



BIPARTISAN POLICY CENTER

Medicare Benefit Modernization

Medicare's benefit package is outdated and fails to provide adequate protections for enrolled seniors and people with disabilities. As a result, approximately 90 percent of Medicare beneficiaries have some source of supplemental insurance to fill in coverage gaps. At the same time, assistance for low-income Medicare beneficiaries is inadequate.

Our Approach

A number of policymakers have recommended improving, simplifying, and modernizing Medicare's benefit package. Beneficiary advocates have raised concerns about this approach, concerned that beneficiaries would see higher out-of-pocket costs, which may result in barriers to access for low- and middle-income beneficiaries. The Bipartisan Policy Center (BPC) proposal combines a redesign of Medicare's cost-sharing, reform of supplemental coverage, enhanced low-income assistance, and reduced subsidies for higher-income beneficiaries within the Medicare program. As a result, BPC's benefit redesign reduces overall costs for beneficiaries, producing savings for the Medicare program and taxpayers, and adopting a modern insurance design that gives beneficiaries, as well as providers, a stake in appropriate utilization. Most importantly, these reforms seek to provide beneficiaries protection against the costs of catastrophic illness through a simpler and more up-to-date benefit structure.

Cost-sharing Redesign

Replace the outdated system of deductibles and coinsurance in order to strengthen the Medicare benefit, reducing the need for supplemental coverage, and allowing many beneficiaries to save money.

Provide financial protection from the costs of a catastrophic illness by establishing an annual cost-sharing cap of \$5,400. This cap would cover cost-sharing for both Part A (hospital/facility care) and Part B (physician/medical care).

Replace the current complicated array of deductibles and coinsurance rates with a single \$500 deductible and a simplified copay schedule. For example:

- \$20 copay for office visit to a primary care physician, \$40 for a specialist visit.
- \$750 per hospital admission.
- \$80 per day for skilled nursing.
- The combined deductible would not apply to physician office visits. Beneficiaries would never pay more than the standard copay for an office visit (\$20 for primary care, \$40 for a specialist), even if the deductible hasn't been met.

Maintain preventive services and annual wellness visits with no beneficiary cost-sharing.

Medicare accountable care organizations (ACOs) could waive primary-care office-visit copayments for assigned beneficiaries.

Aggregate beneficiary cost-sharing amount would remain unchanged program-wide.

EXAMPLES OF BENEFICIARY COST-SHARING: TODAY VS. PROPOSED REFORM

Scenario			
	A beneficiary visits her doctor about headaches. She has not met her deductible.	A beneficiary develops a condition that requires long stays in a hospital and a skilled nursing facility.	A beneficiary sees a doctor and receives an MRI for lower back pain. He has not met his deductible.
Cost Today	\$73	\$17,464	\$210
Explanation of today's cost	Beneficiaries currently pay the entire cost of an office visit before meeting the Part B deductible.	Medicare currently has very high cost-sharing for long hospital and skilled nursing stays. There is also no out-of-pocket maximum.	After meeting the Part B deductible, beneficiaries currently pay coinsurance for advanced imaging.
Cost after Reform	\$20	\$4,750	\$407
Explanation of post-BPC reform cost	Office visits would be a flat \$20 copay, even if the deductible is not yet met.	Per-day hospital copayments for long stays would be replaced with one copay per admission. Additionally, the skilled nursing copay would be lower.	Because the new combined deductible would be higher than the old Part B deductible, a beneficiary who has not met the deductible would pay more of the cost for advanced imaging.

Note: The post-reform amounts would be lower for a beneficiary who qualifies for expanded low-income cost-sharing assistance, described on the next page.

Source: Medicare fee-schedule payments from Codemap.com for CPT Codes 99213 and 72148, BPC calculations.



Supplemental Coverage Reform

Revise Medicare supplemental coverage to address incentives for overuse of services and support development of alternative payment models. Under current law, which includes the passage of the Medicare Access and CHIP Reauthorization Act of 2015, Medigap plans sold to newly eligible Medicare beneficiaries beginning in 2020 will be prohibited from covering the Part B deductible (\$147 per year in 2015). Under the BPC proposal, all supplemental plans, including Medigap, employer-sponsored plans, and TRICARE-for-Life, would be prohibited from covering first-dollar beneficiary cost-sharing. All supplemental coverage should:

Include a deductible of at least \$250.

Include an out-of-pocket maximum no lower than \$2,500 (out of the beneficiary's pocket).

Cover no more than half of beneficiary copayments and coinsurance (once the deductible is met and before the out-of-pocket maximum is reached).

Enhanced Low-Income Assistance

Expand cost-sharing assistance to beneficiaries up to 150 percent of poverty. Currently, help with cost-sharing is available for Medicare beneficiaries with income below 100 percent of the Federal Poverty Level (FPL), but not for those with incomes just above the poverty level. This new assistance would reduce cost-sharing by:

50 percent for beneficiaries between 100 percent and 135 percent of FPL.

25 percent for those between 135 percent and 150 percent of FPL.

This new low-income assistance would be federally funded and administered. There would be no resource test, and those who file an income-tax return and meet income-eligibility guidelines would be automatically enrolled.



Reduce Subsidies for Higher-Income Beneficiaries

The vast majority of Medicare beneficiaries pay Part B and D premiums equal to 25 percent of program costs or less, and about 10 percent of beneficiaries pay more. Under this proposal, about 20 percent of Medicare beneficiaries would pay higher, income-related premiums.

REDUCE SUBSIDIES TO HIGHER-INCOME MEDICARE BENEFICIARIES

Current Law Thresholds			Proposed New 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-\$133,500	\$214,001-\$267,000	50%	\$82,001-\$135,000	\$123,001-\$202,500	50%
\$133,501-\$160,000	\$267,001-\$320,000	65%	\$135,001-\$189,000	\$202,501-\$283,500	65%
>\$160,000	>\$320,000	80%	>\$189,000	>\$283,500	80%

Medicare Benefit Modernization is part of a comprehensive approach to health care delivery system improvement developed by the Bipartisan Policy Center, which also includes the concept of Medicare Networks, an enhanced, enrollment-based model for the future of accountable care organizations (bipartisanpolicy.org/mednets), a reformed, competitively priced Medicare Advantage program, and reforms to the tax treatment of employer-sponsored health benefits, among other proposals. To learn more, please see *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*: <http://bipartisanpolicy.org/library/health-care-cost-containment/>.

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End Notes

¹ For more information on BPC recommendations on Medicare Accountable Care Organizations, see *Transitioning to Organized Systems of Care: Near-Term Recommendations to Improve Accountable Care Organizations in Medicare*.

Available online at bipartisanpolicy.org/aco-medicare

