

Proposal 3: Restructuring Cost Sharing and Supplemental Insurance for Medicare

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Deficit Reduction (10-year): \$125 billion

Broader Benefits: Insures consumers against high out-of-pocket costs; aligns the costs faced by consumers with the actual cost of care; discourages incentives in private plans that encourage excess use of Medicare benefits.

Introduction

As the federal government considers options for deficit reduction, all eyes are on the Medicare program. Medicare is the single biggest driver of the long-run deficit problem facing the United States. According to the most recent projections from the Trustees for Medicare, our long-run obligations in terms of Medicare exceed the taxes we will collect to finance that program by \$42.7 trillion over the entire future path of the program (Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 2012).

Traditionally, efforts to control the costs of the Medicare program have focused on the “supply side,” changing the method and amount that Medicare pays its providers. There has been much less focus on the “demand side,” using financial incentives to encourage less medical spending by enrollees. Indeed, the most important change in the demand side of Medicare in the past fifty years was the introduction of the Medicare Part D program, a prescription drug benefit, which substantially increased program spending.

Yet efforts both to improve the value of the Medicare program for beneficiaries and to lower its costs to the government would benefit from some focus on the demand side. Medicare confronts enrollees with a very poorly designed set of financial incentives. Some services are provided at no enrollee cost while others expose enrollees to uncapped financial risk, without regard to value. Facing such exposure, most enrollees have obtained some form of supplemental coverage from the government (Medicaid coverage of the “dual” population) or employers (employer-provided retiree health insurance),

or have purchased coverage on their own (so-called Medigap coverage or Medicare Advantage plans). Supplemental insurance is typically expensive, and the self-purchased products deliver much less value per dollar of premium than does traditional health insurance. Moreover, because supplemental insurance covers the patient costs of care, it encourages enrollees to consume more care. Supplemental insurance thus induces increased medical spending, the bulk of which is financed by Medicare, and imposes an important fiscal externality on the program.

In this chapter, I present a proposal to address these shortcomings with the existing Medicare cost-sharing structure. I propose a new cost-sharing structure within Medicare that will provide more protection to elders than the existing program, and will save many of them money by removing the costs of supplemental coverage.

The Challenge

BACKGROUND: COST SHARING AND SUPPLEMENTAL INSURANCE IN MEDICARE

Other than Medicare Part D, Medicare beneficiaries receive benefits through three programs. One program, Medicare Advantage, allows participants to enroll in private plans, which the government subsidizes. In the other two programs, the government directly provides insurance: Medicare Part A covers hospital care, including services such as inpatient care and skilled nursing, while Medicare Part B covers doctors’ fees and other medical services not covered by Part A.

The existing level of cost sharing in Medicare Parts A and B is both variable and uncapped, with an overall structure that is hard to rationalize. The current structure is

- A deductible per hospital episode of \$1,156;
- Additional charges per day for stays of more than sixty days;
- A skilled nursing facility (SNF) copayment of \$141.50 per day for twenty-one to one-hundred days;
- A \$162 deductible for Part B services; and
- An uncapped 20 percent coinsurance rate for most Part B services.

This is a problematic cost-sharing structure for a number of reasons. First, patients who use similar amounts of hospital services can pay very different amounts depending on whether hospitalizations are considered part of the same episode. Second, the sickest patients who stay in the hospital the longest bear the highest hospital costs. The sickest patients with the most need for SNF services pay the most, amounting to over \$10,000 for a hundred-day stay. Out-of-pocket exposure under Part B is also unlimited; patients can bear out-of-pocket costs that are a huge fraction (if not a multiple) of their income if they use extensive SNF or Part B services. Meanwhile, other services such as home health care and clinical and laboratory services are delivered with no cost sharing.

Perhaps for these reasons, only about one in ten Medicare beneficiaries faces this cost sharing. The remainder have supplemental coverage that picks up some or all of these costs. This supplemental coverage comes from one or more of five sources:

- The Medicaid and Qualified Medicare Beneficiary (QMB) programs cover all cost sharing (except for some nominal amounts) for the lowest-income elders. The income and asset limits to which individuals are subject in order to qualify for this program vary by state, although there is a federal floor at roughly 75 percent of the federal poverty line.
- The QMB program extends this cost-sharing protection to elders below the poverty line (or higher income in some states) who meet certain (higher) asset limits.
- Employer-provided retiree health coverage replaces Medicare cost-sharing provisions with (typically more-modest) employer-sponsored insurance (ESI) cost-sharing provisions.
- Individually purchased supplemental (Medigap) policies typically cover most cost sharing.

- Enrollment in privately run Medicare Advantage plans typically provide much lower cost sharing.

A well-known problem with supplemental coverage is the fiscal externality on the Medicare program. This arises because supplemental coverage increases medical utilization (by lowering the price faced by consumers), and the burden of that higher utilization is borne largely by Medicare (through the majority of spending that occurs after cost sharing). This significantly raises overall Medicare spending.

Estimating the size of this externality has been difficult because individuals who choose supplemental coverage may differ from those who do not. Two recent estimates from quasi-experimental analysis of changing supplemental coverage generosity suggest an externality of 30-45%; that is, for every \$1.00 of coverage provided by supplemental coverage, Medicare spending rises by 30 to 45 cents.¹

Another problem with individually purchased supplemental coverage is that it is a highly cost-inefficient product; Starc (2012) estimates an administrative load for Medigap policies of around one-third, largely due to substantial advertising and endorsement expenditures. These policies are not subject to limits put in place by the Affordable Care Act (ACA), which requires that health insurance for small groups and individual purchasers have an administrative load of no more than 20 percent.

CBO-SCORED OPTIONS

The starting point for recent debates over reforming cost sharing in Medicare is several options considered by the Congressional Budget Office (CBO) in its December 2008 volume, *Budget Options: Volume 1, Health Care*. In particular, CBO considered the following reforms:

- ***Integrated (and increased) cost sharing.*** This cost sharing would replace the variable and uncapped out-of-pocket payments under Parts A and B with an integrated structure that applies to all (combined) Part A and Part B costs, consisting of a \$525 deductible, a 20 percent coinsurance rate above the deductible, and a \$5,250 out-of-pocket maximum. CBO estimates that such a reform would save the Medicare program \$32 billion over a decade.
- ***Restricted Medigap coverage.*** To reduce the Medicare externality, the government could restrict the ability of Medigap plans to cover cost sharing. The particular option considered by CBO is a restriction that Medigap could not cover the first \$525 of cost sharing, and could only cover 50 percent of the next \$4,275. CBO estimates that this reform would save Medicare \$53 billion over a decade.

- **Combined cost sharing and Medigap reforms.** Were Medicare to combine the two previous reforms, CBO estimates that it would save Medicare \$95 billion over a decade (which is larger than the programs by themselves due to interaction effects between them).

These are innovative concepts that have permeated policy debates over reforming Medicare. But the proposals also have limitations that have made many wary of endorsing them. In particular, there are legitimate concerns about affordability of revised cost sharing among elders. Many elders live on low incomes, with 17 percent living below the poverty line and almost half living below twice the poverty line. Elders up to the federal poverty line have their cost sharing fully covered by the Medicaid and QMB programs, although participation in these programs is less than full: many elders do not take advantage of that coverage. At the same time, an elder at twice the poverty line enjoys no protection. That is, under the first CBO plan, an elder with an income of about \$22,000 could face an out-of-pocket cost of \$5,250, or more than 25 percent of his or her income. This is an unreasonable burden to impose.

In addition, the proposed regulation on supplemental plans is very stringent and does not allow the plans to reflect diversity of elders' tastes for supplemental coverage. In particular, some elders may prefer first dollar Medigap coverage as a paperwork reduction device or simply as a way to avoid having to worry about liquidity at the time of service. At the same time, allowing supplemental plans to cover 50 percent of out-of-pocket costs after \$525 still imposes a very large fiscal externality on Medicare. Moreover, this restriction is inequitable because it does not apply to employer-sponsored retiree insurance, a major source of retiree coverage.

The Proposal

A few revisions to the CBO options could provide many of its benefits (and much of its cost savings) while providing protection to low-income elders that is much more valuable.

REVISION #1: PROGRESSIVE OUT-OF-POCKET MAXIMUM

Medicare would introduce an *income-related out-of-pocket maximum*. Rather than a flat amount of \$5,250, the out-of-pocket maximum could be related to income in the same way that the ACA relates to income, with a schedule that sets the maximum as a share of the Health Savings Account (HSA) out-of-pocket payment limit:

- 100%–200% of poverty: one-third of HSA limit (\$1,983)
- 200%–300% of poverty: one-half of HSA limit (\$2,975)

- 300%–400% of poverty: two-thirds of HSA limit (\$3,987)
- 400% of poverty and over: HSA limit (\$5,950)

In addition, to minimize the burden on the lowest-income elders, the deductible would be reduced to \$250 below 200 percent of poverty.²

There are two disadvantages of this plan. The first is administrative: computing the out-of-pocket protections would require knowing elders' incomes. This would require coordination between Medicare and the IRS, akin to the coordination that is being used to implement the ACA. The IRS would alert Medicare as to elders' incomes, and Medicare would set a cost-sharing limit based on those values. This cost-sharing limit would be communicated to elders and would be applied by Medicare at the point of service. While income information is available from the IRS only with a lag, elders typically live on fixed incomes that make changes in income less of a concern; that said, there would be a mechanism, as in the ACA, to allow elders to apply for lower out-of-pocket limits as their income falls. For the lowest-income elders that do not file taxes, there would have to be an alternative mechanism to allow elders to report their incomes to Medicare.

A related issue is that for those with supplemental coverage, the insurance companies would need to know their income in order to integrate their payments with Medicare's. Even though the IRS would simply release information on the family's income category, this raises potential privacy concerns. To resolve these concerns, all elders would be allowed at the start of the year to deny insurers' access to this information, in which case insurers would default to the highest out-of-pocket limit.

The second disadvantage of this plan, however, is that by itself it is unlikely to produce any budget savings. The lower out-of-pocket maximums on low-income elders will likely offset any revenue gains from this approach. A recent study by the Kaiser Family Foundation found that lowering the out-of-pocket limit in the CBO plan to \$4,000 across the board reduced rather than increased revenue (Kaiser Family Foundation 2011).

REVISION #2: TREATMENT OF SUPPLEMENTAL INSURANCE

The rationalization of cost sharing under Medicare mitigates the need for supplemental insurance, but elders have diverse tastes for supplemental coverage and might not want just one restricted option. Instead, I propose a tax on supplemental coverage to offset the fiscal externality to the Medicare program. This tax would apply in different ways to different forms of supplemental coverage. The exact level of this tax would be subject to political negotiations, but the enormous

externalities documented above suggest that a tax rate of up to 45 percent would be justified. While such a tax rate seems high, consumers then would face the overall cost of supplemental insurance, including the cost to Medicare, when making decisions about how much coverage to purchase.

- There would be an excise tax of up to 45 percent on Medigap plan premiums.
- Employer-sponsored retiree coverage for those over age sixty-five (but not for early retirees) would be taxed at the same rate as well.³
- Finally, Medicare Advantage plans are unique in that they pay the full costs of patient care, so that they will effectively “internalize” this externality. However, the amount that Medicare Advantage plans are paid is tied to traditional Medicare costs, which includes this externality. As this externality is resolved for traditional Medicare, it will lower program costs and thereby reimbursement to Medicare Advantage plans in a manner that will cause them to rationalize their own cost-sharing structures.

IMPLICATIONS

The budgetary implications of this proposal are difficult to infer. A recent Medicare Payment Advisory Commission (MedPAC) proposal (MedPAC 2012) that is similar to the CBO approach, but that includes a 20 percent tax on Medigap plans rather than a ban on first dollar coverage, was estimated to reduce net (of Medigap tax revenues) Medicare spending by 0.5 percent to 4 percent, depending on the responsiveness of supplemental coverage. Relative to that score, the present proposal would save less because of the progressive cost-sharing structure, but would ultimately save much more because of the (presumably) higher rate and the application to employer retiree coverage as well as to Medigap. A net savings

of 2.5 percent of Medicare spending, or roughly \$12.5 billion per year, seems a reasonable guess based on this other work. But this estimate obviously depends critically on the tax rate for supplemental insurance and other plan details.

While the effects of this overall proposal for government budgets are likely to be quite positive, the impact on elders will be mixed. Elders will receive real protection against financial risk in a way that corresponds to their ability to bear such risk. And since supplemental coverage will no longer be necessary to provide financial protection, elders will save billions of dollars in spending on Medigap policies that are highly inefficient. Of course, the implications depend on the extent to which elders drop their supplemental coverage in the face of this tax versus retaining the coverage at much higher prices.

Conclusion

The Medicare program is the single largest spending-side contributor to our long-term budget shortfall, and as such is destined to receive an outsized share of attention in debates over reducing the deficit. To date, these debates have focused on the supply side, with proposals that either cut provider payments outright, or introduce alternative payment methodologies that might be able to deliver lower costs without sacrificing quality of care.

But the demand side of Medicare should not be ignored. This is a program with a broken and ineffective set of demand-side incentives that are masked by overpurchase of supplemental insurance coverage by elders. By rationalizing cost sharing and making supplemental insurance purchasers face the fiscal externality they are placing on Medicare, we can both reduce deficits and provide more-effective protection for elders against the costs of their medical care.

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Jonathan Gruber is a Professor of Economics at the Massachusetts Institute of Technology (MIT), where he has taught since 1992. He is an Associate Editor of both the *Journal of Public Economics* and the *Journal of Health Economics*. In 2009, he was elected to the Executive Committee of the American Economic Association. Gruber received his B.S. in Economics from MIT, and his Ph.D. in Economics from Harvard University. Gruber's research focuses on the areas of public finance and health economics. He has published more than 140 research articles, has edited six research volumes, and is the author of *Public Finance and Public Policy*, a leading undergraduate text, and *Health Care Reform*, a graphic novel. During the 1997–1998 academic year, Gruber was on leave as Deputy Assistant Secretary for Economic Policy at the Treasury Department. From 2003 to 2006, he was a key architect of Massachusetts' ambitious health reform effort. During the 2008 election, he was a consultant to the Clinton, Edwards, and Obama presidential campaigns. During 2009–2010, he served as a technical consultant to the Obama Administration and worked with both the Administration and Congress to help craft the Patient Protection and Affordable Care Act.

Endnotes

1. Chandra, Gruber, and McKnight (2010) studied a population of retired public employees receiving supplemental insurance coverage from the CalPERS program. There was a staggered rise in patient copayments for office visits and prescription drugs under CalPERS, allowing for a quasi-experimental analysis of the impact of changing supplemental coverage on Medicare spending. To summarize the calculations, in that paper we find that an average copayment increase of \$16.50 per month led to a reduction in Medicare spending of \$5.00 per month on physicians and hospitals (the latter actually saw an increase due to offset effects), for an externality effect of 0.3. A new working paper by Cabral and Mahoney (2013) uses cross-state variation in the price of Medigap coverage as a shifter for supplemental coverage; individuals living near borders of states with higher Medigap prices than their neighbors have lower Medigap coverage. This lower Medigap coverage is in turn associated with a reduction in Medicare spending; they estimate that Medigap coverage raises Medicare spending by \$640, which is about 45% of Medigap premiums.
2. The 20 percent coinsurance would be revisited based on standard “value-based” benchmarks to ensure that it is not raising total costs (e.g., by excluding the coinsurance for maintenance prescriptions for those with chronic illnesses).
3. This provision will be criticized by those who claim that retired workers have “paid for” their retiree coverage through lower wages during their working life. While the incidence of retiree benefits is unclear, even in this case the provision is not unfair because retired workers have paid for the base cost of these plans through their wages but not the fiscal externality portion, which they would pay now if they maintain coverage.

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