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Exploring 'Medicare for All' proposals and addressing inevitable out-of-pocket expenses

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Proposals to expand Medicare are not new, and discussions surrounding expanding Medicare eligibility have occurred at many junctures in the past. However, lately, possible Medicare eligibility expansion is gaining more attention, including in the media, as policymakers continue to grapple with perennial health care issues, such as the affordability and availability of health insurance coverage and controlling the underlying costs of health care services.

Current proposals are still in the idea stage of development, and although Congress recently held hearings to explore some of these options, no proposal is moving through the legislative process – at least not yet. Enactment of any proposal in the near term is not, and may never be, likely. However, the recent attention to these proposals raises a number of questions, one of which is: "What sort of out-of-pocket health care-related expenses could individuals face in a single-payer health care system?"

This article provides a high-level overview of the current Medicare program and proposals to expand Medicare. It also discusses potential exposure to out-of-pocket expenses and options to help individuals plan for such expenses, including the role of supplemental health benefits.

What does Medicare look like today?

Medicare covers almost 60 million Americans, and the vast majority (85%) of individuals enrolled in Medicare qualify because they are 65 and older.

Individuals can qualify for Medicare if they are:

- 65 and older.
- Under age 65 with certain disabilities.
- Any age with end-stage renal disease.

Medicare benefits include three parts:

- ✔ **Part A hospital coverage:** Helps cover costs for inpatient hospital care, post-admission skilled nursing facility care, hospice care and home health care.
- ✔ **Optional Part B medical coverage:** Helps cover costs for services from doctors and other health care professionals, outpatient care and procedures, home health care, durable medical equipment (e.g., wheelchairs and walkers) and some preventive services.
- ✔ **Optional Part D prescription drug coverage:** Helps cover the cost of prescription drugs. Private insurance companies typically run Medicare Part D plans under rules set by Medicare.

Medicare offers enrollees two different ways to receive their coverage.

Individuals eligible for Medicare can choose between two options: (1) Traditional Medicare and (2) Medicare Advantage. Medicare Advantage plans are run by private insurers that contract with Medicare. There are significant differences between the two options and among different Medicare Advantage plans. Individuals need to consider their own personal circumstances in making their choice for coverage.

The following table provides a very high-level overview of some of the differences between Traditional Medicare and Medicare Advantage.

	Traditional Medicare	Medicare Advantage
Coverage and premiums	Includes Part A and Part B. Individuals at least age 65 and eligible for Social Security are automatically enrolled in Part A. Part A doesn't require a premium for individuals who paid payroll taxes for at least 40 calendar quarters (10 years).	Combines Medicare Parts A, B and often D into a single plan. There may be a premium for the Medicare Advantage plan, and the participant pays their Part B premium to Medicare. Some Medicare Advantage plans do not require a premium, and some help pay all or part of the Part B premium. Medicare Advantage may include benefits in addition to those covered by traditional Medicare, such as vision or dental benefits.
Part D prescription drug coverage	Individuals who want Part D coverage need to enroll in a stand-alone Medicare private drug plan. A separate premium is required.	Part D coverage is often included. If not included, individuals who want this coverage must choose a Part D plan and pay the required premium.
Choice of health care provider	Enrollees may go to any doctor or other health care provider that accepts Medicare.	Generally, enrollees need to use in-network health care providers.
Out-of-pocket costs for covered services	Deductibles, copayments and coinsurance amounts apply under Parts A and B. For example, for covered services under Part B, enrollees must pay 20% of the Medicare allowed cost of the service. For Part D coverage, the specific out-of-pocket costs are determined by the plan.	The amount of any deductible, copayment or coinsurance for covered services varies from plan to plan. Some plans have relatively low out-of-pocket costs.

	Traditional Medicare	Medicare Advantage
Limit on out-of-pocket costs	No limit on out-of-pocket costs.	Plans have a yearly limit on what enrollees pay out of pocket for Medicare Part A and B in-network covered services.
Availability of Medigap coverage	Enrollees may choose to buy separate, privately offered Medigap coverage to help pay for out-of-pocket costs such as deductibles and coinsurance.	Not available.

Medicare expansion proposals

A variety of proposals could expand Medicare eligibility or create a new public health plan option based on Medicare. Current proposals to expand Medicare (or Medicare-like plans) fall into the following three general categories. Within each category, the details of specific proposals may vary. In addition, many issues need to be resolved if any of these proposals move forward in the legislative process. For example, most proposals do not address the critical issue of how new health plan options are paid for.

1. **Option for older individuals to buy into Medicare:** This is a relatively incremental approach that targets individuals age 50 or 55 and older who are not yet eligible for Medicare. This type of proposal is designed to assist older individuals who may not have employer-sponsored health plan coverage (particularly if they are retired) and often face higher age-based premiums in the individual market.

2. **Medicare for All:** This is the most extreme approach and is often referred to as "single payer" because the federal government pays health care providers directly for covered services, just as is the case now under traditional Medicare. This approach proposes replacing the current health care system with a system based on traditional Medicare. This system phases out individual and group market private primary health coverage.

3. **Public health plan options:** A number of proposals create a new public health plan option with some features based on Medicare, but would be offered through the Affordable Care Act exchanges. The public plan option may include many similar requirements as ACA-qualified health plans, such as coverage of essential health benefits. Some proposals also include state-based public options.

The reality of out-of-pocket expenses

The practical reality is that regardless of their primary major medical health coverage, individuals face health-related out-of-pocket expenses. Some of the common circumstances that result in out-of-pocket expenses for health coverage, ***in addition to premiums***, include:

- **Covered services:** If services are covered by a health plan, the participant may have out-of-pocket expenses due to:
  - Deductibles: The amount the participant owes for covered health care services before their health plan begins to pay any amount.
  - Copayments: A fixed amount the participant pays for a covered service (e.g., $25 for a primary care visit).
  - Coinsurance: The participant's share of the cost of a covered service calculated as a percent (e.g., 20%) of the allowed amount for the service.
  - Treatment limits: Some plans may limit the number of treatments for a particular service (e.g., a limit on the number of days of skilled nursing care or physical therapy treatments for an injury). In such cases, treatments in excess of the plan's limit are not covered services.
- **Non-covered health services:** The specific services covered by, and not covered by, a health plan vary based on the plan. Some of the services that are not covered by Medicare Parts A and B include: skilled nursing care (the absence of a hospital admission), most dental care, eye exams related to prescribing glasses, dentures, hearing aids and exams for fitting them, routine foot care, infertility treatments, experimental treatments or drugs, long-term care and cosmetic surgery. In addition, prescription drug expenses are not covered unless the individual enrolls and pays for a separate Part D plan or is enrolled in a Medicare Advantage plan that provides Part D coverage.
- **Other accident or health-related expenses:** In the event of an accident or illness, individuals may face a variety of expenses that primary health insurance is not designed to cover, such as transportation to the doctor or hospital, meal and lodging expenses to be near a hospitalized family member, respite care, bills or other household expenses.

In 2019, the Kaiser Family Foundation reported that the average out-of-pocket expense for persons in both Medicare Parts A and B in 2016 was $5,806, including medical expenses, long-term care services, and premiums for Medigap and other supplemental insurance. The Kaiser Family Foundation also recently reported that the average deductible for employer-sponsored plans is $1,573. Yet, the Federal Reserve recently reported in May 2019 that almost 40% of Americans have difficulty handling an unexpected $400 expense, either having to borrow or sell something to pay for the expense or not being able to cover the expense at all. In addition, one-fourth of adults reported skipping medical care in 2018 because they were unable to afford the cost.

Addressing out-of-pocket health-related costs

Supplemental insurance policies (e.g., accident, cancer and hospital indemnity) provide an additional layer of financial protection in the case of an accident or illness. These types of policies are not intended as and do not serve as primary major medical coverage or a substitute for such coverage. For this reason, federal and state laws have long recognized these plans as "excepted benefits." They are generally "excepted" from requirements that apply to major medical coverage, including the ACA requirements.

These types of policies include:

- Accident.
- Disability.
- Specified disease policies (e.g., cancer or critical illness policies).
- Hospital fixed indemnity and other fixed indemnity policies that pay a specified amount due to hospitalization or other specified medical event.

Unlike typical primary medical policies or Medicare, these policies generally pay a cash benefit triggered by a covered accident or illness unrelated to the amount of the expense(s) incurred. This cash benefit is available for any purpose as determined by the policyholder, whether to pay for the out-of-pocket costs that add up even with major medical insurance or for other financial needs.

Conclusion

Regardless of what big or small changes are ahead for our health care system, one reality is that there will always be health-related costs that are not covered by primary medical insurance. Supplemental benefits, including specified disease, critical illness, and hospital indemnity and other fixed indemnity health excepted benefits, are one way individuals can help reduce their exposure to unexpected costs.