Medicare Services and Cost Shifting

NAIC Senior Issues Task Force

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Consumer Protections and Medigap

- Medigap plans are an important consumer protection from economic disaster
  - Fewer MA plan available in rural area
  - Narrowing MA networks
  - Doctors and specialists leave MA plans
  - Retiree plan choices shrinking, employers paying stipends not premiums
- Rising health care costs shouldn’t become an excuse for restricting access to Medigap
- Access to protection from health care expenses is an important consumer protection and public policy goal

Medicare Coverage Structure

- **Medicare Part A** (inpatient)
  - Premium tax paid while working
  - Hospital stays, deductible is episodic (based on length of time between stays)
    - Daily dollar amount copayments for stays after 60 days
  - Nursing home stays no deductible
    - Daily dollar amount copayments after 20 days

- **Medicare Part B** (outpatient)
  - Premium paid monthly
  - Annual deductible
  - Coinsurance based on percentage of Medicare payment
  - Self administered drugs covered separately (Part D)

Medicare Structure Creates Costs Disparity

- **Medicare Part A benefit structure**
  - Limits beneficiary costs differently than Part B
    - High episodic deductible
    - Limited daily costs
      - Exception long length of stay based on per day dollar amount
  - Beneficiary cost sharing paid by most Medigap plans

- **Medicare Part B**
  - Unlimited annual costs
    - Lower annual deductible
    - Higher percentage coinsurance for every service or supply of medications
      - Excess charges for non-participating providers and suppliers
  - Beneficiary cost sharing paid by most Medigap plans

Part B Outpatient Sites and Services

- **Outpatient sites of care**
  - Hospital outpatient Departments
  - Ambulatory surgical centers
  - Specialized surgical offices
- **Medical outpatient services**
  - Doctor and Medicare treatment, services, supplies, DME
  - Outpatient surgical and treatment procedures
  - Outpatient Part B drugs
  - Infusions
  - Radiology studies
  - Radiological procedures
  - Diagnostic cardiology
  - Ambulance transportation
- **Shifting services are leading to increased Medicare Part B cost-sharing**
  - Paid by supplemental coverage

Reasons that Services Have Shifted from Medicare Part A to Medicare Part B

- **Observation Rule**
  - In 2013, CMS Rule implemented a timed-based presumption of medical necessity; two nights or less in a hospital would be considered outpatient observation. [1, 2] If a patient is in the hospital for three midnights, Medicare A will pay. If two nights or less, Medicare Part B is largely responsible, with patient and/or patient insurance paying the 20% coinsurance.
  - Extends to skilled nursing facilities, Medicare Part A will pay SNF if the beneficiary was in the hospital for at least three nights. If not, Medicare Part B is largely responsible for services, with patient and/or patient insurance paying the 20% coinsurance.[3]
- **Technological advances: inpatient procedures moving to outpatient procedures**
  - Knee replacement and hip replacement are two examples.[4]
- **Needed physician-administered drugs**
  - Drugs for macular degeneration and cancer are two examples.[5]

Suggested Actions for States or the NAIC

- **Closer Examination of**
  - Closed blocks and new lower priced offerings by sister companies
    - Consider amendment to NAIC Model Regulation #651 Section 15
  - Commission and other inducements or disincentives
    - For the sale of favored products only to certain favorable applicants, or
    - Withholding the sale of certain products to unfavored applicants
    - Loss ratio calculations
- **Consider**
  - Potential forms of risk adjustment to mitigate cost
  - Legitimate tradeoffs between access and cost
- **Support**
  - Annual cap on out-of-pocket Part B costs
  - Other federal cost limitations, including changing the
- **Resist**
  - Efforts to narrow existing access to coverage
  - Efforts to blame beneficiaries for cost effects of coverage

Endnotes

[1] 78 Fed. Reg. 27486, 27644 (May 10, 2013). *See* CMA, "CMS Addresses Observation Status Again . . . And Again, No Help for Beneficiaries," (Weekly Alert, May 16, 2013), https://www.medicareadvocacy.org/cms-addresses-observation-status-again-and-again-no-help-for-beneficiaries/.

[2] https://medicareadvocacy.org/observation-status-new-final-rules-from-cms-do-not-help-medicare-beneficiaries/#_edn2

[3] Goldstein JN. The Unintended Consequences of Medicare Observation Status. Dela J Public Health. 2019 Dec 18;5(5):26-28. doi: 10.32481/djph.2019.12.006. PMID: 34467067; PMCID: PMC8389145. https://pmc.ncbi.nlm.nih.gov/articles/PMC8389145/

[4] Chen AT, Saynisch PA, Song H, Smith-McLallen A, David G, Bergman A. Inpatient to Outpatient Shifts in Surgical Care: Persistence of COVID-19 Era Changes and Socioeconomic Variations. Med Care Res Rev. 2026 Apr;83(2):156-164. doi: 10.1177/10775587251396718. Epub 2025 Dec 6. PMID: 41351455; PMCID: PMC12946234. https://pmc.ncbi.nlm.nih.gov/articles/PMC12946234/

[5] https://www.kff.org/medicare/medicare-part-b-drugs-cost-implications-for-beneficiaries-in-traditional-medicare-and-medicare-advantage/

[6] **https://www.johnahartford.org/blog/view/fending-off-financial-catastrophe-hospital-observation-status-and-medicare-policy**

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