

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 more than \$1,200 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. The Middle Class Tax Relief and Job Creation Act of 2012 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 paid 88 percent of allowable bad debt in FY 2013, 76 percent in FY 2014, and 65 percent in 2015 and beyond.

AHA POSITION

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

WHY?

- **Reducing or eliminating this reimbursement disproportionately affects hospitals that treat high numbers of low-income Medicare beneficiaries – safety-net hospitals and rural hospitals:**
 - It leaves safety-net hospitals with less ability to serve low-income Medicare beneficiaries, who may not be able to afford cost-sharing requirements.
 - It puts 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 almost 50 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 59 percent of hospitals’ Medicare bad debt.**
- **The Medicare program already pays less than the cost of providing care to Medicare beneficiaries.** Reductions 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).
- **Medicare reimburses PPS hospitals for 65 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. The Middle Class Tax Relief and Job Creation Act of 2012 reduced it to 65 percent for PPS hospitals in 2013 and beyond.

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KEY FACTS

- Beneficiaries' out-of-pocket expenses for Medicare can be significant. 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 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) – \$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 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 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.
- About half of Medicare beneficiaries have incomes between 100 and 300 percent of the FPL, and cost sharing can represent a substantial portion of their income – they often cannot afford it.
- 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	\$16,653	\$1,260
Physician	\$10,514	\$2,250
Total	\$27,167	\$3,510

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. Hospitals must meet specific and detailed criteria to receive reimbursement.

A typical example of what a hospital must do in order to meet the criteria:

1. Upon admission and at discharge, the hospital lets the patient know that he/she has a deductible and copayment and that he/she will be billed when Medicare pays the hospital;
2. The patient receives an explanation of benefits from Medicare, which informs him/her of his/her 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 a 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, the 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.

