American Hospital Association®

Reject Reductions to Assistance to Low-income Medicare Beneficiaries (Bad Debt)

AHA View

The Medicare program must continue to reimburse hospitals for the unpaid debt they incur when low-income Medicare beneficiaries cannot make their coinsurance and deductible payments. Congress should reject further cuts to hospital payments for assistance in covering these financial obligations.

Background

The Medicare program requires its beneficiaries to pay a portion of the cost of their care, for example, through deductibles and coinsurance. Many low-income beneficiaries cannot pay these amounts to the hospital, resulting in unpaid debt (sometimes referred to as "bad debt"). Historically, Medicare reimbursed hospitals for 100 percent of the debt incurred by Medicare beneficiaries, particularly those with low incomes. However, the Balanced Budget Act of 1997 reduced that amount to 75 percent in 1998, 60 percent in 1999 and 55 percent in 2000 and beyond. In the Benefits Improvement and Protections Act of 2000, Congress increased reimbursement to 70 percent when the negative effects of cutting payments for the most vulnerable and poor Medicare beneficiaries became evident. The Middle Class Tax Relief and Job Creation Act of 2012 again reduced these payments – for prospective payment system (PPS) hospitals from 70 percent to 65 percent beginning in fiscal year (FY) 2013, and for critical access hospitals (CAHs) from 100 percent to 65 percent, phased-in over three years beginning in FY 2013. Thus, for CAHs, Medicare will pay 65 percent of allowable bad debt in 2015 and beyond.

The Centers for Medicare & Medicaid Services (CMS) has set forth stringent criteria that must be met in order for unpaid Medicare deductibles and coinsurance to be reimbursed. For example, CMS requires hospitals to ensure that reasonable collection efforts were made and the debt was actually uncollectible.

Key Facts

- **Out-of-Pocket Expenses Can Be Significant.** Beneficiaries' out-of-pocket expenses for Medicare can be significant and, unlike much private insurance, there is no maximum amount. In 2015, the Part A hospital deductible is $1,260 per benefit period. The Part B deductible is $147 per year and the Part B coinsurance is 20 percent of the Medicare-approved payment amount. In addition, there is a Part B premium of about $105 per month, which is "means tested" depending on the beneficiary's income. Although this premium cannot become bad debt, it still represents an out-of-pocket expense that could contribute to seniors' inability to pay their other out-of-pocket expenses – deductibles and coinsurance. This is especially true given that about half of Medicare beneficiaries have incomes between 100 and 300 percent of the federal poverty level (FPL), or $11,770 to $35,310 for an individual. Below is an example of the cost sharing that would be incurred by a Medicare beneficiary with one hospital stay and associated physician visits in 2015 (in addition to this cost sharing, the beneficiary will have paid approximately $1,260 in Part B premiums for the year).

Service	Medicare-approved Payment	Beneficiary Cost-sharing
Inpatient Hospital Stay	$16,000	$1,260
Physician	$10,000	$2,147
Total	**$26,000**	**$3,407 + $1,260 in Part B premium = $4,667**

- **Dually Eligible Beneficiaries Account for Large Portion of Bad Debt.** In addition, about 20 percent of Medicare beneficiaries are dually eligible – low-income seniors and younger persons with disabilities who are enrolled in both Medicare and Medicaid. To qualify, a beneficiary's income is generally limited to less than the FPL – $11,770 for a single person in FY 2015. These Medicare beneficiaries receive coverage under Medicaid, as well as Medicaid's assistance in paying Medicare premiums and cost sharing. Cost sharing varies by state; however, Medicaid typically pays much less than the full deductible and co-insurance due. The unpaid amount is classified as Medicare bad debt. Although these dually eligible beneficiaries account for roughly 20 percent of Medicare beneficiaries, they account for about 59 percent of hospitals' Medicare bad debt.

  Finally, beneficiaries with incomes above the dual-eligible qualification level but below 120 percent of the FPL also may qualify for Medicaid assistance in paying Medicare premiums and cost sharing. For these beneficiaries as well, Medicaid typically pays much less than the full deductible and coinsurance due to hospitals, and the unpaid amount is classified as bad debt.

- **Disproportionate Effect on Safety-net and Rural Hospitals.** Reducing or eliminating reimbursement for unpaid debts disproportionately affects hospitals that treat high numbers of low-income Medicare beneficiaries – safety-net hospitals and rural hospitals:

  - Inner-city urban communities have large numbers and high proportions of Medicaid recipients and uninsured residents, and are highly likely to have large numbers and high proportions of low-income Medicare beneficiaries.
  - Hospitals in the highest quartile of disproportionate share hospital (DSH) patient percentages have Medicare bad debt reimbursement as a percentage of their Medicare revenue that is more than two times higher than hospitals in the lowest quartile of DSH patient percentages, on average.
  - Rural hospitals' small size leaves them with more limited cash flow and less of an ability to absorb payment cuts, which puts them and the patients they serve at risk. This is especially true given that rural hospitals have Medicare bad debt levels that are 50 percent higher than urban hospitals, on average.

- **The Medicare Program Already Pays Less than the Cost of Care.** The Medicare program already pays less than the cost of providing care to Medicare beneficiaries – only 88 cents on the dollar. Further reductions to hospital reimbursements for assistance covering the debts of low-income Medicare beneficiaries are inappropriate and exacerbate government underfunding, especially for those hospitals that serve many low-income beneficiaries.