sharing. While the central policy is the same—ending first dollar coverage—there can be variations on this approach. Thomas Miller, a resident fellow at the American Enterprise Institute, suggests revisiting the 1994 proposal developed by economists Martin Feldstein and Jonathan Gruber: increasing co-insurance to 50 percent, while limiting patients' out-of-pocket spending to 10 percent of their income.[13] The Congressional Budget Office has also suggested an annual catastrophic cap ($5,500), plus a single Medicare deductible and uniform co-insurance. If Congress also restricted Medigap coverage of cost sharing by exempting just the first $550 of enrollee payment from that coverage, the 10-year savings would amount to $92.5 billion.[14]

By contrast, President Obama proposes a new tax on newly retiring seniors who buy generous supplemental coverage. In his fiscal year 2014 budget, the President proposes a Medicare Part B premium "surcharge" for new enrollees who buy "near first dollar" Medigap coverage. Beginning in 2017, the surcharge would be equivalent to 15 percent of the average Medigap premium, adding even more to seniors' out-of-pocket costs. The President's proposal, however, would yield a 10-year savings of only $2.9 billion.[15]

Realigning economic incentives—as proposed by the Congressional Budget Office—is a much better policy than simply leaving them in place and clawing back excess Medicare spending through a premium tax on Medicare beneficiaries. Eliminating perverse incentives is clearly preferable both on economic and budgetary grounds.

Second, add a catastrophic benefit in combination with these Part A and Part B cost-sharing reforms. The whole point of insurance is to guarantee patient protection against the unforeseen and financially devastating costs of catastrophic illness. But, as noted, traditional Medicare does no such thing.

The level at which a catastrophic threshold should be set is a prudential question. The Heritage proposal, for example, would initially set the catastrophic coverage level on the average that is obtained in the Medicare Advantage program, and subsequently allow that cap to be set by free-market forces of consumer choice and competition, as is the case today in the Federal Employees Health Benefits Program.[16] The Bipartisan Policy Center has proposed an

12. For a review of the common features of the major Medicare reform plans, see Robert E. Moffit, "Saving the American Dream: Comparing Medicare Reform Plans," Heritage Foundation *Backgrounder* No. 2675, April 4, 2012, http://www.heritage.org/research/reports/2012/04/saving-the-american-dream-comparing-medicare-reform-plans.
13. "The major risk approach to Medicare reform makes the most sense for most beneficiaries. It balances protecting them effectively against catastrophic financial risks with increasing their cost consciousness for decisions involving health care costs they can manage better within the limits of their income. By relying on a higher percentage of coinsurance (rather than a large front end deductible), this approach also produces the best mix of stop-loss protection and greater sensitivity to the noncatastrophic costs of covered services." Thomas P. Miller, "Daring to Be Cautious? Bigger Steps Needed for Medicare Cost-Sharing Reform," American Enterprise Institute *Health Policy Outlook*, No. 2 (March 2013), pp. 4–5.
14. Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March 2011, p. 49, http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf (accessed May 29, 2013).
15. Office of Management and Budget, *Budget of the United States Government: Fiscal Year 2014*, http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/budget.pdf (accessed May 31, 2013).
16. Recent out-of-pocket catastrophic caps have run between $4,000 and $5,000 annually for Medicare Advantage plans and PPO (preferred provider organization) plans in the FEHBP. Francis, *Putting Medicare Consumers in Charge*, p. 145.

annual out-of-pocket cap of $5,250, and the National Commission on Fiscal Responsibility and Reform (Bowles–Simpson Commission) has recommended an annual catastrophic cap of $7,500.[17] Economist Walton Francis proposes implementing a Medicare catastrophic benefit only for those who do not have such coverage, or would be willing to switch from more expensive supplemental coverage to the less expensive catastrophic benefit. If structured properly, this policy change would also yield budget savings.[18] In any case, the higher the catastrophic benefit threshold, the lower the beneficiaries' premium cost.

The bottom line: Congress can control Medicare costs and reduce seniors' premium increases.

*—**Robert E. Moffit, PhD,** is Senior Fellow in the Center for Health Policy Studies at The Heritage Foundation, and **Drew Gonshorowski** is Policy Analyst in the Center for Data Analysis at The Heritage Foundation.*

17. Henry J. Kaiser Family Foundation, Program on Medicare Policy, "Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals," July 22, 2011, http://www.passagescenter.org/wp-content/uploads/2011/07/8124compare.pdf (accessed May 29, 2013).
18. "For example, a modestly subsidized benefit for catastrophic expense protection could be added to original Medicare. This could be done at a level and in an amount that would make it always a better buy than the equivalent protection in any Medigap plan, and made available only to those who did not have benefit supplementation for inpatient or outpatient costs." Francis, *Putting Medicare Patients in Charge*, p. 204.