2016 MAKING ISSUES COUNT

REVISING MEDICARE'S TRADITIONAL BENEFIT DESIGN

IMPROVING THE QUALITY AND COST-EFFECTIVENESS of care under the Medicare program is a key health policy challenge. While many efforts are rightly focused on realigning financial incentives in Medicare's provider payment and delivery system, better aligning incentives on the beneficiary side should also be considered. In particular, updating the program's traditional fee-for-service (FFS) benefit design (i.e., its cost-sharing features) and addressing other shortcomings of the current benefit structure could help encourage Medicare beneficiaries to seek more cost-effective care.

Current Medicare Fee-For Service Benefit Design

Like most other health insurance plans, Medicare uses patient cost-sharing requirements—deductibles, copayments, and coinsurance—to help balance the cost of the program with the comprehensiveness of the benefits provided. Patient cost sharing directly lowers Medicare spending by shifting a portion of medical costs to the beneficiary. In addition, cost sharing can lower spending overall by reducing health care utilization. Whereas private health insurance programs typically have integrated benefit structures that are designed to manage hospital and non-hospital expenses in a coordinated fashion, the Medicare Part A (inpatient hospital) and Part B (physician and outpatient hospital) benefits are structured very differently from each other—and the patient cost-sharing provisions are not coordinated between the two. In addition, traditional Medicare doesn't cap beneficiary cost sharing, leaving beneficiaries unprotected against catastrophic health costs. In part because of this, most Medicare beneficiaries have supplemental coverage that provides such protection by filling in the cost-sharing requirements. Although this supplemental coverage protects against catastrophic costs, it also reduces the incentives for beneficiaries to seek cost-effective care. Medicare Advantage plans, unlike traditional Medicare, are required to include an out-of-pocket cap and have more flexibility in terms of offering alternative cost-sharing requirements.

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Unifying Part A and B Deductibles and Adding a Cost-Sharing Limit

To address some of the limitations of the current benefit design, proposals have been suggested that would combine a new cost-sharing limit with a unified Part A and Part B deductible. The copayment and coinsurance requirements also could be restructured. These changes would result in more coordinated Part A and Part B cost-sharing requirements and would bring the traditional program's benefit design more in line with the structure of private health insurance programs.

Unifying the Part A and Part B deductibles has the potential to better align beneficiary incentives designed to reduce unnecessary care and promote more cost-effective care. But the majority of Medicare beneficiaries have supplemental coverage that can limit the effectiveness of the incentives in Medicare's cost-sharing requirements. Beginning in 2020, Medigap plans will be prohibited from covering the Part B deductible for new Medicare beneficiaries. Additional changes also may need to be considered to avoid limiting the effectiveness of any new cost-sharing design incentives, while at the same time protecting beneficiaries with limited financial resources or chronic conditions who may be more sensitive to increases in cost-sharing requirements.

Enhanced Benefit Targeting

While redesigning the FFS benefit structure could help to better align beneficiary incentives to seek cost-effective care, broad changes in cost sharing would not necessarily distinguish between necessary and ineffective care. In the longer term, moving to a value-based insurance design (VBID) and allowing supplemental benefits for beneficiaries with certain conditions could allow for better targeting of health care services. Under a VBID approach, cost sharing would be lower for high-value services and higher for low-value services. Behavioral design principles could improve adherence to evidence-based treatment protocols. Research that focuses on interventions among the chronically ill could help distinguish between low-value and high-value services and better target interventions.

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Revising Medicare's Fee-For-Service Benefit Structure READ MORE...