FACTSHEET

# Assistance to Low-Income Medicare Beneficiaries (bad debt)

## THE ISSUE

**The Medicare program requires its beneficiaries to pay a portion of the cost of their care, for example, through the inpatient hospital deductible of about $1,100 and through the outpatient hospital coinsurance of 20 percent.** Many low-income beneficiaries cannot pay these amounts to the hospital, resulting in unpaid debt (sometimes referred to as "bad debt"). Historically, the Medicare program has reimbursed hospitals for a portion of the debt incurred by Medicare beneficiaries, particularly those with low incomes. House bill H.R. 3630 would reduce these payments from 70 percent for hospitals and from 100 percent for critical access hospitals to 55 percent, over three years starting in 2013. Thus, for hospitals, this is a reduction of more than 20 percent. For critical access hospitals, the cut is much larger reduction – 45 percent.

## AHA POSITION

**Reject cuts to hospital payments to for assistance in covering the debts of low-income Medicare beneficiaries.**

## WHY?

- **For America's already financially constrained hospitals, reducing or eliminating this reimbursement would disproportionately affect hospitals that treat high numbers of low-income Medicare beneficiaries – safety-net hospitals and rural hospitals.**
  - It will leave safety-net hospitals with less of an ability to serve low-income Medicare beneficiaries who may not be able to afford cost-sharing requirements.
  - It will put rural hospitals and the patients they serve under severe stress, as their small size leaves them with more limited cash flow and less of an ability to absorb such losses. In addition, rural hospitals have Medicare bad debt levels that are 60 percent higher than urban hospitals, on average.
- **Medicaid frequently underpays beneficiaries' Medicare cost-sharing obligations, leading to high levels of dual-eligible beneficiary debt. Dually eligible beneficiaries account for roughly 20 percent of Medicare beneficiaries, but about 55 percent of hospitals' Medicare bad debt.**
- **The Medicare program already pays less than the cost of providing care to Medicare beneficiaries.** Further reductions would exacerbate this problem, especially for those hospitals that serve many low-income beneficiaries. Cutting reimbursement to hospitals for assistance to cover the debts of low-income Medicare beneficiaries while still paying less than the cost of care to Medicare beneficiaries is inappropriate.
- **Under Medicare's statutory reasonable cost principles, costs of care that are attributable to Medicare beneficiaries cannot be shifted to non-Medicare patients, and vice versa.** Thus, when hospitals are unable to collect cost-sharing payments owed by Medicare beneficiaries, they record these payments as bad debt and are reimbursed a portion of that Medicare debt directly from the Centers for Medicare & Medicaid Services (CMS).
- **Currently, Medicare reimburses hospitals for 70 percent of Medicare beneficiary debts.** Historically, Medicare reimbursed hospitals for 100 percent of Medicare beneficiary debt; however, the *Balanced Budget Act of 1997* reduced that 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.

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# KEY FACTS

- Beneficiaries' out-of-pocket expenses for Medicare can be significant. In 2011, the Part A hospital deductible is $1,132 per benefit period. The Part B deductible is $162 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 $100 per month, which varies depending on the beneficiary's income. Although this premium cannot turn into 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.
- About 20 percent of Medicare beneficiaries are dual eligibles – low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs. To qualify as a dual eligible, a beneficiary's income is generally limited to less than the Federal Poverty Level (FPL) – $10,890 for a single person in 2011. These Medicare beneficiaries receive coverage under Medicaid, as well as Medicaid's assistance in paying Medicare premiums and cost-sharing. However, Medicaid typically pays much less than the full deductible and coinsurance due. The unpaid amount is classified as Medicare bad debt. 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, and the unpaid amount is classified as bad debt.
- Inner-city urban communities have large numbers and high proportions of Medicaid recipients and uninsured residents, and are also highly likely to have large numbers and high proportions of low-income Medicare beneficiaries.
- Hospitals in the highest quartile of disproportion¬ate share hospital (DSH) patient percentages have Medicare bad debt reimbursement as a percentage of their Medicare revenue that are 2.5 times higher than hospitals in the lowest quartile of DSH patient percentages, on average.
- Beneficiaries with incomes just above 120 percent of the FPL do not receive Medicaid assistance, and cost sharing can represent a substantial portion of their income – they often cannot afford it. About half of Medicare beneficiaries have incomes between 100 and 300 percent of the FPL.
- 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 2011 (in addition to this cost sharing, the beneficiary will have paid approximately $1,200 in Part B premiums for the year).

| Service | Medicare-Approved Payment | Beneficiary Cost-Sharing |
|---|---|---|
| Inpatient Hospital Stay | $16,653 | $1,132 |
| Physician | $10,514 | $2,232 |
| **Total** | **$27,167** | **$3,364** |

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 that, to obtain reimbursement to cover the debts of Medicare beneficiaries, the hospital ensure that reasonable collection efforts were made and the debt was actually uncollectible. These criterion create substantial administrative hurdles for hospitals in practice.

An example of what a hospital must do in order to meet the criterion is:

1. Upon admission and at discharge, the hospital lets the patient know that they have a deductible and copayment and that they will be billed when Medicare pays the hospital;
2. The patient receives an explanation of benefits from Medicare, which informs them of their liability;
3. When Medicare pays the hospital, the hospital sends a bill to the patient;
4. After 30 days with no payment, the hospital sends another bill to the patient;
5. After another 30 days with no payment, the hospital sends another bill to the patient;
6. The hospital follows up with personal phone call to the patient;
7. After another 30 days with no payment, the hospital sends another bill to the patient;
8. The hospital follows up with another personal phone call and a collection letter to the patient;
9. After another 30 days, hospital sends the bill to a collection agency;
10. After 90 days, the collection agency returns the bill to the hospital as uncollectible;
11. At this point, the hospital has satisfied Medicare's criteria and may claim reimbursement for the debt.

Finally, CMS requires hospitals to use the same collection practices for private pay patients as it does for Medicare patients. Because hospitals have a strong incentive to collect private pay debts, they have an equally strong incentive, therefore, to use thorough collection practices for all their patients, Medicare beneficiaries included.