DEMYSTIFYING MEDICARE:
2012 INTERN ACADEMY POLICY DISCUSSION

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Social Insurance Principles

1) Universal
2) Earned Right
3) Wage Related
4) Contributory and Self-Financed
5) Redistributive
6) Not Means-Tested
7) Wage Indexed
8) Inflation Protected Compulsory
Raise Medicare’s Age of Eligibility

• Since the creation of the program, Medicare’s age of eligibility has been 65.

• Proposals would raise by two years, to 67.
Redesign Medicare’s Co-Pays and Deductibles

- “Benefit design” has remain unchanged since 1965
- Significant gaps leave beneficiaries vulnerable to sizeable financial burdens from out-of-pocket costs.
  - High deductible for inpatient stays, a relatively low deductible for physician and outpatient care, and
  - No upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur.
- Proposal include:
  - 1) A combined deductible and coinsurance for Part A and Part B
  - 2) A cap on out-of-pocket costs
  - 3) A tax on supplemental coverage
Require Drug Companies to Give Rebates or Discounts to Medicare


- Dual eligibles used to receive care from Medicaid, now Medicare.

- Drug companies required to give rebates of 23.1 percent to Medicaid; rebate for Medicare is 8.1 percent.
Generate New Source of Revenue by Increasing the Payroll Tax

- Reform could come from combination of tax increases and spending cuts
- Main source of funding for Medicare Part A = 1.45% payroll tax (2.9% altogether)
- Trustees estimate that funds HI Trust Fund are not sufficient to fully cover benefits past 2024
- Proposal to raise Medicare payroll tax to 1.95% (3.9% altogether) – a 1% increase
**Generate New Source of Revenue Through A Value Added Tax**

- **Value Added Tax (VAT)** applied incrementally at each stage of the production process
- As opposed to a sales tax that is levied only at the final retail stage
  - For example, the production of a loaf of bread involves contributions from the farmer who grows the wheat, the baker who bakes the bread, and the grocer who sells it to the consumer.
  - The U.S. is one of the few members of the Organization for Economic Co-operation and Development (OECD) not to have a VAT at the national level.
**RAISING MEDICARE PREMIUMS FOR HIGHER-INCOME BENEFICIARIES**

- MMA introduced an element of means-testing --
  - Part B premiums in 2012 = $99.90/month (25% of costs)
  - Part B premiums in 2012 for higher-income individuals = anywhere from $139.90 to $319.70/month (35% to 80% of costs)

- Policy Option 1: Increase premiums for high-income beneficiaries by an add’l 15%
- Policy Option 2: Increase premiums for all beneficiaries so cover 35% of program costs
Questions to Consider

- How does this affect the cost of the program?
- How does this affect beneficiaries’ access to care?
- How does this affect the quality of care?
- Does this slow the growth in health spending or just shift costs from one payer to another?
- Does this give health care providers and their patients incentives that encourage the kind of integrated and coordinated care that could help both control costs and improve quality?