

COVID-19 and Affordability of Coverage and Care for Medicare Beneficiaries

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ABSTRACT

ISSUE: The COVID-19 pandemic is underscoring how the benefit design of traditional Medicare can leave beneficiaries financially vulnerable.

GOALS: 1) Summarize financial challenges faced by Medicare beneficiaries before and after the pandemic; 2) identify federal measures to assist beneficiaries financially during the pandemic; and 3) recommend policy changes to ensure beneficiaries with COVID-19, and potentially all beneficiaries, have affordable access to care.

METHODS: Use 2017 Medicare Current Beneficiary Survey and Cost Supplement data to profile current cost burdens and analyze policies to reduce cost-sharing and increase premium assistance.

FINDINGS AND CONCLUSIONS: Many Medicare beneficiaries face financial hardships because of limited incomes and high out-of-pocket expenses. The health and economic impacts of the COVID-19 pandemic is making their financial situation that much more precarious. While Congress and the administration have adopted measures to financially shore up health care providers, not enough has been done to help Medicare beneficiaries, especially those with low incomes who do not have supplemental coverage. Needed policy changes include waiving cost-sharing for beneficiaries with COVID-19, offering Medicare as a choice for those ages 55 to 64, placing a ceiling on out-of-pocket costs, expanding benefits, and ensuring the solvency of the Medicare Part A trust fund.

TOPLINES

- ▶ **Because of their limited incomes and high out-of-pocket expenses, many Medicare beneficiaries are in a more precarious financial situation during the COVID-19 pandemic.**
- ▶ **Medicare changes that could help include waiving cost-sharing for beneficiaries with COVID-19, opening Medicare to adults 55 to 64, limiting out-of-pocket costs, and expanding benefits.**



INTRODUCTION

By design, Medicare covers Americans with the greatest health care needs: those age 65 and older and those under age 65 with permanent disabilities. This is the same group with the greatest risk for mortality and serious complications from COVID-19.¹ The Centers for Disease Control and Prevention estimates that people age 65 and older account for eight out of 10 COVID-19 deaths.² In addition, 89 percent of adults hospitalized in March 2020 had preexisting medical conditions.³

Medicare and Medicaid finance 58 percent of payments to hospitals for COVID-19 patients. Medicare beneficiaries are much more likely to be hospitalized but payment rates by Medicare are lower than payments for privately insured patients.⁴

The economic recession caused by the pandemic also has put current and future Medicare beneficiaries at financial risk. Many still in the workforce have lost jobs and will likely experience difficulty regaining employment.

Even prior to the COVID-19 pandemic, many Medicare beneficiaries with limited incomes and serious health problems faced financial hardships related to out-of-pocket health care expenses, including premiums for Medicare and supplemental coverage and outlays for deductibles and noncovered services (for example, dental, vision, hearing care, long-term services and supports).⁵ While the Affordable Care Act added an out-of-pocket limit for most private insurance and Medicare Advantage, traditional Medicare does not offer such protection, leaving many enrollees exposed to burdensome health costs.

In this policy brief we 1) summarize financial challenges faced by Medicare beneficiaries before and after the pandemic; 2) identify federal measures to assist beneficiaries financially during the pandemic; and 3) recommend policy changes to ensure beneficiaries with COVID-19, and potentially all beneficiaries, have affordable access to care.

MEDICARE AFFORDABILITY BEFORE THE PANDEMIC

Most Medicare beneficiaries live on fixed incomes and savings accumulated during working years. Approximately 17 million Medicare beneficiaries (28%) live on annual incomes below 150 percent of the federal poverty level, or less than \$18,000 a year for a single person (Exhibit 1).

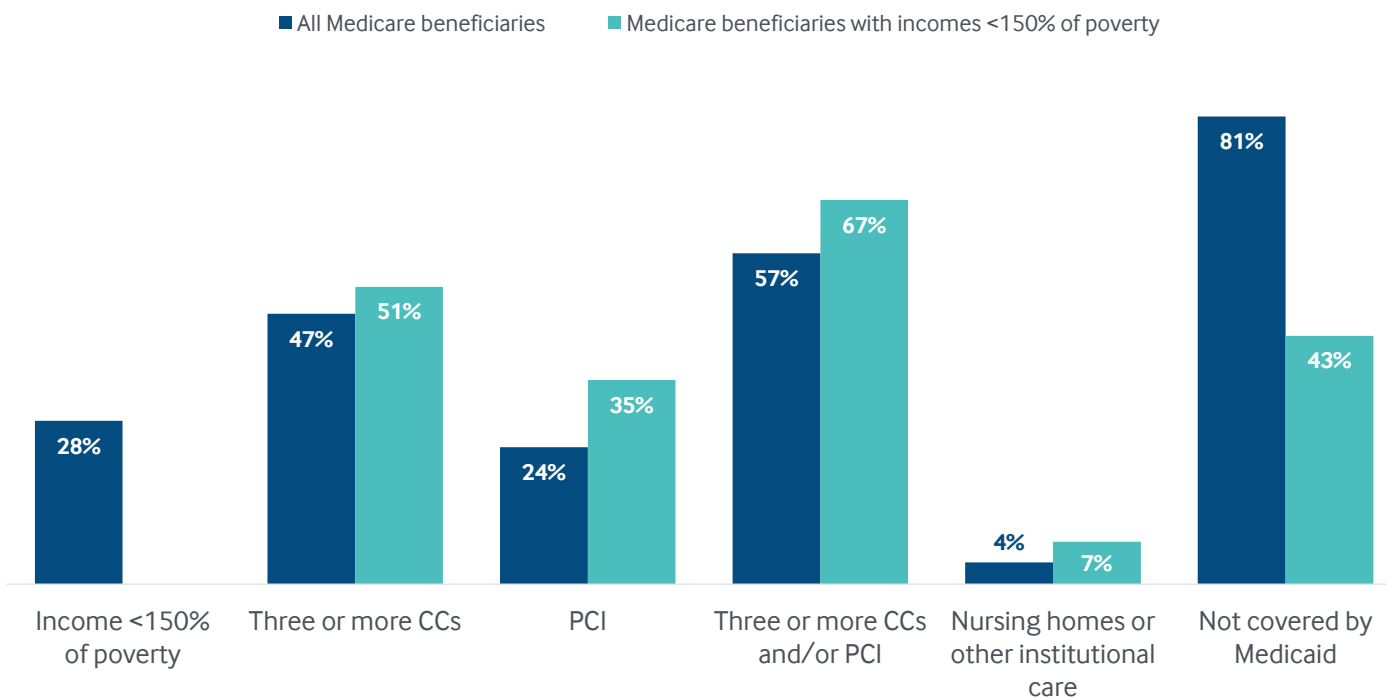
Poor health, multiple chronic conditions, and physical or cognitive impairment combined with financial insecurity accentuate the health and financial risks beneficiaries face. Among those beneficiaries with incomes below 150 percent of poverty, half have three or more chronic conditions, and about one in three (35%) have physical or cognitive impairments that causes difficulties with activities of daily living. One and a half million beneficiaries reside in nursing homes or other long-stay facilities.

Annual out-of-pocket costs average \$2,243 a year for Medicare beneficiaries who are dual eligible for Medicaid and have incomes below 150 percent of poverty and three or more chronic conditions or impairments. Out-of-pocket costs rise to \$3,731 a year for Medicare beneficiaries who meet the same criteria but have no supplemental coverage.⁶

In 2020, traditional Medicare beneficiaries pay annual premiums of \$1,735 for Part B Medicare coverage. The hospital deductible is currently \$1,408 per hospital episode, and physician services are covered after a \$198 annual deductible is met. Beneficiaries then pay 20 percent in coinsurance for all covered charges (including the costs of surgeons and physician-administered drugs, such as cancer treatments).

Beneficiaries also face, on average, \$476 a year for Medicare Part D prescription drug premiums.⁷ In 2020, Part D deductibles were \$435 a year. Even for outpatient prescription drugs, after reaching the out-of-pocket maximum of \$6,350 in 2020, beneficiaries remain on the hook for 5 percent of drug costs for the remainder of the year.

Exhibit 1. Characteristics of Medicare Beneficiaries Placing Them at Higher Risk for Short-Term and Longer-Term COVID-19 Consequences



Note: CCs = chronic conditions; PCI = physical or cognitive impairment.
 Data: Authors' analysis of the Medicare Current Beneficiary Survey 2017.

Given Medicare's inadequate financial protection, 90 percent of Medicare beneficiaries have Medicare Advantage managed care plans or supplemental coverage through retiree health plans, Medi-gap private coverage, or Medicaid.⁸ The cost of premiums for Medicare Part B and Part D as well as private supplemental coverage and out-of-pocket expenses consumes a large share of beneficiary incomes, particularly for those without Medicaid.⁹

Although very-low-income people may be eligible for Medicaid to supplement Medicare, 29 percent of Medicare's poor (defined as income at 100% of poverty, or less than \$12,120 if single) are not enrolled in Medicaid.

In addition, there is only limited help for the near-poor unless they incur high expenses and exhaust their savings. Of Medicare beneficiaries with incomes below 150 percent of poverty, 43 percent do not receive Medicaid assistance. A third of these beneficiaries spend 20 percent or more

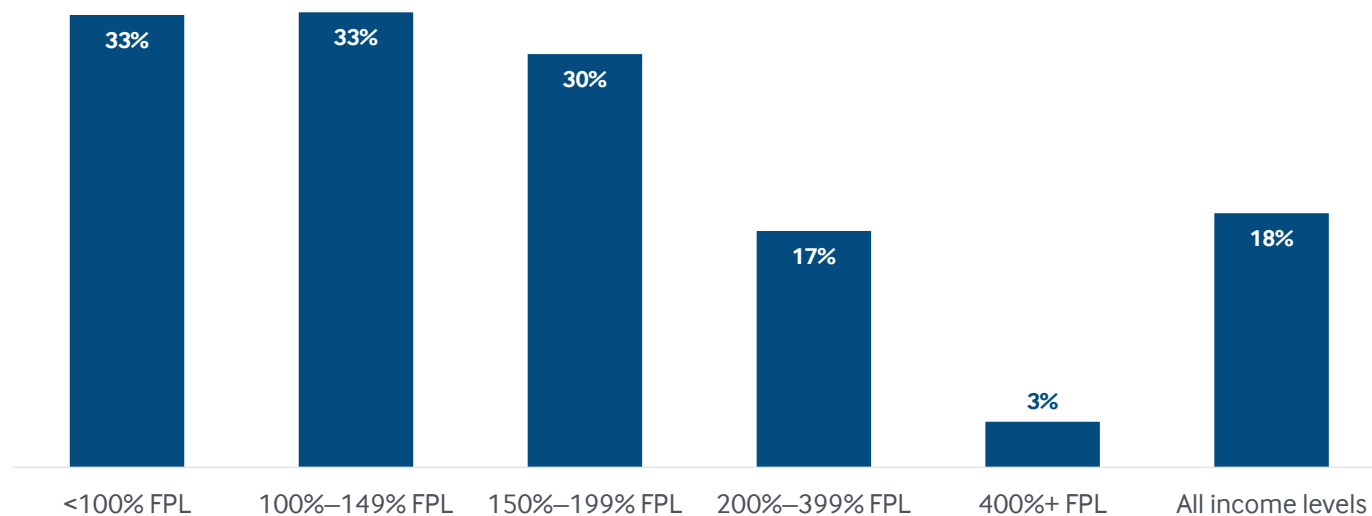
of their income on premiums and health care each year (Exhibit 2). Prior research has shown broad evidence of unmet care needs as well as financial hardship.¹⁰

Existing programs to assist low-income beneficiaries with Medicare cost-sharing, premiums, and Part D prescription drug costs leave substantial gaps in protection for Medicare's low-income beneficiaries. Low-income beneficiaries are most likely to have only Medicare coverage, and least likely to be protected by employer-sponsored retiree coverage.¹¹ Given the cost, few low-income beneficiaries buy private Medigap supplements.

Almost two-thirds of Medicare beneficiaries living in the community rely on some level of long-term services and supports, including personal care at home. These services are not covered under Medicare.¹² One in 12 beneficiaries with high long-term care needs reported spending more than \$1,000 in 2015 on assistive devices.¹⁵

Exhibit 2. Medicare Beneficiaries Spending 20 Percent or More on Premiums and Medical Care, by Poverty Level, 2017

Percent of federal poverty level, 2017



Note: FPL = federal poverty level.

Data: Authors' analysis of the Medicare Current Beneficiary Survey 2017.

Among Medicare beneficiaries who report needing help or having difficulty with an activity, many experience adverse consequences because their support needs are not met.¹⁴ They are at greater risk of hospitalization, nursing home placement, and entry into Medicaid.¹⁵ In addition, they experience lower quality of life because of difficulty toileting, going outside, and moving around the house.¹⁶

ECONOMIC IMPACT OF THE COVID-19 PANDEMIC ON BENEFICIARIES

During the COVID-19 pandemic, workers age 65 and older have experienced a surge in unemployment, rising to 15.6 percent in April 2020 from 3.7 percent in March, exceeding the unemployment rate for workers ages 25 to 54 by three percentage points.¹⁷ Unemployment also has risen sharply for workers approaching Medicare eligibility: 12.5 percent

of workers ages 55 to 64 were unemployed in April, up fourfold from March.¹⁸

Older workers are less likely to become reemployed than younger workers and, as a result, are more likely to simply retire and drop out of the labor force, taking Social Security as early as age 62.¹⁹ However, retirees who enroll in Social Security at age 62 receive 30 percent less each month than those who wait until age 67. In addition, those who retire early have less time to build up savings and are more likely to tap into those savings sooner.

All of these effects are compounded for minority and low-income Medicare beneficiaries who experience higher levels of unemployment, have lower incomes, and less accumulated savings. Fifteen percent of non-Hispanic white individuals over age 65 have incomes below 150 percent of poverty, but rates for Hispanic elderly people (36%) and Black elderly people (32%) are more than twice as high.²⁰

Minority elderly people have disproportionately lower earnings during their working years, are less likely to have retirement pensions, and have a higher incidence of chronic disease and uncovered health care expenses. As a result, seniors in racial/ethnic minority groups have, on average, greater health care needs and fewer are able to save for retirement.²¹ The age-adjusted hospitalization rate because of COVID-19 is 4.6 times higher among non-Hispanic Black and Hispanic people, than non-Hispanic white people.²²

MEDICARE POLICY CHANGES IN RESPONSE TO THE PANDEMIC

Medicare policy changes in response to the COVID-19 pandemic have been largely focused on providing financial assistance to hospitals and health care providers and easing regulatory requirements. The CARES Act increased Medicare payments to hospitals for COVID-19 patients by 20 percent.²³

Two important changes have been made to Medicare benefits. First, Medicare explicitly covers COVID-19 tests with no beneficiary cost-sharing. It also covers COVID-19 antibody (or “serology”) tests that have been authorized by the Food and Drug Administration.²⁴

Second, Medicare has temporarily covered telehealth visits. As a result, beneficiaries who are sheltering in place can minimize the risk of exposure to the coronavirus by obtaining care from their physicians and other health care providers by telephone, audiovisual technology, or website portals. Services covered include virtual check-ins, mental health counseling, and preventive health screening. Such services, other than preventive health screenings, are subject to regular Medicare cost-sharing requirements.

POLICY RECOMMENDATIONS

Research is needed on policy changes that will assist Medicare beneficiaries contracting the coronavirus, as well as ensure affordability and coverage for all beneficiaries. The cost and impact of a range of policy solutions needs to be estimated, using different scenarios related to the spread of COVID-19. These policy solutions include the following:

Waiving Cost-Sharing

One immediate action that would address financial worries among Medicare beneficiaries who contract the coronavirus would be to waive cost-sharing for those who don't have supplemental coverage. While fewer than one in 10 beneficiaries rely on Medicare alone, this group is disproportionately low-income.²⁵ This targeted action would provide immediate assurance to beneficiaries that they will not face financial hardship by seeking needed care to combat this disease.

Medicare as a Choice for Older Adults

Given the high rate of unemployment of those approaching eligibility for Medicare, consideration should be given to a targeted policy of offering Medicare as a choice for older adults ages 55 to 64.

Medicare Extra

Reduce Medicare cost-sharing for Part A to \$100 per year and place a ceiling of \$3,500 on beneficiary out-of-pocket costs. The authors estimated that these improved benefits would have cost Medicare an additional \$44 per beneficiary per month in 2016.²⁶

Low-Income Subsidies

With more Medicare beneficiaries facing financial hardship, priority should be given to providing assistance with premiums and cost-sharing to all Medicare beneficiaries with incomes below 150 percent of the poverty level. Prior research estimates that this targeted low-income reform would help an estimated 8.1 million Medicare beneficiaries who do not currently receive Medicaid or extra assistance.²⁷ Updated research estimating the cost and benefit of administering low-income assistance directly through Medicare without an asset test (similar to the Part D low-income assistance test) is needed.

Coverage of Dental, Vision, and Hearing Services

Research is also needed on options for adding a dental, vision, and hearing services package of benefits to traditional Medicare. One promising option is a targeted benefit under Part B, which was passed by the House of Representatives in 2019 as part of the Elijah E. Cummings Lower Drug Costs Now Act [H.R.3].²⁸ A beginning step would be to cover preventive and maintenance dental, vision, and hearing services, such as dental cleanings or hearing loss rehabilitation services that were postponed or neglected during the pandemic.

Medicare Help at Home

One option for helping Medicare beneficiaries continue to live independently is to provide targeted home- and community-based services for these beneficiaries. For instance, this benefit might cover up to 20 hours weekly of personal care for individuals with two or more functional limitations or severe cognitive impairments.²⁹ An alternative incremental approach would be to extend the same flexibility to providers who care for traditional Medicare beneficiaries that is currently afforded to Medicare Advantage plans to provide nonmedical benefits, including personal care, meal delivery services, or home modifications.³⁰ Eligibility for additional nonmedical services could be linked with the eligibility process for the Part D low-income subsidy. This would reduce administrative burden while prioritizing beneficiaries with the highest needs.

Medicare Part A Solvency

The economic downturn, likely to be the deepest since the Great Depression, will result in a sharp reduction in payroll tax revenues that are used to finance Medicare Part A, which covers hospital and posthospital care. In April 2020, the Medicare trustees projected that the Part A trust fund will be insolvent by 2026 under prepandemic conditions.³¹ It is anticipated that the trust fund depletion date could differ substantially from this estimate as a result of the health and economic impacts of the pandemic.

Previous debates on how to ensure trust fund solvency raised concerns about shifting more costs to beneficiaries.³² Alternatively, consideration should

be given to merging the Part A and Part B trust funds and ensuring that general revenues are committed to maintaining fiscal solvency. Research on new sources of revenue that could ensure the financial stability of the program postpandemic could help identify the best way forward. A recent study has estimated the effect of options of ensuring adequate financing, including:

- shifting home health benefits to Part B
- implementing site-neutral payments for all hospitals
- adjusting the physician add-on to the Part B drug reimbursement structure
- competitive bidding for Medicare Advantage.³³

CONCLUSION

Although Medicare provides a stable, trusted source of health insurance for older adults and younger people with disabilities, the program's benefit design can leave beneficiaries exposed to high out-of-pocket costs and premiums. In the current crisis, this is particularly a concern for those without supplemental coverage. Waiving cost-sharing for beneficiaries with COVID-19 would provide immediate assistance. Offering Medicare as a choice for older adults ages 55 to 64 and waiving cost-sharing for those with COVID-19 would similarly assist a vulnerable population experiencing job loss and dim prospects for reemployment. Longer-term, the policies described in this issue brief could help all Medicare beneficiaries, significantly lowering their risk of high cost burdens and ensuring access to care for Medicare's elderly and disabled beneficiaries.

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Editorial support was provided by Maggie Van Dyke.

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