A Special Report from Families USA
March 1999

The Impact of Medicare Reform on Low-Income Beneficiaries

INTRODUCTION

The National Bipartisan Commission on the Future of Medicare is considering recommendations to radically restructure Medicare. These recommendations are likely to have a particularly profound effect on the one out of four Medicare beneficiaries who have low -incomes. The proposal under consideration-called "premium support"-could diminish significantly affect both the availability and affordability of health care for the low-income elderly and disabled.

In the three decades of Medicare's existence, cost-sharing and out-of-pocket spending has increased steadily. The average Medicare beneficiary spends about one-fifth of income on out-of-pocket health care costs, but those at or below the federal poverty level spend more than a third of their incomes on health care. About half of these low-income beneficiaries do not have Medicaid coverage, and out-of-pocket spending consumes an astounding 50 percent of their income.1-2

Congress has taken a number of steps over the past decade to protect low-income beneficiaries from rising costs by paying their Medicare premiums and, in some cases, their Medicare cost-sharing. These programs have worked imperfectly- they actually reach only about half those eligible- -- but have made a significant difference to the seniors who have participated in them.

Now, the Bipartisan Commission is about to propose a significant restructuring of Medicare. The proposal under consideration builds on a competitive, market-based approach and limits federal fiscal responsibilities. If not carefully structured, this proposal could further increase the financial burden on beneficiaries-in particular, the low-income beneficiaries. The Commission's draft proposal addresses low-income issues in only a limited way.3 The proposal calls for the continuation of the existing buy-in program that provides assistance to low-income beneficiaries but leaves serious questions unanswered. No consideration is given to the significant administrative obstacles involved in folding the low-income assistance program into a premium support model or to the significant reforms needed to make it work effectively. To adequately meet the

needs of low-income people, the Commission's final proposal should include these four protections:

1. Medicare reform should include coverage of Medicare premiums as well as realistic, meaningful assistance with deductibles and copayments for beneficiaries with low incomes. Eligibility should be expanded over time to keep pace with the increasing burden of Medicare premiums and cost-sharing.
2. The plan must ensure that all those eligible for low-income protections actually know about the assistance and can easily apply for and receive the benefits to which they are entitled.
3. The plan should assure that low-income people have access to the full range of medically necessary services, guaranteed in a "defined benefit" package, and that they have a variety of health plan choices. They should not be forced into a few segregated plans.
4. The plan should not increase the number of uninsured seniors (as will happen if the eligibility age is raised), and it should provide opportunities for people below age 65 to buy in to Medicare, with adequate subsidies for those with low incomes.

CURRENT LOW-INCOME PROTECTIONS IN MEDICARE

As health costs grew in the 1980s along with Medicare cost-sharing, Congress recognized the burden on low-income beneficiaries and acted to protect those who were particularly hard hit. As a result, a number of programs-imperfect, but important nonetheless-now exist to help low-income beneficiaries.:

- Under the Qualified Medicare Beneficiary (QMB) program , beneficiaries with incomes up to 100 percent of the federal poverty level are entitled to full coverage of their Medicare premiums, deductibles, and copayments, paid for by the Medicaid program.
- Under the Specified Low-Income Beneficiary (SLMB) program, those with incomes between 100 and 120 percent of poverty are entitled to Medicaid coverage of their Medicare Part B premiums (but not their cost-sharing).
- Under the Qualified Individual-1 (QI-1) program , those with incomes between 120 and 135 percent of poverty are eligible for-but not entitled to-Medicaid coverage of their Part B premiums from a pool of limited funding available on a first-come, first-served basis.

Collectively, these programs are referred to as the Medicare buy-in.

The Medicare buy-in has helped millions of seniors afford the health care they need, but obstacles to participation have prevented millions more from receiving the help to which they are entitled. About 45 percent of the 8 million individuals who are eligible for QMB and SLMB benefits-about 3.5 million people-are not receiving their benefits. The result is that these eligible individuals are paying about $2 billion annually in Medicare Part B

premiums through inappropriate deductions from their Social Security checks. Another 1.6 million individuals are eligible for assistanceare under QI-1 but only a fraction of them currently receive assistance. All told, there are now more than 5 million Medicare beneficiaries who need, but do not receive, Medicare cost-sharing assistance.4

One obstacle to full participation in the buy-in is that many different entities are responsible for the program, and each appears to "pass the buck" to others. The Social Security Administration (SSA), the Health Care Financing Administration (HCFA), and state social service agencies are all involved. SSA deducts Part B premiums from Social Security checks, but to date SSA has had no consistent role in administering the buy-in. HCFA oversees the buy-in but does not directly implement it.

Currently, Medicare beneficiaries sign up for Medicare Part B benefits when they apply for Social Security at local SSA offices. However, beneficiaries cannot apply for buy-in benefits at the same time. Instead, they must go to a state social services office to apply. Many beneficiaries are never told by Social Security personnel that they may be eligible for of the buy-in and have little or no experience with social services offices. Unfamiliarity with social services offices and the inconvenience of traveling to another location deter some beneficiaries from applying. Other beneficiaries are discouraged by the complex application processes at social services departments. In some states, social service agencies require buy-in applicants to complete the same time-consuming application required of Medicaid clients; these forms often ask difficult and involved financial questions. Additionally, social service workers are ill-informed about the buy-in program and its procedures, which delays the application process. In some cases, social service workers have denied the existence of the program and turned applicants away.

Another obstacle to full participation is that states have to pay part of the costs. Under the buy-in program, Medicare premiums and cost-sharing are paid for by the Medicaid program; states, on average, pay, 45 percent of the cost of Medicaid. Thus, states have a disincentive to improve the application process and increase enrollment.

Even if there were no impending changes in Medicare, the buy-in program should be redesigned so that all eligible beneficiaries actually receive the protections to which they are entitled. Several steps should be taken:5

- First, the program should be administered fully by the federal government. The Social Security Administration, which already determines Medicaid eligibility for beneficiaries of the Supplemental Security Income (SSI) program in 32 states, should take all applications for the Medicare buy-in program.
- Second, all Social Security personnel should be knowledgeable about the program and, as a matter of protocol, should discuss the buy-in program and the individual's potential eligibility when taking applications for Social Security and Medicare. Personnel should encourage applicants to apply and should help them with their applications.
- Third, the buy-in program should be funded fully by the federal government. The buy-in program is essentially a Medicare benefit, not a Medicaid benefit.

Requiring states to pay for what is essentially a federal program is unreasonable and, as experience has shown, unworkable. With full federal funding and administration, the buy-in program stands a better chance of reaching Medicare beneficiaries who are entitled to its benefits.

HOW MEDICARE REFORMS AFFECT THE LOW-INCOME

The Medicare Commission's draft recommendations call for transforming Medicare into a "premium support" program and for making major changes in traditional fee-for-service Medicare. These recommendations could leave low-income beneficiaries with increased cost-sharing. To see why this is true, it is necessary, to outline understand the proposed reforms.

The Impacts of the Premium Support Model

The premium support model proposed by the Commission is patterned on the Federal Employees Health Benefits Program. The Commission's model works like this:6

1. A new "Medicare Board" will takes premium bids from health plans, including the traditional Medicare program.
2. The Board will negotiates with the health plans on the price and scope of benefits. A precise benefit package with specific cost-sharing limits is not required.
3. The Board will average the agreed-upon premium prices from the different plans in each market to determine a "benchmark" premium for each market.
4. The federal government will pays an average of 88 percent of the benchmark premium toward the cost of the health plan chosen by each beneficiary. Beneficiary contributions will be income-related. This means that beneficiaries with incomes below 135 percent of poverty (if the proposal maintains consistency with current law, as it says it will) will pay no premium; beneficiaries with incomes between 135 and 300 percent of poverty will pay about 12 percent of the benchmark premium (plus any additional premium required if they select a higher cost plan); and beneficiaries with incomes above 300 percent of poverty will pay a surcharge according to a graduated scale ranging from 1.5 percent to 15 percent of the premium amount. The funds from income-relating premiums will be used to augment low-income protections above those that exist now. As possible low-income expansions, the proposal cites "support for prescription drug coverage, efforts to expand participation in assistance currently offered, and extending assistance to the near poor."

How would the premium support model affect low-income beneficiaries?

Premium Assistance under the Premium Support Model

All Medicare beneficiaries currently pay a Medicare Part B premium of $546 a year. The Medicare buy-in program covers pays this premium for beneficiaries with incomes below 135 percent of poverty. The Commission projects that an average premium under its proposal would be about $5,700 with a beneficiary contribution of about $708.7 This average beneficiary share of premium ($708) is $162 higher than the current share.

The Commission's proposal includes premium and cost-sharing assistance for low-income beneficiaries. However, the proposal does not explicitly define "low-income;." nor does it describe the assistance that will be provided to low-income beneficiaries. Instead, the proposal refers only to extending buy-in protections "as under current law." If people at or below 135 percent of poverty are included, as under the current QMB/SLMB/QI-1 programs, these low-income beneficiaries would remain eligible for premium assistance. However, if the income threshold is set below 135 percent, millions of people currently eligible for buy-in protection could lose it and would be required to pay a potentially unaffordable premium.

Since the Commission's estimate of the average premium is about the same as the current per capita cost of the traditional Medicare program, the projected premium does not allow for any new benefits. If benefits-such as prescription drugs- are added, premiums would have to increase further to cover the additional cost.

The Breaux proposal raises a host of questions about how premium assistance for low-income beneficiaries will be implemented in a premium support model.

Who will be eligible? How will they find out about the assistance?

What exactly will low-income people get premium assistance for? Will it be the beneficiary premium for the traditional fee-for-service plan, the average-cost plan, or a lesser amount? (Since there will be one national premium for the traditional Medicare plan, but the amount provided towards each beneficiary's premium will be based on regional costs, beneficiaries who live in low-cost areas may not receive enough to make the traditional Medicare plan affordable.)

How will low-income beneficiaries know how much assistance they will get when they choose a health plan?

How will the Medicaid program administer an assistance program that provides different amounts of assistance for different people?

Cost-sharing Assistance Uunder the Premium Support Model

The premium amount for which low-income beneficiaries would be liable is only one concern. Of equal concern is how the proposed low-income assistance would cover cost-sharing responsibilities. These questions remain to be answered:

The Commission's proposal allows each health plan to vary the scope and duration of benefits, as well as the amount of cost-sharing. Exactly how much support will low-income people get to cover their cost-sharing? Will it be tied to the traditional fee-for-service plan, the average-cost plan, or a less expensive plan?

Who will decide what cost-sharing low-income people actually get? Will it be the state Medicaid program, the Medicare Board, or the Health Care Financing Administration? How will a program that pays varying amounts in cost-sharing be administered effectively?

However these questions are answered, it is crucial that low-income beneficiaries' out-of-pocket requirements be realistic and that assistance be sufficient to ensure that needed health services remain affordable in the full spectrum of health plans.

The Impacts of a Reconfigured Traditional Medicare Program

Cost-sharing is also a serious concern in traditional Medicare as reconfigured in the Commission's proposal, which contains these changes:

1. Like private health plans, traditional Medicare will submit a premium bid to the Medicare Board. The rules governing premium contributions will be the same as for private health plans, described above.
2. Beneficiaries will pay a combined deductible of $350. Currently, the deductible for Part A (hospital services) is $768, and the deductible for Part B (out-patient services) is $100.
3. Coinsurance of 10 percent will be required for home care and in-patient hospital care.8 In the current program, there are no co-payments are required for home care or for the first 60 days of hospital care.

The combination of two deductibles into one means that most beneficiaries-the 80 percent who are not hospitalized in a given year-will have higher out-of-pocket costs up front. Even if the current cost-sharing protections for low-income beneficiaries eligible for QMB benefits (those underwith incomes below 100 percent of poverty) are continued as under current law, beneficiaries currently eligible for SLMB and QI-1 benefits (those with incomes between 100 percent and 135 percent of poverty) will be responsible for a $350 deductible before Medicare coverage applies-$250 more than the deductible they pay today. This new burden will deter these low-income seniors from securing the health care they need.

Just as troubling are the provisions that establish 10 percent copayments for home health care and hospitalization. If current law is continued, low-income people currently eligible for SLMB and QI-1 benefits (those with incomes between 100 percent and 135 percent of poverty) who need hospital and home care would experience a dramatic increase in out-of-pocket costs. Low-income people, whose health is generally worse than average, are at greater risk of needing home care and hospitalization than other income groups.

WHAT LOW-INCOME PEOPLE NEED IN MEDICARE REFORM

Medicare reform should include coverage of Medicare premiums as well as and realistic, meaningful assistance with deductibles and copayments beneficiaries with low incomes. Eligibility should be expanded over time to keep pace wiith the increasing burden of Medicare premiums and cost sharing.

A premium support system in Medicare must contain buy-in protections that cover not only premiums but cost-sharing a realistic package of benefits that includes prescription drugs.

Under current law, beneficiaries with incomes up to 100 percent of poverty are eligible for full cost-sharing protection, but those eligible for the SLMB and QI-1 benefits are not eligible for cost-sharing. A restructured program should explicitly provide subsidies for these low-income individuals. The precise income levels that determine eligibility should be legislatively guaranteed and not contingent on cost-savings expected from Medicare reform.

If, as expected, health care costs again begin to increase faster than inflation, the income ceiling for buy-in protections must increase accordingly and more beneficiaries should be eligible for buy-in protection. Medicare reforms should include effective mechanisms to raise the ceiling of buy-in eligibility in accordance with increases in Medicare premiums and out-of-pocket costs.

Medicare reform should ensure that all those eligible for low-income protections actually know about the assistance and can easily apply for and receive the benefits to which they are entitled.

The Commission proposal calls for extending the current buy-in program - a program that is inherently unworkable. In the current program, around 5 million people-about half of those eligible-are not receiving their benefits due to its complex application requirements and faulty administrative structure. The proposal fails to explain how the premium support model will fix the buy-in program so that all those eligible actually receive benefits.

As part of reform, the low-income protection program should should be redesigned so that all beneficiaries who are entitled to the benefit actually receive it. It is not unreasonable to expect that the participation rate in the buy-in program be the same as in Medicare-about 98 97 percent.

To accomplish this, buy-in protections must be administered and funded by the federal government, as outlined above. Low-income beneficiaries should be able to apply for and receive buy-in protections from agencies that are knowledgeable and helpful. Many eligible beneficiaries have never been to a social services office; the inconvenience and

the lack of familiarity with welfare agencies discourages beneficiaries from applying for buy-in benefits. The Social Security Administration, which administers Part B Medicare applications, would be the more appropriate agency to administer the buy-in program.

Medicare reform should assure that low-income people have access to medically necessary services guaranteed in a "defined benefits" package, and that they have a variety of health plan choices. They should not be forced into a few segregated plans.

Under the current Medicare program, beneficiaries are guaranteed a defined set of benefits, and all beneficiaries, regardless of income, have access to these benefits. The Commission's draft proposal would reduce or eliminate this guarantee. It would allow health plans to determine the scope, duration, and dollar limits on specific health benefits, possibly resulting in less health coverage than in Medicare's current "defined benefit" system. Beneficiaries would have no guarantee that a specific uniform set of benefits would be available in every health plan. As a result, the cost of needed health benefits might be shifted onto the backs of low-income beneficiaries.

The absence of comprehensive standard benefits would pose several specific problems for low-income people: First, Beneficiaries beneficiaries would have to pick up the costs of excluded services-a financial burden that cost-sharing protections do not address. Second, low-income beneficiaries would becould become unfairly restricted to choosing from those health plans offering less valuable benefits to keep premiums low. With restricted choices, low-income beneficiaries would become segregated into certain plans. This would inevitably lead to a two-tiered health system, with low-income beneficiaries receiving second class service and coverage.

For low-income people to be assured access to necessary services, all health plans must offer a defined, comprehensive set of guaranteed benefits. This package should include existing Medicare benefits, plus prescription drug coverage and protection against catastrophic expenses-two of the most glaring gaps in Medicare's current benefit package. A health plan, if it desired, could offer additional optional benefits in a supplementary package for a separate premium.

An increase in the age for Medicare eligibility will cause many seniors to become uninsured and will cause greater hardship to low-income seniors. A buy-in program, with adequate subsidies for the poor and near-poor, should be established for people under 65 years of age.

If the eligibility age for the Medicare participation increases form 65 to 67 years of age as proposed by the Bipartisan Commission, a significant increase is likely to occur in the number of seniors who are uninsured. Increasing the eligibility age in such a manner could result in as many as 1.7 million seniors becoming uninsured or seriously underinsured.9 Seniors would have to fend for themselves in procuring health coverage in the individual insurance marketplace, and many would find that health coverage, if available, is unaffordable. This would be especially be true for sick and frail elders in an insurance marketplace where premiums are based on individual health history.

At the same time that the Commission is contemplating increasing Medicare's eligibility age, seniors are losing access to employer-subsidized retiree health benefits. During this decade, employer-provided retiree health coverage dropped steadily and significantly. A recent survey of large employers (those with more than 500 workers) found that 40 percent offered retiree health benefits in 1993 but only 31 percent did so in 1997.10 This trend is likely to continue in the future on as employers strive to contain health care spending.

To protect seniors who have not yet reached the eligibility age for Medicare, a program must be established that allows them to buy in to Medicare and that includes meaningful subsidies for low-income seniors. These seniors have had a tenuous connection to the job market throughout their lives; old age and health problems further weaken the connection. The failure to provide a subsidized buy-in assistance will leave these seniors without the means to obtain health coverage.

CONCLUSION

Advocates of the premium support model for Medicare expect the model to produce savings by making beneficiaries more cost-conscious in purchasing health care, presumably more cost-conscious than they are under Medicare's current system of copayments and deductibles. However, by its design, premium support is also a mechanism for the government to lower its financial risk and shift more risk to beneficiaries.

Supporters and opponents both agree that any savings from premium support will be too little to cover the bulging Medicare population in coming years. Under the model proposed by the Commission, the Medicare Board would have the authority to shape benefits and negotiate bids. As medical costs rise, the Board will have an incentive to allow plans to reduce benefits, raise premiums, and increase cost-sharing in order to limit the government's exposure to rising costs. Under the Commission's model, these decisions could be made without congressional approval. Therefore, low-income beneficiaries would be at greater risk of going without crucial health benefits or having to pay out of pocket for those benefits.

For a premium support model to work for all the nation's elderly, low-income beneficiaries must have the certainty of a good uniform benefits package and federally funded wraparound protections that cover premiums and cost-sharing. These protections must be designed and administered so that all eligible low-income beneficiaries actually receive the wraparound benefits to which they are entitled. Furthermore, the program design must be flexible so that wraparound subsidies can be modified to meet the rising costs of health care premiums and cost-sharing over time. Because premium support shifts a portion of the government's financial burden to beneficiaries, well-defined protections for low-income people are vital.

ENDNOTES

1 David Gross, Lisa Alecxih, et al., "Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections" (Washington, DC: AARP Public Policy Institute and the Lewin Group, 1997).

2 Marilyn Moon, Crystal Kuntz, and Laurie Pounder, "Protecting Low-Income Medicare Beneficiaries" (New York: The Commonwealth Fund, 1966). Moon's estimate of Medicare out-of-pocket spending is 21 percent for all non-institutionalized beneficiaries, and the AARP/Lewin estimate is 19 percent. The Moon estimate projects from the National Medical Expenditure Survey of 1987 and includes home care, while the AARP projection uses data from the 1993 Medicare Current Beneficiary Survey and excludes home care.

3 National Bipartisan Commission on the Future of Medicare, "Preliminary Staff Estimate: Senator Breaux's Medicare Proposal" (Washington, DC: February 16, 1999); "Draft Working Document" (Washington, DC: January 22, 1999).

4 Families USA, Shortchanged: Billions Withheld from Medicare Beneficiaries (Washington, DC: Families USA, 1998).

5 Ibid.

6 National Bipartisan Commission on the Future of Medicare, op. cit.

7 Ibid.

8 Memorandum from Sen. John Breaux to the Medicare Commission, February 23, 1999, "Premium support estimate from the HCFA Actuary." The reform package scored by the HCFA Actuary contains the provision for 10 percent hospital coinsurance under a chart labeled, "Draft Medicare legislative package introduced by Senator Breaux at January 26 Commission meeting."

9 Timothy Waidman, "Potential Effects of Raising Medicare's Eligibility Age," Health Affairs, Vol 17, No. 2, 1998, 156:64; John Sheils, David Stapleton, Jessica Graus, Andrea Fishman, "Rethinking the Medicare Eligibility Age" (Washington, DC: The Lewin Group, for the National Coalition on Health Care, June 1998.).

10 Paul Fronstin, "Features of Employment-Based Health Plans," Issue Brief No. 201 (Washington, DC: Employee Benefits Research Institute, September 1998).

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