

## THE ISSUE

Historically, the Medicare program has reimbursed hospitals for a portion of the bad debt incurred by its beneficiaries. Bad debt occurs because many Medicare beneficiaries cannot pay their required cost sharing — for example, the annual inpatient deductible and 20 percent coinsurance for outpatient and physician services. The President's Plan for Economic Growth and Deficit Reduction proposes to reduce bad debt payments to 25 percent (from the current 70 percent) for all eligible providers, including hospitals, over three years starting in 2013. Additionally, the Simpson-Bowles deficit commission and others have advocated for a severe reduction in, or elimination of, Medicare reimbursement for beneficiaries' bad debt. Proposed reductions range from \$14 to \$26 billion.

## AHA POSITION

**Reject cuts in Medicare bad debt reimbursement for hospitals.**

## WHY?

- **Reducing or eliminating Medicare bad debt could result in the loss of health services and programs that are essential for Medicare beneficiaries, as well as other patients.**
- **The Medicare program already pays less than the cost of providing care to Medicare beneficiaries.** Further reductions would exacerbate this problem.
- **For America's already financially constrained hospitals, reducing or eliminating Medicare bad debt 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 bad-debt losses. In addition, rural hospitals have Medicare bad debt percentages 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 bad debt.** Dually eligible beneficiaries account for roughly 20 percent of Medicare beneficiaries, but about 55 percent of hospitals' Medicare bad debt.

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## KEY FACTS

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 the amount directly from the Centers for Medicare & Medicaid Services (CMS).

Currently, Medicare reimburses hospitals for 70 percent of Medicare bad debts. Historically, Medicare reimbursed hospitals for 100 percent of Medicare bad 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 bad debt reimbursement to 70 percent when the effects of cutting payments for the most vulnerable and poor Medicare beneficiaries became evident.

### Key facts about Medicare bad debt and its impact on hospitals:

- Beneficiaries' out-of-pocket expenses for Medicare can be substantial. 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 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 disproportionate 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