



Medicare Out-of-Pocket Health Cost Limits

The Unfinished Business of Protecting Medicare Beneficiaries from Catastrophic Health Care Costs

Executive Summary

One of the landmark achievements of the Patient Protection and Affordable Care Act of 2010 is that it prohibits insurance plans from imposing any annual or lifetime limits on the dollar value of covered benefits. The legislation also caps the amount individuals and families must pay out of their own pocket each year, setting an out-of-pocket limit that varies by income, but in no case is higher than the current law limit for Health Savings Accounts (\$5,950 for individuals and \$11,900 for families in 2010). These protections apply to almost all plans by 2014.

Unfortunately, the protection against ruinous health costs that Congress will guarantee as a right to nearly all Americans under the age of 65, Congress denies categorically to those who are most vulnerable: senior citizens. Unlike employer-sponsored insurance for employees – or plans sold to individuals through the American Health Benefit Exchanges – Medicare alone will have no limit on out-of-pocket spending. Seniors, especially older retirees, are very vulnerable to sudden, serious and costly medical incidents. While younger Americans will be protected from medical bankruptcy, the share of senior citizens forced to forgo needed care, forced into bankruptcy, or forced onto the demeaning dole of Medicaid will continue to rise steadily in coming years. Ironically, the only other group denied this protection comprise *early retirees* who happen to be covered by their former employers in “retiree-only” plans.

Out-of-pocket health spending by Medicare beneficiaries is twice as high on average as for adults under 65, while their household income is typically far lower, fixed and steadily eroded by inflation. Median out-of-pocket spending as a percentage of income for all Medicare enrollees rose by more than a third in less than a decade, from 12% in 1997 to more than 16% in 2005. Among the largest category – those living on income between 100 and 200 percent of the Federal Poverty Line – out-of-pocket health costs rose steeply to an average 22.4% in 2005. For Medicare beneficiaries with costs in the top quartile, health care eats up more than one-third of total household expenditures.

The rapid rise of healthcare costs over the past decade, combined with employer cost shifting of defined health care benefit costs in the form of higher premium sharing, higher deductible and copayment allocations, and the reduction or elimination of scheduled benefits to retirees has resulted in a rapid erosion of middle class purchasing power among retirees and retiree-eligible active employees. The older adults impacted by this trend include current retirees over age 55, baby boomers about to enter the Medicare system and future generations of retirees. The

unexpected reduction in the fixed retirement income of the former engineers, managers and other salaried employees who make up 80% of the retired salaried universe has been 10-to-20%. It is ironic that Congress saw fit to label this set of retirees as members of “retiree-only plans” and excluded them from consideration for major protections included in the 2010 Affordable Care Act. This group of retirees experience higher rates of home foreclosures, personal bankruptcies and the destruction of the retirement dream they sacrificed to achieve.

During Medicare’s first two decades, the program’s relatively high cost-sharing requirements and unlimited out-of-pocket spending was less of a problem, since the vast majority of retirees had supplemental coverage. However, the situation has changed radically as companies continue to drop retiree health coverage. Surveys show that the share of large firms (200 or more employees) that offer *any* retiree health coverage has dropped dramatically over the past two decades – from 66% in 1988, to 40% in 1999, to below 28% in 2010. The share of large firms offering supplemental coverage to Medicare-age retirees has fallen even faster, to 21% in 2010. Another sharp drop off in coverage for retirees 65 and older occurred immediately after the EEOC’s 2007 ruling that allowed companies to cancel supplemental coverage for retirees 65 and older, while maintaining coverage for early retirees. Indeed, few employers are expected to pay for, or even administer, supplemental health plans in the future, particularly for new retirees. There has also been a steady cost-shifting to retirees. A majority of firms have capped their contribution; and about 20 percent of firms already require retirees to pay the entire premium.

An examination of this situation reveals that while companies went through tough times recently, many of these companies are now very profitable and are piling up cash reserves in 2010 yet, although they continue to rail about health care costs, they continue to shift incremental health care costs to employees and retirees. Their health care costs are actually declining. Indeed U.S. corporations will significantly benefit from health care reform but their Medicare eligible retirees will permanently lose most of their earned health care benefits, including supplemental and catastrophic (out-of-pocket) coverage they earned. The loss of catastrophic health care coverage is itself catastrophic and continues to drive up the incidence of personal bankruptcies.

Congress should extend protection against catastrophic medical costs to the Medicare population before employer-sponsored coverage drops substantially below its current 20% level. Roughly one in six Medicare enrollees purchases individual medigap policies, which provide some protection. But these supplemental plans have limits as well and are far more expensive than necessary (owing to high non-group marketing, administration and Medicare coordination costs). Another 7 million rely on Medicaid to pay most of their out-of-pocket costs under Medicare. These so-called “dual eligibles” qualify on a means-tested basis because they have low incomes and depleted assets. Medicaid is financing a steadily-rising share of the out-of-pocket costs of the Medicare population, squeezing state budgets. Currently “dual eligibles” consume 35% of all Medicaid expenditures, not just for long-term nursing care, but to cover Medicare deductibles, coinsurance and premiums that exceed beneficiaries ability to pay out-of-pocket.

Another 11% of Medicare beneficiaries had no supplemental coverage at all in 2006. Studies show that seniors without any supplemental coverage are 2.5 times more likely to delay needed care because of cost, or to report skipping doses of needed medication, endangering their own health and eventually imposing larger costs on Medicaid or charitable providers.

There are credible policy options available that would provide protection against catastrophic costs and encourage health cost containment without increasing the budget deficit. For example, the Congressional Budget Office, in its December 2008 report on health care budget options, reported that replacing the divergent Part A and B deductibles with a single, combined deductible and a uniform coinsurance rate could finance a \$5,250 cap on annual out-of-pocket spending. CBO assumed a combined \$525 deductible, resulting in overall budget savings of \$26 billion over 10 years, suggesting that the cost of catastrophic protection could be spread across the Medicare population – and without any premium increase – on a budget-neutral basis.

A better, more comprehensive approach would be to add a new Medicare ‘Part E’ as a voluntary but very low-cost supplemental coverage option that puts a combined cap on all Part A, B and D expenses. This “Medicare Extra” option was proposed in a 2005 *Health Affairs* article by Karen Davis of the Commonwealth Fund and Marilyn Moon of the American Institutes for Research. They proposed a public medigap option with an overall out-of-pocket limit of \$3,000 on doctor, hospital and drug costs for a monthly premium of just under \$100. The incremental cost would be 40% below the typical premium for non-group medigap policies and be revenue-neutral from a budgetary perspective. It also offers employers a more affordable and predictable option to provide basic supplemental retiree coverage.

Now that national health reform legislation has established the principle that no American should be forced into bankruptcy or onto the public dole to pay catastrophic medical bills, Congress should ensure that this protection is extended equitably to the 65-and-older population as well. The NRLN recommends the adoption of a voluntary and self-financing Medicare ‘Part E’ that offers all Medicare beneficiaries an option to purchase protection against catastrophic out-of-pocket health care costs without adding cost or expense to Medicare.



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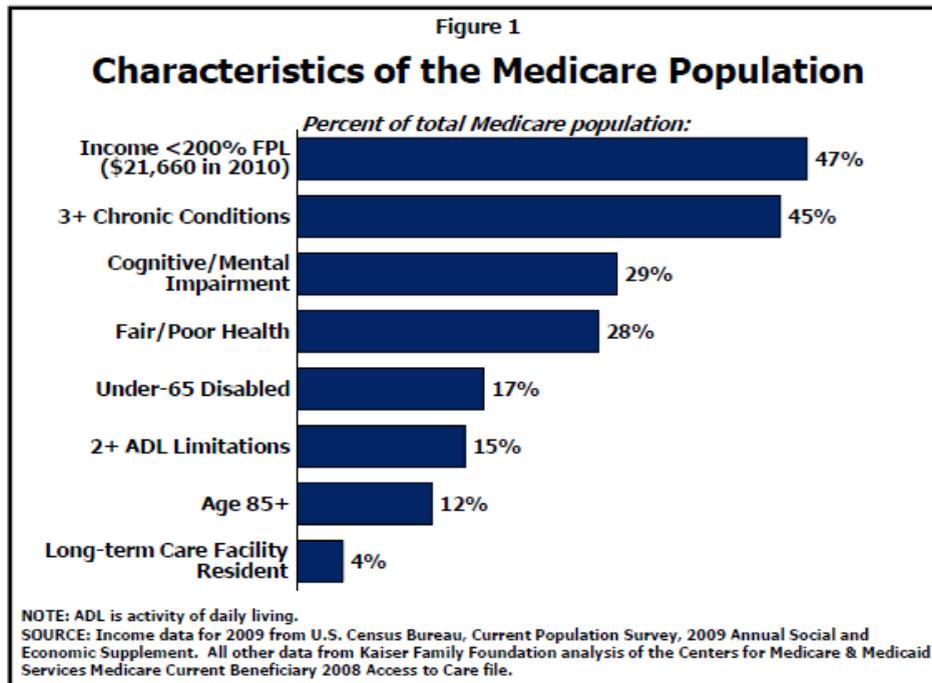
I. Introduction and Background

Although the Patient Protection and Affordable Care Act of 2010 remains controversial, perhaps the most popular and promising provisions were the insurance market reforms that protect most Americans from being denied insurance coverage due to pre-existing medical conditions, or from plans imposing annual or lifetime limits on the dollar value of covered benefits. Critically, the legislation also protects family financial security by capping the amount individuals and families must pay out of their own pocket each year, setting an out-of-pocket limit that varies by income, but in no case is higher than the current law limit for Health Savings Accounts (\$5,950 for individuals and \$11,900 for families in 2010). These protections apply to almost all plans by 2014.

Unfortunately, the protection against ruinous health costs that Congress has guaranteed to nearly all Americans under the age of 65, Congress denies categorically to those who are most vulnerable: Senior Citizens. Unlike employer-sponsored insurance for employees – or plans sold to individuals through the American Health Benefit Exchanges – Medicare beneficiaries alone will have no limit on out-of-pocket spending. Medicare covers basic care, including care in hospitals, physician services, diagnostic tests, preventive services and, under Part D, a substantial portion of outpatient prescription drug costs. However, Medicare does not have an annual cap on out-of-pocket spending for deductibles and co-payments; nor does it cover long-term care, nor dental, vision or hearing services, nor the full cost of prescription drugs.

Seniors, especially older retirees, are very vulnerable to sudden, serious and costly medical incidents. While younger Americans will be protected from medical bankruptcy, the share of senior citizens forced to forgo needed care, forced into bankruptcy, or forced onto the demeaning dole of Medicaid will continue to rise steadily in coming years.

Ironically, the only other group denied this protection comprise *early retirees* who happen to be covered by their former employers in “retiree-only” plans. As the *Wall Street Journal* reported in October 2010: “Thanks to a little-noticed clause in a 1996 law, retiree-only health plans are exempt from the Patient Protection and Affordable Care Act that went into effect last month.”¹ Although President Obama and many Democrats claimed that “all Americans” would be eligible for the Act’s protections from abusive practices and financial ruin, retirees – including early retirees under age 65 who are not eligible for Medicare – were excluded from protection through an obscure, pre-existing ERISA exemption for “retiree-only” plans that received no public notice until after the law was passed. “A retiree health plan is one that provides coverage until age 65, after which it either phases out or acts as a supplement to Medicare,” the *Journal* article reported. “While the health-care overhaul doesn’t cover retiree-only plans, it does cover retirees with individual policies, as well as health plans that include both employees and retirees.” While the NRLN advocates a repeal of the exclusion of early retirees from the insurance market reforms in the PPACA, the Act’s limit on ruinous and unpredictable out-of-pocket payments should be extended to Medicare-eligible retirees as well.



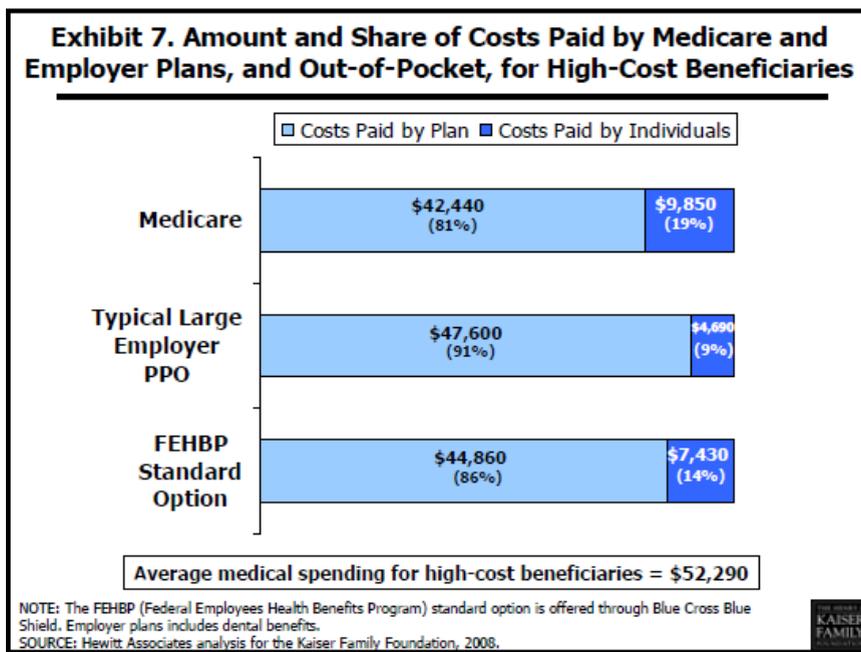
Out-of-pocket health spending by Medicare beneficiaries is twice as high on average as for adults under 65, while their household income is typically far lower, fixed and steadily eroded by inflation. During Medicare’s first two decades, the program’s relatively high cost-sharing requirements and unlimited out-of-pocket spending was less of a problem, since the vast majority of retirees had supplemental coverage. However, the situation has changed radically as companies continue to drop retiree health coverage. Surveys show that the share of large firms offering supplemental coverage to Medicare-age retirees has fallen from roughly two-thirds (66%) in 1988 to 21% in 2010.²

Congress should extend protection against catastrophic medical costs to the Medicare population before employer-sponsored coverage drops substantially below its current 20% level. Roughly one in four Medicare enrollees purchases individual policies, which provide some protection. But these supplemental plans have limits as well and are far more expensive than necessary (owing to high non-group marketing, administration and Medicare coordination costs). Even before the Affordable Care Act put limits on annual out-of-pocket spending, the benefit value of Medicare coverage was roughly 15% below the value of both the typical private sector employer-provided plan and coverage that federal employees receive under the Federal Health Benefit Plan (FEHBP) standard option.³ Medicare is less generous in ways that directly make the out-of-pocket costs of senior citizens higher and less predictable than they are for most adults under age 65. Medicare has higher cost-sharing for inpatient care under Part A (a \$1,132 deductible in for short hospital stays in 2011), no out-of-pocket spending limit on services provided under Parts A and B, and less generous coverage under the standard Part D benefit for prescription drugs.⁴ In addition, while nearly all large employer-provided plans provide at least a partial benefit for dental and vision costs, these costs are out-of-pocket under Medicare.

According to a study by Hewitt Associates for the Kaiser Family Foundation, even with the new Part D drug benefit, Medicare’s overall benefit value is 87% of the benefit value of a typical large employer PPO, on average, and 90% of the standard FEHBP option.⁵ As the Exhibit just below indicates, the average out-of-pocket liability for a high-cost Medicare beneficiary (\$9,850) is more than double \$4,700 cost imposed under a typical large employer plan – and also about 60% higher than the annual cap imposed by the Affordable Care Act for most Americans under age 65.

According to the Hewitt/Kaiser study:

If employer plans were arrayed based on their benefit value, Medicare would be among plans in the bottom decile. . . . As a result, the average individual covered under Medicare pays a larger share of total costs (26%) than the average individual covered under the typical large employer PPO (15%) or the FEHBP standard option (17%).⁶



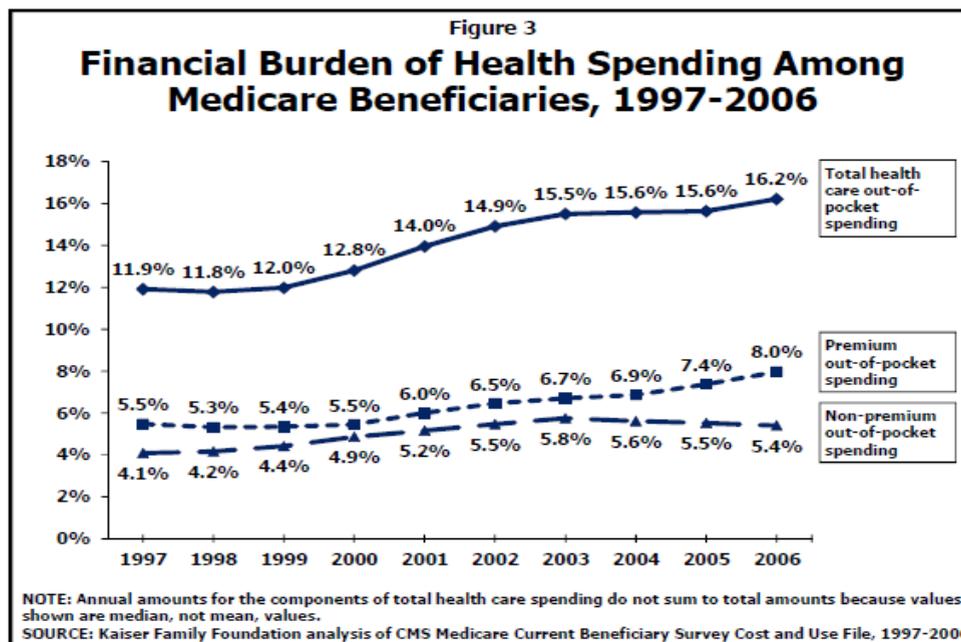
Although Medicare by itself does not provide either adequate health care coverage or protection from catastrophic costs, more than 11% of Medicare beneficiaries had no supplemental coverage at all in 2006. Studies show that seniors without any supplemental coverage are 2.5 times more likely to delay needed care because of cost, or to report skipping doses of needed medication, endangering their own health and eventually imposing larger costs on Medicaid or charitable providers. Another 7 million rely on Medicaid to pay most of their out-of-pocket costs under Medicare, squeezing state budgets. Currently these “dual eligibles” consume 35% of all Medicaid expenditures, not just for long-term nursing care, but to cover Medicare deductibles, coinsurance and premiums that exceed a beneficiary's ability to pay out-of-pocket.

Policy options are available to provide America’s senior citizens with protection against catastrophic health care costs and to encourage health cost containment without increasing the budget deficit. The Congressional Budget Office has reported that replacing the divergent Part A

and B deductibles with a single, combined deductible and a uniform coinsurance rate could finance a \$5,250 cap on annual out-of-pocket spending – and without any premium increase – on a budget-neutral basis. A better, more comprehensive approach would be to add a Medicare ‘Part E’ as a voluntary but very low-cost supplemental coverage option that puts a combined cap on all Part A, B and D expenses. These options are described further in the final section below.

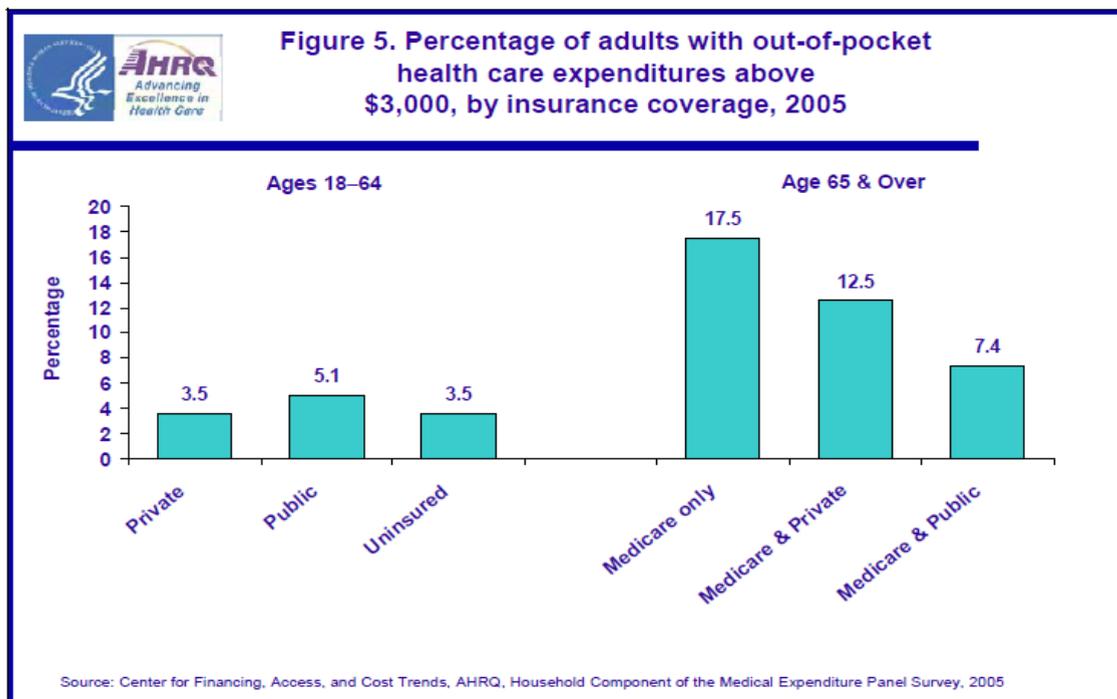
II. Medicare Beneficiaries Face the Greatest Risk of Catastrophic Medical Costs

Although the vast majority of senior citizens live on modest and fixed incomes, under Medicare their annual out-of-pocket health care costs are both rapidly rising and unpredictable. **Median out-of-pocket spending by Medicare beneficiaries increased by one-third** as a share of income between 1997 and 2005, from 11.9% to 16.1% of personal income on average (see Figure 3 below).⁷ In 2005, nearly one in five seniors who rely on Medicare alone – and lack supplemental coverage – had out-of-pocket health care expenditures greater than \$3,000.⁸ This out-of-pocket spending burden was far higher than for adults below age 65. Among adults age 18–44, only 6% had out of pocket expenses greater than \$1,500 in 2005. In contrast, nearly one-third of persons age 65 and over had out-of-pocket expenses greater than \$1,500 and 13.1 percent had expenses that exceeded \$3,000.⁹



Catastrophic medical costs can be financially devastating at any age, but the oldest and sickest among Medicare beneficiaries are most vulnerable. The lack of a cap on out-of-pocket spending is doubly punishing for the oldest retirees, who have both lower incomes and much higher out-of-pocket medical costs on average. Average out-of-pocket costs for seniors increase as health status declines and also increase sharply with age. Medicare beneficiaries age 85 and older spend far more out-of-pocket (an average \$7,000 in 2005) than those age 75 to 84 (\$4,450 in 2005), who in turn are spending far more than ‘younger’ retirees age 65 to 74 (\$3,380 in 2005). Average out-of-

pocket spending for women is about 15% higher than for men (\$4,280 versus \$3,770 in 2005), due in large part to longer life expectancies and the fact that under Medicare out-of-pocket costs climb steadily with age.¹⁰



Among Medicare beneficiaries, while out-of-pocket spending has risen substantially for every income group, those with modest incomes have been hit particularly hard. For those seniors living on incomes between 100 and 200% of the federal poverty level (below \$20,000 for an individual and roughly \$26,000 for a couple), median out-of-pocket health spending exceeded 22% of income in 2005 – a 30% increase over 1997. Retirees with incomes between 200 and 400% of poverty had out-of-pocket costs equal to 15% of income – a 40% increase over 1997.¹¹

According to a report released on November 30, 2010 by the Employee Benefit Research Institute men retiring in 2010 at age 65 will need anywhere from \$65,000 – \$109,000 in savings to cover health insurance premiums and out-of-pocket expenses in retirement if they want a 50% chance of being able to have enough money; to improve the odds to 90%, they'll need between \$124,000 – \$211,000. Women retiring this year at 65 will need even more: between \$88,000 – 146,000 in savings if they are comfortable with a 50% chance of having enough money, and \$143,000– \$242,000 if they want a 90% chance. These estimates are for Medicare beneficiaries age 65 and older: Anyone retiring early, before age 65, would need even more savings.

While seniors live in fear of unlimited out-of-pocket liabilities under Medicare, adults younger than age 65 will be protected under the new Affordable Care Act. The new legislation caps the amount individuals and families must pay out of their own pocket each year, setting an out-of-pocket limit that varies by income, but in no case is higher than the current law limit for Health Savings Accounts (\$5,950 for individuals and \$11,900 for families in 2010). These protections

apply to almost all plans by 2014, but exclude both Medicare beneficiaries and even pre-Medicare retirees covered under employer-sponsored “retiree-only” plans.

Bankruptcy Rates Rising Rapidly Among Senior Citizens

Unlimited liability for out-of-pocket medical costs has a particularly devastating impact on senior citizens living on fixed incomes – and with little ability to recover financially if their savings are wiped out. The 2007 Consumer Bankruptcy Project study of personal bankruptcies over a 16-year period found that people 65 and older were more than twice as likely to file and that the filing rate among those 75 and older had more than quadrupled. The bankruptcy population is aging far more rapidly than the population in general. “The story from these data is one of rising financial risk with age,” observed Elizabeth Warren, a Harvard Law professor who led the study and more recently chaired the Congressional Oversight Panel to investigate the TARP bank bailouts. “The average age for filing bankruptcy has increased, and the rate of bankruptcy filings among those ages sixty-five and older has more than doubled since 1991.”¹²

The impact of bankruptcy is also far more severe for older people, who find themselves with few assets, unmanageable debts and few options (if any) to reenter the workforce. Warren noted that her study reinforced previous studies showing that a rising share of bankruptcies among senior citizens are related to medical problems and their catastrophic costs.¹³

Adverse Health Consequences

At least 11% of Medicare beneficiaries had no supplemental coverage at all in 2006. Studies show that seniors without any supplemental coverage are 2.5 times more likely to delay needed care because of cost, or to report skipping doses of needed medication, endangering their own health and eventually imposing larger costs on Medicaid or charitable providers.¹⁴ Putting a limiting on annual out-of-pocket spending – and making the maximum cost each year more predictable – would lower barriers to essential care and also reduce the number of Medicare beneficiaries who become bankrupt and fall back on other more costly public assistance, particularly Medicaid.

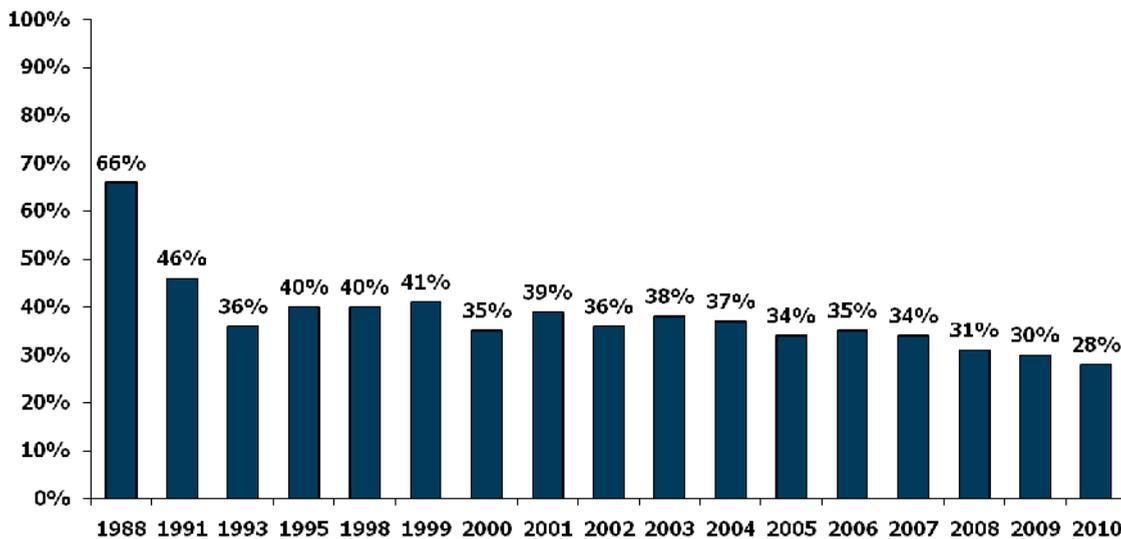
III. Fewer and Fewer Seniors Have Adequate Supplemental Coverage

During the initial decades after Medicare’s enactment in 1965, the program’s relatively high cost-sharing requirements and unlimited out-of-pocket spending presented a less widespread problem because the vast majority of retirees had supplemental coverage through their former employer. Medicare’s gaps in coverage and high out-of-pocket costs make a supplemental “medigap” plan essential for retirement security. However, the share of large firms (200 or more employees) that offer any retiree health coverage has dropped dramatically over the past two decades – from 66% in 1988, to 40% in 1999, to 28% in 2010, according to the Kaiser Family Foundation’s annual survey (see chart below).¹⁵

Unfortunately, even the overall 28% coverage rate reported by the Kaiser survey considerably overstates the degree to which private sector employers continue to provide supplemental coverage for Medicare-eligible retirees in three respects: First, the Kaiser survey is limited to large employers (200 or more employees) that offer health benefits to their active employees. Among firms with fewer than 200 employees, only 4% offer retiree health coverage.¹⁶

Second, the Kaiser survey also found that only 75% of large employers offering retiree health benefits offer them to Medicare-age retirees. This means that among large employers that offer health benefits to active workers, only 21% report offering Medicare supplemental coverage to their retirees 65 and older. And while nearly all large firms that offer retiree benefits to early retirees, the share maintaining supplemental coverage for Medicare-age retirees has tumbled from 81% to 68% since 2003. Most of that decline came immediately after the EEOC's 2007 ruling that it is not age discriminatory for companies to cancel coverage for Medicare-eligible retirees 65 and older, while maintaining coverage for younger retirees.

Among All Large Firms (200 or More Workers) Offering Health Benefits to Active Workers, Percentage of Firms Offering Any Retiree Health Benefits, 1988-2010



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2010; KPMG Survey of Employer-Sponsored Health Benefits, 1991, 1993, 1995, 1998; Health Insurance Association of America (HIAA), 1988.

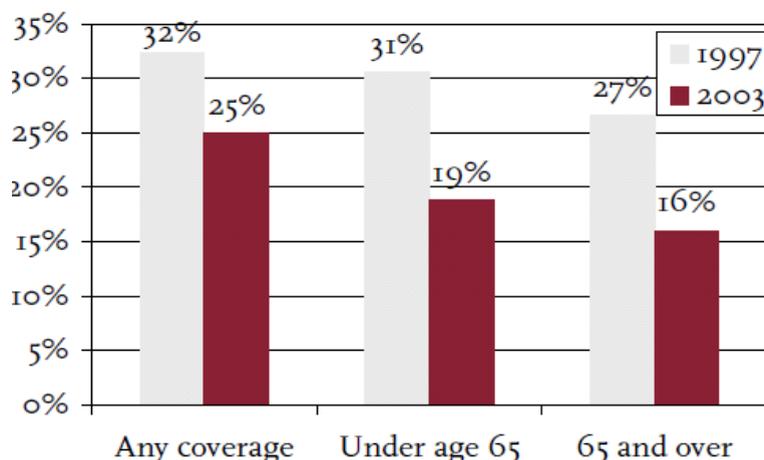
Finally, the Kaiser survey includes both public and private sector employers. However, state and local governments are far more likely to offer retiree health coverage (87% in Kaiser's survey) than even large private sector firms. As the chart just below suggests, the share of large private sector firms still providing supplemental coverage for their Medicare-eligible retirees fell to 16% by 2003 and is probably closer to 12% today based on the overall decline in firms offering *any* retiree health coverage.

The unfortunate reality is that fewer and fewer private sector employers are expected to pay for, or even to administer, supplemental health coverage to new retirees in the future. Among firms

continuing to provide coverage, there is a steady cost-shifting to retirees. About 20% of firms still offering coverage require retirees to pay the entire premium.¹⁷ Moreover, a majority of companies have now capped their contribution to the cost of premiums that continue to rise far faster than the general inflation rate.

For older retirees on fixed incomes, the unexpected cost is increasingly unaffordable. A typical example among NRLN association members is John Devitto, who worked for 39 years at Lucent Technologies (and its predecessor companies) and retired just shy of age 60 with a promise of a fixed monthly pension and full health benefits for himself and his family. Ten years later, at age 70 and unable to return to regular employment, Lucent was requiring Devitto to contribute \$700 per month from his pension income for health insurance co-premiums – and another \$200 per month to replace his life insurance policy and death benefit that Lucent eliminated.

PERCENT OF PRIVATE SECTOR WORKERS AT FIRMS OFFERING RETIREE HEALTH BENEFITS BY COVERED AGE GROUP: 1997 & 2003



Source: Center for Retirement Research (2007)¹⁸

This cost-shifting of health costs to retirees was accompanied by a near elimination of the annual Cost of Living Adjustments (COLAs) designed to prevent the steady erosion of the purchasing power of defined-benefit pension payments due to inflation. Data collected by the NRLN shows that the erosion of purchasing power caused by the diversion of retiree pension income to pay for rising health care premiums, deductibles and co-pays has reduced the typical retiree’s disposable pension income by 15-to-20% over the past decade alone.¹⁹

Relief for Businesses and Individual Retirees

Adding catastrophic cost protection to Medicare would not only protect individuals, it would in many cases lower the cost of supplemental coverage to employers, making it less likely that the companies still covering their older retirees will cancel their plans entirely. When Congress added the Early Retiree Reinsurance Program to the Affordable Care Act, it recognized that employers shouldering legacy costs for retiree health coverage would be far more likely to maintain their

plans – and avoid more people falling back on Medicaid and other public assistance – if the federal government provided assistance with catastrophic claims. The Early Retiree Reinsurance Fund reimburses employers for 80% of the cost of catastrophic claims between \$15,000 and \$90,000, thereby lowering the overall cost (and risk) of maintaining coverage for pre-Medicare retirees.²⁰ Similarly, if Medicare beneficiaries – like all other Americans – have the back-stop of a limit on out-of-pocket expenses each year, maintaining high-quality supplemental coverage for older retirees will be less burdensome for employers as well.

Only 1 in 6 Seniors Purchase Supplemental Coverage Directly

As fewer and fewer retirees are offered supplemental coverage by their employers, limits on out-of-pocket Medicare costs become increasingly important since most individual retirees find medigap coverage to be unavailable (due to pre-existing conditions) or unaffordable. Only one in six Medicare enrollees (17%) purchase individual policies, which provide some protection but not against catastrophic loss.²¹ They typically cover just the 20% coinsurance and co-pay and deductibles not covered under Medicare plan benefit schedules. Since catastrophic coverage is not a Medicare benefit, these supplemental plans also have limits on benefits paid and have considerably higher out-of-pocket costs on average than employer coverage.²² Compared to group plans provided by employers, the premiums charged for individual medigap also are more expensive on average due to high non-group marketing, administration and Medicare coordination costs.

Another 11% of Medicare beneficiaries have no supplemental coverage at all. The government's Medical Expenditures Panel Survey shows that as of 2005, the share of seniors with out-of-pocket costs greater than \$3,000 in 2005 was 40% higher among seniors relying on Medicare alone.²³ The share of Medicare beneficiaries without supplemental coverage is also substantially higher among African-Americans and Hispanics, as well as among seniors living in rural areas.²⁴ Since a disproportionate share of the more than 7 million seniors with no supplemental coverage are living on low and fixed incomes, most of them are one serious medical incident away from financial hardship and quite possibly joining the far larger number of Medicare beneficiaries who fall back on Medicaid to pay for catastrophic costs and/or coverage gaps in Medicare.

'Dual Eligibles' Increasingly Burden Medicaid Budgets without Catastrophic Coverage

More than 7 million Medicare beneficiaries rely on Medicaid to pay most of their out-of-pocket medical costs. These so-called “dual eligibles” qualify on a means-tested basis because they have low incomes and depleted assets. While the majority of “dual eligibles” were already poor when they became eligible for Medicare, many were middle-class retirees who were forced onto the Medicaid rolls because of their unlimited liability for out-of-pocket costs under Medicare. Since a majority of seniors are living on annual incomes less than 200% of the federal poverty line, one catastrophic health incident – or even the steady drain of multiple chronic conditions – can rapidly deplete assets and leave them in need of public assistance from another source.

Medicaid is financing a steadily-rising share of the out-of-pocket costs of the Medicare population, squeezing state budgets. Currently “dual eligibles” consume nearly half of all Medicaid expenditures, not just for long-term nursing care, but to cover Medicare deductibles, Part B premiums (\$96.40 per month for 2011) and cost-sharing (for example, the \$1,132 deductible on inpatient hospitalizations for 2011) that exceed beneficiaries ability to pay out-of-pocket.²⁵ Medicaid also covers gaps in Medicare’s coverage that beneficiaries need to pay for out-of-pocket, or with supplemental coverage, including inpatient psychiatric treatment or therapy, vision, dental, case management and medical transportation services. The combined cost of Medicare and Medicaid spending on “dual eligibles” totaled nearly \$200 billion in 2005 – more than five times the per-person average for Medicare – and is far higher today.²⁶

Adding a limit on out-of-pocket costs to Medicare will not solve the problem of rapidly rising Medicaid costs for the over-65 population, but it will take some pressure off state budgets in particular by reducing the number of seniors who end up on Medicaid because of a catastrophic health incident or the ongoing costs of multiple chronic conditions. The cost of long-term care for “dual eligibles” with Alzheimer's and other mental impairments represent roughly 60% of Medicaid spending on “dual eligibles” – and 27% of total Medicaid spending – an increasing burden on state budget that will only grow as the nation’s population ages.²⁷ However, another very substantial portion of Medicaid spending on “dual eligibles” goes to cover acute care and prescription drug costs that could instead be spread at least in part over the Medicare population under one of the budget-neutral approaches described in the next section.

IV. Medicare Catastrophic Coverage Can Be Self-Financing and Budget-Neutral

Current economic conditions and record federal budget deficits make the adoption of any costly new spending program unlikely, however well justified, and particularly if it does not have a “pay-for” that makes it revenue neutral. Fortunately, there are credible policy options available that would provide protection against catastrophic costs and encourage health cost containment *without increasing the budget deficit*. One approach would be to spread the cost of an annual out-of-pocket limit across all beneficiaries through a modest increase in the average cost of deductibles and co-payments. For example, the Congressional Budget Office, in its December 2008 report on health care budget options, reported that replacing the divergent Part A and B deductibles with a single, combined deductible and a uniform cost-sharing rate could finance a \$5,250 cap on annual out-of-pocket spending.

A more comprehensive approach would be to add a Medicare ‘Part E’ as a voluntary but very low-cost supplemental coverage option that puts a combined cap on all Part A, B and D expenses. This approach would also offer employers a more affordable and predictable option to provide basic supplemental retiree coverage. Both of these general approaches are discussed below.

The Unfortunate History of Medicare Catastrophic Protection

If the challenge of protecting seniors from catastrophic medical losses feels like a political re-run, it’s because a “solution” has already been enacted once – and later repealed. On July 1, 1988,

President Reagan signed the Medicare Catastrophic Coverage Act into law. Otis R. Bowen, Reagan's then-Secretary of Health and Human Services, became the law's initial architect and principal advocate based in part on his own personal experience. Bowen's wife spent the last three months of her life in a hospital with terminal bone cancer – and because Medicare eliminated hospital coverage entirely after 90 days, he understood firsthand how an elderly couple could be left destitute after a serious illness.²⁸ Indeed, insurance against catastrophic health costs had a history of support by Republicans in particular: It was first proposed by President Nixon in 1971 and President Reagan had advocated it when he was governor of California.

The 1988 Act didn't simply cap out-of-pocket spending at a reasonable level, as the Affordable Care Act provides for Americans under age 65 did. It capped individual liability more indirectly by expanding benefits, but subject to higher deductibles. For example, the Act provided for full coverage of hospital stays of any length after a \$560 deductible for hospital costs and a \$1,370 deductible for doctor bills; it added on coverage for 80% of prescription drug costs after a \$600 deductible; and offered up to 150 days of home nursing care and 80 hours of respite care, among other benefits. Although President Reagan had proposed to pay for a more modest bill with a modest \$59 annual increase in premiums (\$4.92 per month) – and which capped out-of-pocket costs at \$2,000 – Democrats in Congress added the additional benefits, increased the monthly premium increase to \$10 (by 1993) and, perhaps most controversially, imposed a 15% surtax (up to a maximum of \$800 per beneficiary) to be added to the income tax bills of beneficiaries above a modest income level.²⁹

While protection from catastrophic costs remained popular, the perception of a substantial new tax on the elderly was not. A political backlash ensued, with a number of advocacy groups opposing what they called the “Seniors-only Income Tax Increase.” Although only the highest-earning 5% of seniors would pay the maximum surtax of \$800, millions of seniors believed they would be hit with both the surtax and a large increase in Medicare premiums. Senior citizens focused mainly on the surtax – and its perceived unfairness – while the prescription drug coverage and other benefit increases were largely ignored. Members of Congress were accosted by angry seniors at town meetings and, in the case of House Ways & Means Chairman Daniel Rostenkowski, mobbed on the street. Just 16 months after enactment, the House voted to repeal the program by a vote of 328 to 73.

As many observers have written since, it's likely that the original Bowen/Reagan proposal – which was limited to catastrophic cost protection for a small, flat increase in premium – would have been popular, particularly if it had been voluntary. However, as it turned out, the label “catastrophic coverage” was used to push through a costly expansion of Medicare benefits to be paid for with a new tax and fee perceived to be both large and unfair. There is no reason that Congress should avoid solving this long-standing public policy challenge so long as it does so through a narrowly-tailored, fair and possibly voluntary approach that avoids the pitfalls of the 1988 Act.

Two Possible Paths to a Budget-Neutral Protection Against Catastrophic Costs

In recent years at least two viable approaches have been proposed, each of which could be revenue-neutral.

The first involves paying for a cap on annual out-of-pocket costs for Medicare beneficiaries by replacing the current complicated mix of cost-sharing provisions with a single combined annual deductible, a uniform co-payment rate and an annual cap on total spending. In a December 2008 report to Congress on health care budget options, CBO reported that replacing the divergent Part A and B deductibles with a single, combined deductible of \$525 (in 2011) and a uniform cost-sharing rate of 20% could finance a \$5,250 cap on annual out-of-pocket spending *and* yield overall budgetary savings of \$26.4 billion over 10 years (through fiscal 2019).³⁰

As the CBO explained, cost-sharing under Medicare’s traditional Part A (hospital and acute care) and Part B (physician and other out-patient services) varies significantly depending on the type of service provided. For 2011, the deductible under Part A will be \$1,132 for each “spell” of illness for which a person is hospitalized, whereas the Part B deductible will be \$162. Part A has varying co-payments for extended stays in the hospital, and for skilled nursing care (each for a limited number of days in total), while under Part B seniors typically pay 20% of allowable costs for physician services, but substantially higher co-pays for outpatient hospital care. Other Medicare services require no cost sharing at all, including home health visits and laboratory tests. According to CBO:

As a result of those variations, enrollees lack consistent incentives to weigh relative costs when choosing among options for treatment. Moreover, if Medicare patients incur extremely high medical costs, they can face a significant amount of cost sharing because the program does not cap those expenses.³¹

The NRLN does not endorse CBO’s specific proposal, which caps out-of-pocket liabilities, but does so by increasing the combined Part A and B deductible and cost-sharing rate far more than necessary to offset the cost of catastrophic protection. It would be neither good policy nor good politics to use this mechanism to cut overall spending on Medicare by another \$26 billion. However, the CBO’s estimates do suggest that a *lower* combined deductible and uniform cost-sharing rate could finance a cap on annual out-of-pocket spending *of \$5,000 or less* without charging a separate premium or increasing the program’s overall cost to the federal budget. While the specific combination of deductible, cost-sharing and out-of-pocket limit figures would need to be studied and adjusted, the CBO’s basic concept of spreading the cost of preventing catastrophic loss across all beneficiaries in proportion to their consumption of benefits each year is a credible but second-best option.

A far more promising approach involves creating a voluntary option (a Medicare Part E) for seniors willing to pay a relatively low and flat additional premium to insure against catastrophic costs. This would be similar in concept to the Reagan Administration’s original 1985 catastrophic insurance proposal, noted above, except that it could be voluntary and limited to capping an individual’s total out-of-pocket costs under existing Parts A, B and D benefits.

One version of such a “Medicare Extra” option was proposed in a 2005 *Health Affairs* article by Karen Davis of the Commonwealth Fund and Marilyn Moon of the American Institutes for Research.³² They propose a public option with an overall out-of-pocket limit of \$3,000 on doctor, hospital and drug costs for a monthly premium of just under \$100. The incremental cost would be 40% below the typical premium for non-group medigap policies – and provide a real cap on out-

of-pocket costs, which most supplemental plans do not provide. The premium payment would be voluntary and adjusted each year to be budget-neutral.

The Davis/Moon proposal suggests structuring a new Part E option to be equivalent to an integrated, high-quality supplemental coverage option. Like the private Medicare Advantage option, this option would integrate claims administration and reduce administrative costs, as well as ensure beneficiaries a relatively low limit on annual out-of-pocket spending. They would replace the currently separate and widely divergent deductibles for Parts A (\$1,132 in 2011) and B (\$162) with a single \$250 deductible. They would reduce the 20% co-pay under Part B to 10% and eliminate coinsurance for hospital, home health and most preventive care. They recommend a flat 25% co-pay for prescription drugs, with no gaps in coverage (i.e., no “doughnut hole”). Total out-of-pocket outlays for all covered services would be capped at \$3,000.³³ They note that this benefit structure is comparable to the Federal Employees Health Benefits Plan standard option and to the median PPO coverage offered by large employers.

A new Part E option could be budget-neutral. To pay for both the reduced rates of cost-sharing and catastrophic protection, their proposal would collect an additional, voluntary Part E premium of approximately \$100 per month. They argue that many employers now offering supplemental coverage to their Medicare-eligible retirees would find it most cost-effective to pay the Medicare Extra premium rather than administer or purchase a separate private layer of wrap-around coverage.³⁴

The NRLN does not endorse any specific proposal for a “Part E” option to purchase supplemental coverage that caps annual out-of-pocket liability. Nevertheless, the concept of a voluntary option to purchase insurance against the risk of catastrophic medical costs appears to be the most promising approach and should be seriously considered by Congress. Many variations on the concept are possible. For example, the Davis/Moon proposal suggests low deductibles and rates of cost-sharing at the expense of a substantial new premium charge on the order of \$100 per month. In contrast, CBO asserts that the combined deductible should be relatively high and co-payments should be a relatively stiff 20% on nearly all Medicare services in order to make participants more price sensitive. By imposing a higher deductible and co-payment on nearly all services, the CBO approach would avoid the need for an additional premium charge (hence, CBO’s approach delivers a cap on out-of-pocket costs without a Part E). The Davis/Moon approach could similarly be adjusted to maintain higher cost-sharing in return for a lower Part E premium. The NRLN favors this unbundling of a Part E option, which would permit more precise cost analysis of a catastrophic supplement on an ongoing basis and would be easier for Medicare participants to understand.

The voluntary nature of the Davis/Moon proposal has trade-offs as well. The same substantial share of Medicare beneficiaries that today does not purchase supplemental coverage on the private market may continue to decide that however sensible a purchase, the extra monthly premium is either not affordable or not necessary for them. The authors also acknowledge that a voluntary option creates adverse selection risk, since beneficiaries who believe they will have high costs are far more likely to opt for the Part E cap on their total outlays, while younger and healthier seniors not expecting major expense will be more inclined to decline the additional premium cost. Part E premiums will be higher as a result. They suggest that although Part E catastrophic coverage

should ultimately be voluntary, default enrollment could encourage participation by requiring seniors to affirmatively decide to opt out.

V. Conclusion

Now that the Affordable Care Act has established the principle that no American should be forced into bankruptcy or onto the public dole to pay catastrophic medical bills, Congress should ensure that this protection is extended equitably to the 65-and-older population as well. Unlike employer-sponsored insurance for employees – or plans sold to individuals through the American Health Benefit Exchanges – Medicare alone will have no limit on out-of-pocket spending. While younger Americans will be protected from medical bankruptcy, the share of senior citizens forced to forgo needed care, forced into bankruptcy, or forced onto the demeaning dole of Medicaid will continue to rise steadily in coming years.

The NRLN recommends the adoption of a voluntary and self-financing Medicare ‘Part E’ that offers all Medicare beneficiaries an option to purchase protection against catastrophic out-of-pocket health care costs without adding cost or expense to Medicare. While Medicare participants would establish their own pool within Medicare, it is recommend that Medigap and Medicare Advantage plan private insurers be encouraged to compete with Medicare by offering identical coverage to their existing plans or new stand-alone competitive products but without subsidies. Encouraging a competitive market will insure the availability of protection at the most competitive premium levels.

The NRLN believes it is time to extend the protection against catastrophic loss to all Americans. There are credible policy options available that would provide Medicare beneficiaries with protection against catastrophic costs *and* encourage health cost containment without increasing the budget deficit. We urge Congress and the President to make this last longstanding gap in our national health policies a priority during the months ahead.

Endnotes

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