

Medicare Benefit Redesign: Enhancing Affordability for Beneficiaries While Promoting Choice and Competition

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ABSTRACT

ISSUE: Out-of-pocket expenses are capped for enrollees in Medicare Advantage (MA) plans but not for beneficiaries in traditional Medicare, which also requires a high deductible for hospital care. The need for supplemental Medigap coverage adds to traditional Medicare's complexity and administrative costs. Shortfalls in financial protection also make it difficult to offer traditional Medicare as a choice for people under age 65, as some have proposed.

GOALS: Describe alternative benefit designs that would limit out-of-pocket costs for traditional Medicare's core services, assess their cost, and illustrate financing mechanisms.

METHODS: Analysis of a \$3,500 ceiling on annual out-of-pocket expenses for Parts A and B benefits and options for replacing Part A hospital cost-sharing with a \$350 or \$100 copayment per admission.

KEY FINDINGS: Estimates of the costs of the reforms are \$36–\$44 per beneficiary per month, assuming no behavioral or supplemental coverage changes. This could be financed by a \$9–\$11 increase in premiums combined with a 0.3-to-0.4-percentage-point increase in the Medicare payroll tax (split between employer and employees). Medicaid costs would decrease, while employers, retirees, and Medigap enrollees would see reduced premiums.

CONCLUSION: The reforms would improve affordability and put traditional Medicare on a more equal footing with MA plans. They would also make it easier to open traditional Medicare to people under age 65.

TOPLINES

- ▶ High hospital deductibles and exposure to other out-of-pocket costs have long been recognized as a shortcoming in Medicare's benefit design.
- ▶ Redesigning traditional Medicare to limit out-of-pocket costs would make coverage more affordable, stimulate competition in Medicare Advantage markets, and make it easier to offer Medicare to people under age 65.

INTRODUCTION

Providing coverage to 57 million elderly and disabled adults, Medicare is a pillar of the U.S. health insurance system. But with no ceiling on out-of-pocket costs for covered benefits, Medicare leaves its enrollees exposed to burdensome health costs. This lack of financial protection has long been recognized as a flaw in the program's design.

Medicare's deductible per hospital episode as of 2018 is \$1,340. Beneficiaries are also required to pay 20 percent of their medical care expenses, including those for cancer drugs and specialist care, and there is no limit in their out-of-pocket spending. Beneficiaries pay a monthly premium that amounts to \$1,300 a year per person, \$1,462 for those newly eligible for Medicare.¹

Given this cost exposure, beneficiaries choosing traditional Medicare commonly seek Medigap supplemental coverage. But Medigap plans are expensive, averaging \$2,000 in annual premiums, even more for the most comprehensive plans.² In part, this reflects administrative costs that add, on average, 25 percent to claims costs.³

If they are willing to accept a more limited provider network and plan-use rules, beneficiaries can opt instead for a Medicare Advantage (MA) plan, which is required to place limits on out-of-pocket costs. Once they choose a plan, beneficiaries who later wish to return to traditional Medicare can face barriers in the Medigap supplemental insurance market, since not all states protect against coverage denials or higher premiums based on health status.⁴

Despite evidence that beneficiaries already face high financial burdens, some policymakers envision redesigning Medicare benefits in ways that would raise, rather than lower, beneficiary liability.⁵ Their proposals would establish a ceiling on out-of-pocket costs, but a high one — \$5,000 or more. At the same time, the Medicare deductible and cost-sharing would be increased to offset, or more than offset, the costs of implementing the out-of-pocket limit.⁶ In addition, the proposals would

restrict Medigap plans from paying this higher Medicare deductible. The goal of redesigning Medicare benefits in this way is to achieve program savings, rather than making coverage more affordable for beneficiaries. Indeed, such an approach would increase costs for a substantial share of beneficiaries, adding to the high cost burdens of those with moderate or low incomes.⁷

In this brief, we examine options for setting a ceiling on Medicare's out-of-pocket costs and replacing the Part A deductible with a modest hospital copayment. Each design option we describe would make beneficiaries better off. We estimate the costs to Medicare and offer ways to finance them through premiums or a mix of premiums and payroll taxes paid to Medicare's trust funds. We also estimate savings to beneficiaries, employers, and the Medicaid program under each of the three options. In addition, we discuss how these reforms could put traditional Medicare on a more level playing field with MA plans, fostering competition based on added value. Finally, we describe how the reforms would make it possible to open traditional Medicare to people under age 65, potentially ensuring more viable and stable marketplaces for people without access to employer group coverage as well as for small employers.

REVAMPING MEDICARE'S BENEFIT DESIGN TO ENHANCE FINANCIAL PROTECTION

We specified the following changes in Medicare's benefit design (Exhibit 1):

- Implement an annual limit of \$3,500 on beneficiary spending for Medicare services.
- Replace the hospital deductible and per-day cost-sharing with either a \$100 or \$350 copayment per hospital admission (all of Medicare's other cost-sharing policies would remain in place). Our preferred option, the \$100 copayment, would still provide a modest incentive for beneficiaries to seek outpatient care when appropriate. The \$350 option, which represents roughly one-fourth the current deductible, is comparable to what many employer health plans charge.

- Finance the added costs of the improvement either with an increase in Medicare monthly premiums or with a combination of premiums covering 25 percent and payroll taxes covering 75 percent.

Our out-of-pocket limit of \$3,500 reflects the Centers for Medicare and Medicaid Services’ recommendation for MA plans. By replacing the hospital deductible with a modest copayment, the design reduces the likelihood of reaching the \$3,500 limit yet continues to provide patients with an incentive to opt for community-based or outpatient care instead of hospitalization, when appropriate.

We recognize that the illustrative design we put forward provides more protection than insurance policies that are

available for the under-65 population. We made this choice out of consideration of the already high cost burdens Medicare beneficiaries face, the modest or low incomes most beneficiaries live on, and limited assets that must last a lifetime. In 2016, half of all beneficiaries had incomes below \$26,300 (the median for people in Medicare), with a fourth below \$15,250 (the 25th percentile); few had high incomes. Half of all beneficiaries had lifetime savings (including retirement accounts) below the median of \$74,450.⁸ Past studies find that more than a fourth of all beneficiaries and two-fifths of low-income beneficiaries spend 20 percent or more of their incomes on premiums plus medical care costs, despite having Medicare.⁹

Exhibit 1. Current Medicare Benefit Design and Illustrative Benefit Designs

	Medicare 2016	Policy options		
	Medicare A and B cost-sharing	Add out-of-pocket limit; no other changes	Add out-of-pocket limit and reduce hospital cost-sharing	
		Option 1	Option 2	Option 3
Part A and B out-of-pocket limit	None	\$3,500	\$3,500	\$3,500
Part A				
Hospital deductible	\$1,288 per benefit period	Current	\$350 per admission	\$100 per admission
Hospital copayments	\$322/day for days 62–90 \$644/day for days 91+	Current	None	None
Skilled nursing	After hospital 100 days: \$161/day for days 21–100	Current	Current	Current
Hospice	None	Current	Current	Current
Part B				
Premium	\$104.90 month \$1,259 year	Additional premium	Additional premium	Additional premium
Deductible	\$166	Current	Current	Current
Physician, including inpatient	20%	Current	Current	Current
Outpatient; physical therapy; durable medical equipment	20%	Current	Current	Current
Physician admin medications	20%	Current	Current	Current
Diagnostic lab	None	Current	Current	Current
Home health	None	Current	Current	Current

Data: www.Medicare.gov.

How We Modeled the Benefit Design Options

We used the Medicare Current Beneficiary Survey (MCBS) data cost and use file, projected to 2016, to estimate the costs for the designs. The MCBS includes detailed information on use and costs of Medicare covered services, including patient liability for beneficiaries in traditional Medicare. It also includes beneficiary out-of-pocket costs for care and premiums paid for supplemental coverage, as well as payments by Medicaid, Medigap, employers, and other payers for Medicare-covered services. The file is designed to be representative of all Medicare beneficiaries, including those in nursing homes and other institutional settings.

The MCBS thus enabled us to analyze the potential effects on Medicare spending (in 2016) if the program were to cover a higher share of beneficiary costs and the potential decrease in costs currently paid by beneficiaries, employer plans, Medigap, and Medicaid. Although a redesign of Medicare would likely influence people's decisions to supplement their coverage, we modeled the potential impact assuming no changes in beneficiary enrollment in other sources of coverage. In the conclusion, we discuss potential additional savings for Medigap enrollees if they were to drop their supplemental plans because of Medicare's enhanced financial protection.

We focused on beneficiaries in traditional Medicare, based on the availability of detailed data on use and costs of Medicare-covered services, including hospitalization rates and administrative data on the liability patients incur for covered services. This information enabled us to estimate monthly or annual costs per beneficiary for the enhanced benefit and the savings that would accrue to other payers.

The benefit design change also would increase Medicare's costs for Medicare Advantage enrollees because MA rates are set in part based on the cost to care for traditional Medicare beneficiaries in the same area.¹⁰ MA enrollees also would pay any additional Medicare premiums. We used the annual per-person costs derived from traditional Medicare to estimate the total costs that would need to be financed with premiums or payroll taxes, including costs for MA plan members. (For detailed assumptions, see [How We Conducted This Study](#).)

Impact of Medicare Design Change on Costs and Spending

We estimate that implementing an out-of-pocket limit of \$3,500, with no other changes, would increase Medicare's average costs per person by \$428 a year, or \$36 per month, if the limit had been fully implemented in 2016. Replacing the hospital deductible and daily copayments with a per hospital admission copayment of \$350 or \$100 per admission in addition to the out-of-pocket limit, would raise spending per person by \$497–\$523, or \$40–\$44 per month (Exhibit 2).

Once the design includes a limit on annual out-of-pocket spending, the added costs of replacing the hospital deductible with a modest copayment are marginal, with relatively small difference in annual costs between plan designs with \$100 or \$350 per admission hospital copayments.

The combination of lower costs when hospitalized and a limit on spending for Medicare services would provide substantial relief for the 5.4 million beneficiaries with only Medicare. All would have new protection against open-ended costs. The extent of net savings would depend on how the improved benefits were financed, as we discuss below.

The Medicaid program also would reap savings as Medicare paid for more of the costs for beneficiaries dually eligible with Medicaid. We estimate Medicaid savings would range up to \$2.8 billion a year, split between federal and state governments.

For those in employer-retiree plans, the redesign would lower premiums reflecting reduced patient liability for Medicare covered services. We estimate employer plans would save \$6.5 to \$7.3 billion as Medicare paid a higher share of the costs of covered benefits.

The design would also reduce Medigap premiums, lowering their costs by \$3.7 to \$4.5 billion per year, assuming all enrollees kept their coverage. If Medigap enrollees willing to face some cost-sharing were to drop their Medigap coverage altogether, they would save substantially, since premiums average \$1,500 to 2,000 a

Exhibit 2. Estimated Impact of Options to Improve Medicare Cost-Sharing Design (financed by beneficiary premium increase)

	Design change, modeled incrementally		
	\$3,500 out-of-pocket limit	\$350 hospital deductible and \$3,500 OOP limit	\$100 hospital deductible and \$3,500 OOP limit
Traditional Medicare beneficiaries (millions)	38.8	38.8	38.8
Annual cost per person to Medicare	\$428	\$497	\$523
Added monthly cost per person	\$36	\$40	\$44
Net impact by payer If all costs financed by premium increase (billions)			
Low-income subsidy for Medicare premium	\$3.7	\$4.4	\$4.5
Medicaid total	-\$1.6	-\$2.3	-\$2.8
Federal	-\$1.0	-\$1.4	-\$1.7
State	-\$0.6	-\$0.9	-\$1.1
Net federal after Medicaid savings	\$2.7	\$3.0	\$2.8
Beneficiaries: Net	-\$0.4	-\$0.3	\$0
Employer-sponsored insurance	-\$6.5	-\$7.1	-\$7.3
Other payers	-\$1.5	-\$1.5	-\$1.5

Data: Authors' estimates based on the 2012 Medicare Current Beneficiary Survey projected to 2016.

Notes: Medicare premium subsidy would increase for the 8.7 million beneficiaries who would receive full subsidy for premium based on current full subsidy. Estimate assumes Medicare pays this full cost. Federal net of Medicaid assumes 60% share. Medicare Advantage beneficiaries also would pay the additional premiums. See also [How We Conducted This Study](#).

year for even the less-comprehensive Medigap plans. The individuals most likely to be willing to switch would be among the 9 percent of Medigap enrollees in Plans K, L, and N who already have cost-sharing.¹¹ However, we kept the coverage distribution the same, with no switching, because the data did not provide details on Medigap designs to identify those most likely to drop coverage.

Financing

If the entire cost increase for the more-protective benefit designs were financed entirely with premiums, those premiums would need to increase by \$36 to \$44 per month to support the three options. Except for low-income beneficiaries with premium subsidies from Medicaid and Medicare Savings Programs, all beneficiaries would pay this incremental premium, including MA enrollees. We estimate that premium subsidy costs would increase by up to \$4.5 billion (Exhibit 2).¹²

At the same time, Medicaid spending for Medicare services would decrease by up to \$2.8 billion. The

decrease would offset roughly half the cost of the Medicare premium increase.

Alternatively, if the premiums covered 25 percent of the costs and payroll tax financed 75 percent, the additional monthly premium would be an estimated \$9 to \$11 for beneficiaries for designs that limited total liability and reduced hospital cost-sharing (Exhibit 3). For beneficiaries, this financing design would result in substantial savings from lower premiums for private supplemental coverage and reduced out-of-pocket costs for care.

Medicaid would save by paying less for Medicare cost-sharing. The federal share of Medicaid savings would more than offset the subsidy for the premium increase for low-income beneficiaries with the new benefit design.

Employers would save \$6.5 billion to more than \$7 billion in their retiree benefit costs. Such savings would more than offset the increase in Medicare premiums for retirees and would lower premiums for retirees sharing in the supplement costs. Such savings would likely be shared with those retirees who pay a share of employer-based supplements.

Exhibit 3. Estimated Impact of Options to Improve Medicare Cost-Sharing Design (financed by 25%/75% mix of beneficiary premium and tax revenue)

	Design change: modeled incrementally		
	\$3,500 out-of-pocket limit	\$350 hospital deductible and \$3,500 OOP limit	\$100 hospital deductible and \$3,500 OOP limit
Annual cost per person to Medicare	\$428	\$497	\$523
Added monthly cost per person	\$36	\$41	\$44
Premiums (25%)	\$9	\$10.25	\$11
Taxes (75%)	\$27	\$30.75	\$33
Net impact by payer (billions)			
Medicaid savings: federal and state	-\$1.6	-\$2.3	-\$2.8
Medicare low-income premium subsidy, net of federal Medicaid savings	-\$0.02	-\$0.3	-\$0.5
Beneficiaries: Net	-\$10	-\$11.2	-\$11.6
Premium	-\$5.7	-\$6.3	-\$6.3
Cost-sharing out-of-pocket	-\$4.3	-\$4.9	-\$5.3
Employer-sponsored insurance	-\$6.5	-\$7.2	-\$7.3
Payroll-tax financed*	\$15.9	\$17.1	\$18.4
Total percentage-point increase in Medicare Trust Fund payroll tax, divided 50/50 between employer and employees	0.32	0.36	0.39

Data: Authors' estimates based on the 2012 Medicare Current Beneficiary Survey projected to 2016.

* Assuming 75% financing from payroll taxes, split equally between employers and employees.

If payroll taxes were used to cover 75 percent of the improved Parts A and B benefits, it would amount to an estimated 0.16-to-0.20-percentage-point increase in the current rate for both employers and employees.¹³ This mix of financing would, in effect, have the population pay for part of their expected Medicare costs for the improved coverage over their lifetime.

IMPLICATIONS OF MEDICARE REDESIGN FOR MARKET COMPETITION

Most Medicare beneficiaries are living on fixed incomes and are understandably averse to large, unanticipated medical care costs. That is why 90 percent of Medicare beneficiaries have some form of supplemental coverage or opt into a Medicare Advantage plan.

Beneficiaries in MA have a ceiling on their maximum out-of-pocket outlays for covered medical expenses. MA plans also offer an integrated benefit package that covers prescription drugs as well as additional benefits compared to traditional Medicare. However, in recent years the

financial protection offered by MA plans has eroded. Deductibles and cost-sharing for hospital and other care have increased, and the average ceiling on out-of-pocket costs has increased, from \$4,281 in 2011 to \$5,332 in 2017.¹⁴

Improving Medicare's core benefits would provide a check on this erosion, as the new benefit's costs would be automatically added to payment benchmarks for MA plans. Adding an out-of-pocket cost limit within traditional Medicare would place it on a more equal footing with MA. By leveling the playing field, traditional Medicare would challenge MA plans to compete on the value added.

The improvements also would affect Medigap markets. Beneficiaries new to Medicare might forgo buying a Medigap plan altogether, while others might choose to drop their existing Medigap plan. The beneficiaries most likely to do so would be those willing to pay some cost-sharing, including people with Medigap policies that do not fully cover Medicare's deductibles or cost-sharing.

Reconfiguring the core Medicare benefit design would provide a haven for disabled beneficiaries under age 65 as well as for MA enrollees wishing to return to traditional Medicare. Currently, Medigap plans are community-rated only when people first become eligible for Medicare. And, in many states, this option is not available to disabled Medicare beneficiaries under age 65.

CONCLUSION

Implementing a ceiling on liability for traditional Medicare's benefits would provide greater financial protection to people covered by Medicare only, while also reducing the costs of supplemental coverage for other beneficiaries — making all better off. If financed by a mix of premiums and payroll taxes, the savings from these reforms could be substantial. Because we did not offset the costs of an out-of-pocket limit with increased cost-sharing for other services, such an approach could gain beneficiaries' support and make it possible for many to rely on Medicare alone for their health care coverage needs.

Improving Medicare's core benefit design also could make it easier to offer Medicare as a coverage option to people under age 65 who are not eligible for the program. The marketplace for individual coverage nationwide is currently plagued by risk selection, premium instability, and the withdrawal of private insurers. Many markets also lack affordable plan choices: prices paid by private plans to hospitals and physicians for care continue to increase at rates much faster than Medicare, driving up premiums.¹⁵

One option for ensuring more affordable plan choices to people under age 65 would be to offer an improved traditional Medicare plan in the private insurance market. Such a plan also could be offered in the small-group market. Medicare has the strong advantages of low administrative costs and broad provider networks. Improving traditional Medicare thus could help stabilize the insurance market for those seeking individual coverage or small-employer groups who are not yet eligible for Medicare. This could be especially attractive to older adults who are preparing for coverage under Medicare when they retire.

A viable Medicare option in the individual and small-business markets with predictable and affordable benefits would put pressure on private plans to generate value for the coverage they offer. A further step would be to require Medicare Advantage insurers to offer plans in individual marketplaces where they have substantial networks, bringing both their provider networks and ability to pay providers at near-Medicare rates.¹⁶ The enhanced leverage in negotiating provider payment rates, given the alternative of using Medicare provider payment rates for in-network and out-of-network providers, would help counter rising health care prices and costs.¹⁷

A better Medicare benefit package, therefore, is an investment in more affordable coverage as well as lower health care costs across insurance markets. Not only would it ensure that beneficiaries can access the care they need, it also would simplify coverage choices and remove waste from the health system.

HOW WE CONDUCTED THIS STUDY

All estimates are based on analysis of the 2012 Medicare Current Beneficiary Survey (MCBS), with population and spending projected to 2016, based on enrollment and cost trends in the national health expenditure accounts. The MCBS includes 11,299 respondents, with population weights to make them representative of the entire Medicare population, including disabled under-65 and institutionalized beneficiaries.

In addition to information reported by beneficiaries on access, use, and out-of-pocket spending on premiums and services, the MCBS cost and use files include incurred liability for Medicare covered benefits, use of Medicare covered services, and spending for Medicare premiums based on administrative data. MCBS includes premiums paid for Medicare and private plans as well as services not covered by Medicare such as dental, hearing, and long-term care services. The database has sufficiently robust sample sizes to permit analysis of subgroups by income and coverage.

In this analysis, we used income reported by beneficiaries and evidence of Medicaid and other insurance coverage to group beneficiaries by coverage. We modeled the added

program costs using the sample representing 38.8 million beneficiaries in traditional Medicare, because we had detailed information on use of Medicare services and patient liability for Medicare cost-sharing by service type. The event-level data allowed us to estimate the shift to Medicare if there was an out-of-pocket limit and lower patient costs per hospital stay.

The reforms we specified would lower patient liability. The database enabled estimates of the shift in claims costs to Medicare and the associated reduction in payments by supplemental payers (Medigap, Medicaid, employer-sponsored insurance, and others) and beneficiaries.

Estimating Annual Costs

The reforms also would apply to Medicare Advantage (MA) plans, setting new ceilings on beneficiary liability for covered services.

In the analysis, we used detailed data on beneficiaries in traditional Medicare to estimate the shift to Medicare that would need to be covered by premiums or other financing. We held utilization constant and analyzed the costs if Medicare were to cover a greater share of the bill by placing an annual limit on patient liability. We then looked at the incremental costs of replacing the current hospital deductible and copayments with a per-admission copayment. For each of the three designs, we used the reduction in claims costs paid by other payers to estimate the impact on premiums.

Our estimates are static. We held utilization constant based on a study that indicated relatively little expenditure impact among the elderly for hospital or physicians as long as there continued to be front-end deductibles and cost-sharing. (In other words, if the person did not have first-dollar coverage.) In all three designs, beneficiaries would continue to face the Part B deductible and 20 percent coinsurance as well as per-admission cost for hospitals. The 10 percent of beneficiaries with only Medicare (no supplement or MA) would see the greatest reduction in potential liability — but there is little evidence that limits on out-of-pocket costs would increase demand.¹⁸ We thus did not use dynamic modeling, with utilization changing as cost-sharing changed at the margin.¹⁹

Although some beneficiaries with Medigap might decide to drop this coverage, we assumed that beneficiaries would retain current supplement coverage. If Medigap beneficiaries dropped this coverage, they would save on premiums and, to the extent they dropped first-dollar coverage, Medicare might see marginal decreases in utilization, as former Medigap enrollees now faced front-end cost-sharing. Switching would thus lower the cost of the reform.

Impact on Other Payers and Beneficiaries

If Medicare core benefits improved supplemental insurance, payers — Medigap, employer retiree plans, Medicaid, and others — would pay less for covered services. To compute the impact on premiums, we assumed no shift in coverage and used the reduction in claims costs to compute the reduction in premiums. We used a loading factor of 25 percent for Medigap claims, 15 percent for employer-retiree claims, 10 percent for other private, and 5 percent for Medicaid to estimate the reduction in premiums/payments that would result from the shift in costs Medicare. These are same factors used in a recent study based on Office of the Actuary data.²⁰ We used a load of 5 percent mark-up on claims for Medicare premiums (rather than the 2 percent load) to be conservative and to acknowledge that an out-of-pocket limit might involve higher administrative costs to implement.

To estimate the increased cost of premium subsidies, we identified low-income beneficiaries currently receiving a full subsidy for Part B premiums through Medicaid or Medicare Savings programs. These beneficiaries would be exempt from premium increases associated with the revised benefit design.

The impact on beneficiaries includes a reduction in out-of-pocket costs, reduced Medigap premiums, and employer-sponsored insurance premiums and increased spending on the added Medicare premiums. At the beneficiary level, we computed the net impact using average premium reductions for Medigap and ESI, limited by actual payments for private premiums.

Medicare Advantage

The estimates of financing assume that MA enrollees also would pay the additional premium. Payroll taxes would need to support all Medicare beneficiaries, including those in MA plans, since Medicare payment to plans would increase and plans would face new minimum standards. Because we lacked event-level detail in MA plans, we used the ratio of total MA costs per member for Medicare-covered services to those in traditional Medicare to estimate the added costs that would need to be financed for MA enrollees. In the database this is averaged to 60 percent.

Medicare Advantage beneficiaries would pay the additional premium for the enhanced core Medicare benefits. This payment would finance MA plans' additional costs of meeting new minimum standards and could lower MA premiums, improve protection and/or help finance services, such as dental and hearing, beyond Medicare benefits.

NOTES

1. Those on Social Security with Medicare before 2016 are protected from an increase in Medicare Part B premiums that would exceed increases in Social Security benefits. Those new to Medicare pay the higher premium. For details on benefits in 2016, see Centers for Medicare and Medicaid Services, “[2016 Medicare Parts A & B Premiums and Deductibles Announced](#),” press release, Nov. 10, 2015; and the [Appendix](#).
2. For average rates in 2016 see Health Markets, [What Is the Cost of Supplemental Health Insurance for Seniors](#) (Health Markets, Sept. 26, 2018).
3. Juliette Cubanski et al., [Modifying Medicare’s Benefit Design: What’s the Impact on Beneficiaries and Spending?](#) (Henry J. Kaiser Family Foundation, June 2016). See page 23 for administrative expenses for supplemental coverage and sources.
4. Tricia Neuman, “[Traditional Medicare...Disadvantaged?](#)” *Medicare* (blog), Henry J. Kaiser Family Foundation, Mar. 31, 2016. The Medicare website warns, “If you leave the Medicare Advantage Plan, you might not be able to get the same, or in some cases, any Medigap policy back unless you have a “trial right.” Trial right means the plan withdrew from the market — your decision was not voluntary. See Medicare.gov, [Guaranteed Issue Rights](#) (Centers for Medicare and Medicaid Services, n.d.).
5. Cathy Schoen, Karen Davis, and Amber Willink, [Medicare Beneficiaries’ High Out-of-Pocket Costs: Cost Burdens by Income and Health Status](#) (Commonwealth Fund, May 2017).
6. Medicare Payment Advisory Commission, “[Chapter 1: Reforming Medicare’s Benefit Design](#),” in *Report to the Congress: Medicare and the Health Care Delivery System* (MedPAC, June 2012), 24; Cubanski et al., [Modifying Medicare’s Benefit Design](#), 2016; and Congressional Budget Office, [Options for Reducing the Deficit: 2017 to 2026. Change the Cost-Sharing Rules for Medicare and Restrict Medigap Insurance](#) (CBO, Dec. 8, 2016).
7. CBO, [Change in Cost-Sharing Rules](#), 2016; and House Republicans, [A Better Way: Our Vision for a Confident America — Health Care](#) (better.gov, June 22, 2016).
8. Gretchen Jacobson et al., [Income and Assets of Medicare Beneficiaries, 2016–2035](#) (Henry J. Kaiser Family Foundation, Apr. 2017).
9. Schoen, Davis, and Willink, [Medicare Beneficiaries’ High Out-of-Pocket Costs](#), 2018.
10. Medicare pays Medicare Advantage plans based on an adjusted estimated of what the beneficiaries would have cost if in traditional Medicare — this would go up with enhanced benefits, adjusted for the health mix and geographic area of MA enrollees. Traditional Medicare also sets the floor for MA plan benefits. Thus, if MA plans had higher out-of-pocket limits, these would need to be lowered.
11. America’s Health Insurance Plans, [Trends in Medigap Enrollment and Coverage Options, 2015](#) (AHIP, Apr. 2017).
12. The data files included detail on beneficiaries enrolled in Medicaid for premium support and on beneficiaries with zero payment for Part B premiums. There were an estimated 8.7 million with Part B premium subsidies.
13. Based on CBO estimate that a 1 percent payroll tax increase would amount to \$47 billion in 2017. Congressional Budget Office, [Options for Reducing the Deficit: 2017 to 2026. Increase the Payroll Tax Rate for Medicare Hospital Insurance by 1 Percentage Point](#) (CBO, Dec. 8, 2016).
14. Laura M. Keohane et al., “[Medicare Advantage Members’ Expected Out-of-Pocket Spending for Inpatient and Skilled Nursing Facility Services](#),” *Health Affairs* 34, no. 6 (June 2015): 1019–27; and Gretchen Jacobson et al., [Medicare Advantage Plans in 2017: Short-Term Outlook Is Stable](#) (Henry J. Kaiser Family Foundation, Dec. 2016).
15. See Centers for Medicare and Medicaid Services, “[Table 21: Expenditures, Enrollment and Per Enrollee Estimate of Health Insurance](#),” in *National Health Expenditure Accounts for Private Compared to Medicare Trends* (CMS, updated Jan. 2018).
16. Cathy Schoen and Sara R. Collins, “[The Big Five Health Insurers’ Membership and Revenue Trends: Implications for Public Policy](#),” *Health Affairs* 36, no. 12 (Dec. 2017): 2185–94.

17. For Medicare Advantage payments to providers and regulatory rules, see: Jared L. Maeda and Lyle Nelson, *An Analysis of Private-Sector Prices for Hospital Admissions*, Working Paper 2017-02 (Congressional Budget Office, Apr. 2017); and Daria Pelech, *An Analysis of Private-Sector Prices for Physician Services*, Working Paper 2018-01 (Congressional Budget Office, Jan. 2018).
18. Deborah Chollet, *Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature* (Mathematica Policy Research, March 2006). On page 35, the report notes that “differences in out-of-pocket maximums did not significantly affect demand.”
19. Christopher Hogan, *Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly. A Report for MedPAC* (Direct Research, LLC, Aug. 2014; submitted 2012, appendix added 2014). This study found that the group with low cost-sharing (not first-dollar) and Medicare only had similar total expenditures, although the mix differed, with low cost-sharing using more preventive care, office visits, and eye exams. Compared to those with first-dollar coverage, both groups (Medicare-only and modest cost-sharing) had lower total expenditures, adjusting for health status and sociodemographic factors.
20. Cubanski et al., *Modifying Medicare's Benefit Design*, 2016.

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About the Commonwealth Fund

The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

Appendix. Medicare Beneficiary Distribution by Poverty and Coverage, 2016

Poverty group	Medicare only	Medicaid	Employer-sponsored insurance	Medicare Advantage	Medigap	Total
<100% FPL	925,974	5,894,238	468,099	1,234,912	454,639	8,977,863
100%–149% FPL	1,235,114	3,520,054	1,111,478	2,463,852	845,437	9,175,935
150%–199% FPL	1,068,008	852,209	1,484,542	2,546,309	1,133,155	7,084,224
200%–399% FPL	1,569,899	642,964	8,102,574	5,303,818	2,785,646	18,404,901
400%+ FPL	604,605	97,109	7,518,900	2,248,837	1,987,632	12,457,084
Total	5,403,600	11,006,575	18,685,594	13,797,729	7,206,509	56,100,007

Data: Authors' analysis of the 2012 Medicare Current Beneficiary Survey projected to 2016.

Note: FPL = federal poverty level.

