ISSUE BRIEF

JULY 2015

For more information about this brief, please contact:

Mary Mahon
Vice President, Public Information
The Commonwealth Fund
mm@cmwf.org

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1827
Vol. 21

The COMMONWEALTH FUND

Modernizing Medicare's Benefit Design and Low-Income Subsidies to Ensure Access and Affordability

Cathy Schoen, Karen Davis, Christine Buttorff, and Martin Andersen

Abstract Insurance coverage through the traditional Medicare program is complex, fragmented, and incomplete. Beneficiaries must purchase supplemental private insurance to fill in the gaps. While impoverished beneficiaries may receive supplemental coverage through Medicaid and subsidies for prescription drugs, help is limited for people with incomes above the poverty level. This patchwork quilt leads to confusion for beneficiaries and high administrative costs, while also undermining coverage and care coordination. Most important, Medicare's benefits fail to limit out-of-pocket costs or ensure adequate financial protection, especially for beneficiaries with low incomes and serious health problems. This brief, part of a series about Medicare's past, present, and future, presents options for an integrated benefit for enrollees in traditional Medicare. The new benefit would not only reduce cost burdens but also could potentially strengthen the Medicare program and enhance its role in stimulating and supporting innovations throughout the health care delivery system.

BACKGROUND

Over the past 50 years, Medicare has been meeting its goals of enhancing access to health care and providing financial protection against high health costs for its elderly and disabled beneficiaries.[1,2] Still, Medicare's outdated benefit design fails to limit beneficiaries' out-of-pocket costs for covered benefits, and the financial protection provided to low-income beneficiaries falls far short of what the Affordable Care Act offers to the under-65 population. This brief examines illustrative policy options that would, in combination, modernize Medicare's benefits, improve health care access and affordability for low-income beneficiaries, and reduce coverage complexity.

There is a pressing need for reform. An estimated 20 million of Medicare's 52 million beneficiaries live on incomes below 200 percent of the federal poverty level. Nine million beneficiaries have complex care needs with serious functional limitations that hinder their ability to carry out daily activities.[3] Although the poorest are eligible for Medicaid to supplement Medicare, under current policies beneficiaries with low or modest incomes are eligible for only limited help with paying for premiums or medical care expenses.

The absence of a ceiling on out-of-pocket costs can undermine the financial security and exhaust the resources of even higher-income beneficiaries. That's why

This is the second of four briefs in The Commonwealth Fund's **Medicare at 50 Years** *series that explore the key issues confronting the Medicare program and discuss potential policy options. The first brief explored the potential of value-based payment to improve beneficiary care and achieve savings. Upcoming briefs in the series will focus on care for complex patients and Medicare's fiscal outlook.*

most beneficiaries supplement Medicare's core benefits with coverage sold by private insurers, often purchasing multiple plans. This fragmented coverage is inefficient, generates high administrative costs, and undermines efforts to improve coordination of patient care and prevent avoidable hospitalizations. With many beneficiaries filling in Medicare's deductibles and coinsurance with supplemental coverage, there is also little opportunity to use financial incentives to encourage the use of higher-value, lower-cost care.

To modernize Medicare's core benefits and update policies related to low-income beneficiaries, the brief discusses two complementary options. The first would offer a new Medicare-sponsored plan choice. Available for an extra premium, it would provide an integrated design with prescription coverage, more-affordable cost-sharing, and a limit on out-of-pocket costs—making supplemental coverage unnecessary. The second option would expand subsidies for Medicare's premiums and reduce cost-sharing for beneficiaries with incomes up to 200 percent of the federal poverty level in ways that align with the Affordable Care Act's policies for the under-65 population.

We discuss how the two policies could reinforce each other and strengthen Medicare's ability to provide beneficiaries with greater security, while creating a platform for future program innovation. Modernizing Medicare's benefit design and expanding low-income policies together have the potential to lower administrative costs and smooth transitions as adults become eligible for Medicare.

CURRENT MEDICARE BENEFITS AND LOW-INCOME PROVISIONS

Medicare has separate deductibles and cost-sharing provisions for Part A hospital, skilled nursing facility, and home health services and for Part B physician, lab, and diagnostic benefits, with no limit on annual out-of-pocket spending for covered services. Part A includes a $1,216 deductible per hospital episode and substantial cost-sharing for longer-term hospitalization or skilled nursing stays after a hospitalization. Part B has a $104.90 monthly premium ($1,259 per year per person), a separate $147 annual deductible, and open-ended coinsurance of 20 percent for physician services (including surgeons and other hospital inpatient physicians), therapy, durable medical equipment, and outpatient services with no limit on out-of-pocket spending.

For prescription drug coverage, beneficiaries must buy a Part D plan with a separate premium that averages around $440 a year plus a deductible and cost-sharing that varies across private plans. The Affordable Care Act (ACA) is phasing out Medicare's gap in drug coverage—the "doughnut hole"—but beneficiaries requiring specialty drugs or multiple medications can still face substantial costs.

Supplemental private coverage to fill in Medicare's deductibles and cost-sharing is costly, with Medigap premiums adding over $2,000 a year, depending on geographic area. It is also inefficient, with 20 percent of the premium, on average, going toward administrative costs.[4]

Some low-income beneficiaries are eligible for assistance paying their Parts A and B cost-sharing and Part B premiums.[5] Medicaid covers Medicare cost-sharing up to 100 percent of the poverty level and provides subsidies for Part B premiums up to 135 percent of poverty for those meeting

income and asset tests.[6] Personal asset limits for beneficiaries seeking extra help with Medicare premiums or cost-sharing are $7,160 for an individual and $10,750 for a couple (in 2014). The complexity of separate enrollment through Medicaid deters some poor Medicare beneficiaries from participating. Just half of beneficiaries with incomes below $10,000 and only a fifth of those with incomes up to $20,000 have Medicaid supplements for Medicare coverage. (Appendix Table 1 shows the distribution of beneficiaries by income level.)

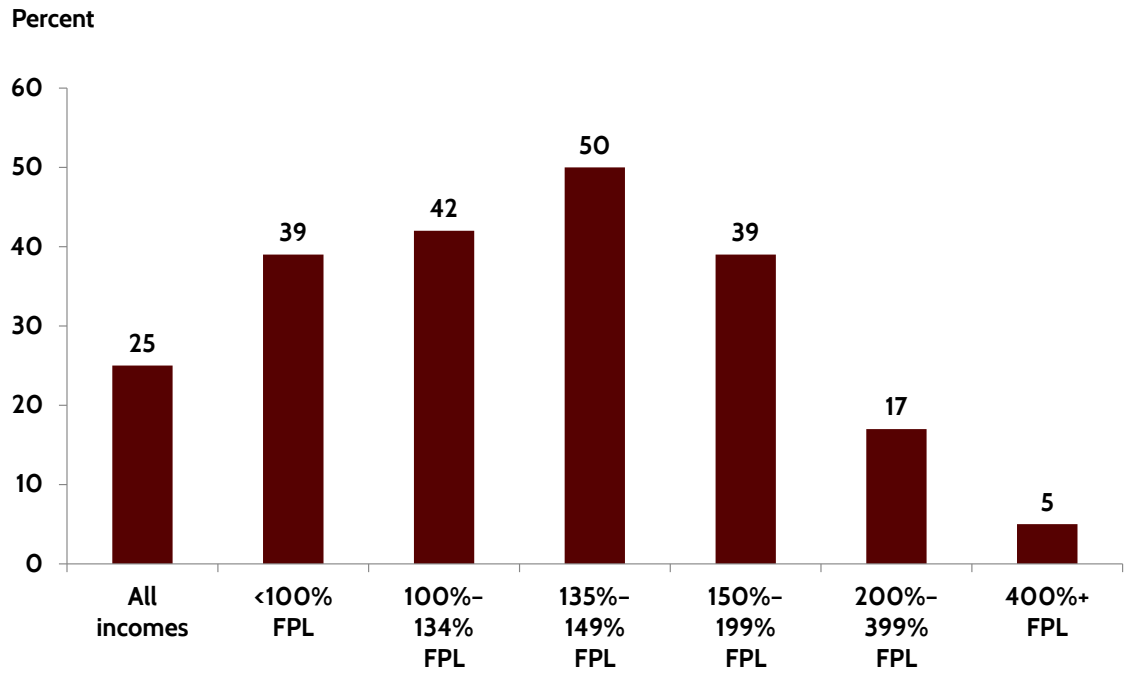
Low-income beneficiaries apply separately to Medicare for help with Part D. Medicare administers subsidies for Part D cost-sharing and premiums on a sliding scale up to 150 percent of poverty. The Part D asset limit is $13,300 for individuals and $26,580 for couples, with lower limits for full premium subsidies.

In contrast to Medicare, the ACA eliminates asset tests and provides substantial premium and cost-sharing subsidies up to 200 percent of poverty for the under-65 population and expands Medicaid to 138 percent of poverty for participating states.[7] ACA provisions exclude Medicare beneficiaries. As a result, lower-income older adults who age into Medicare will face increased financial burdens for coverage and care.

UNDERPROTECTED AND UNDERINSURED MEDICARE BENEFICIARIES

Facing gaps in benefits and premium costs, an estimated 25 percent of all beneficiaries and 40 percent with incomes below twice the poverty level spent 20 percent or more of their income for premiums plus medical care costs in 2014.[8] As Exhibit 1 illustrates, the percentage of beneficiaries with high cost burdens falls sharply for those with incomes above 200 percent of poverty—to less than half the levels experienced by low-income beneficiaries.[9]

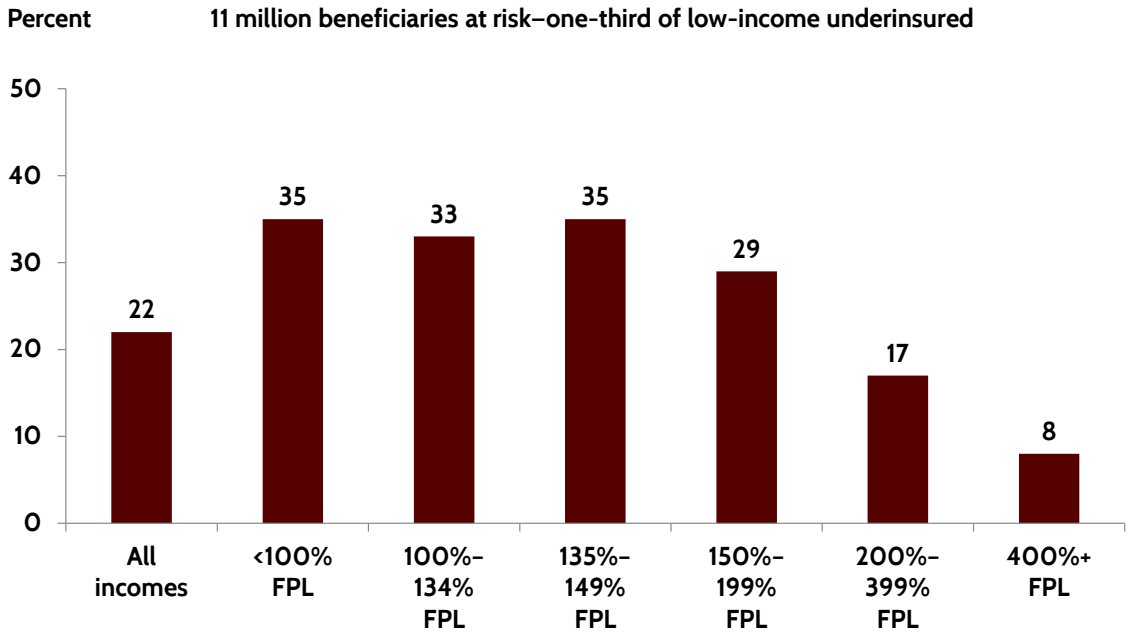
Exhibit 1. Proportion of Medicare Beneficiaries Spending 20 Percent or More of Income on Premiums and Medical Costs



Source: Analysis of 2010 Medicare Current Beneficiary Survey, projected to 2014.

An estimated one of five beneficiaries—11 million people—spent at least 10 percent of their income on medical care alone in 2014, not including premiums. Despite having Medicare, they were underinsured, spending a high share of their income on medical care.[10] The risk of being underinsured was highest for low-income beneficiaries: an estimated one-third of those with incomes up to 150 percent of poverty, and 30 percent of those with incomes between 150 percent and 200 percent of poverty were underinsured, which is at least twice the rate for beneficiaries with higher incomes (Exhibit 2). On average, about half of low-income beneficiaries' out-of-pocket costs were for Medicare covered benefits including prescription drugs; remaining costs were for dental, hearing, and long-term care services beyond those covered by Medicare.

Exhibit 2. One of Five Medicare Beneficiaries Underinsured—Spent 10 Percent or More of Income on Medical Care Alone (premiums excluded)



Source: Analysis of 2010 Medicare Current Beneficiary Survey, projected to 2014.

Such high financial burdens undermine access to care, deplete incomes, and drain resources. Notably, a recent study found that the elderly in the United States are far more likely to go without care because of the cost and face problems paying medical bills than their counterparts in 10 other high-income countries. Beneficiaries with complex care needs are particularly at risk.[11]

POLICY OPTIONS TO MODERNIZE BENEFITS AND IMPROVE LOW-INCOME PROTECTIONS

To improve current Medicare benefits so that beneficiaries will not need to obtain supplemental coverage, and to expand low-income provisions under Medicare to provide adequate financial security for low- and modest-income beneficiaries, we suggest two related policies. The first policy, which we call "Medicare Essential," would modernize Medicare's benefit design by offering a new option for a

supplemental premium sponsored by Medicare with integrated benefits, including prescription drugs. The second would protect low-income beneficiaries by expanding premium subsidies and reducing cost-sharing for beneficiaries up to 200 percent of poverty with the expanded assistance provided directly by Medicare.

Medicare Essential

Modernizing Medicare's benefit design through the introduction of a new option, sponsored by Medicare, that features integrated benefits and an out-of-pocket-cost limit for all covered services would obviate the need for supplemental coverage. Such an option would reduce insurance complexity for beneficiaries, lower administrative costs now incurred by private plans, and enable Medicare to implement value-based incentives that reduce cost-sharing for beneficiaries seeking care from high-quality, lower-cost providers.[12] Such flexibility would complement federal payment policies to promote primary care, coordination, and care system innovations.

Exhibit 3 presents an illustrative benefit design for the Medicare Essential option and contrasts it with Medicare's current core provisions. The illustrative design includes an overarching limit on annual out-of-pocket expenses and one deductible, with exemptions for preventive care, primary care, and prescription drugs. The design eliminates cost-sharing for hospital care after the deductible. For physician care, patients make copayments for primary care, specialists, and emergency department use. Cost-sharing for other Part B services with cost-sharing is reduced from the current 20 percent to 10 percent. A new overall limit on out-of-pocket costs for covered services includes prescription medications. To model the potential premium costs and impact on beneficiaries, we set the out-of-pocket limit at $3,400 and the deductible at $250.

Beneficiaries selecting this option would pay an extra premium set to fully finance the enhanced benefits. The extra premium would be added to the current Part B premium, in one monthly charge that would cover Parts A, B, and D benefits within an integrated insurance plan.

The extra premium for this new option, with drug benefits, comes to an estimated $85 per month in 2014, in addition to Part B.[13] At this level, the option would offer a lower-cost, simpler alternative to purchasing Medigap and Part D plans. Compared with Medigap plans that enroll the greatest number of beneficiaries (Plan F), beneficiaries would experience significant savings in premiums (about $1,500 a year), although with somewhat higher cost-sharing.[14]

The combined Part B and Medicare Essential premium would likely be beyond the reach of low-income beneficiaries. Thus, expanded subsidies (described below) for low- and modest-income beneficiaries would be needed to work in tandem with Medicare Essential. If both policies were enacted, lower-income beneficiaries would be more likely to rely on the expanded low-income policies. Medicare Essential as a voluntary option would be more likely to appeal to those with incomes above 200 percent of poverty.

Exhibit 3. Illustrative Benefit Design to Offer New "Medicare Essential" Choice

	Medicare Essential	Current Medicare A, B, D
Benefit design	Integrated cost-sharing and incentives. Benefits include prescription drugs.	Parts A, B, and D (drugs) separate.
Deductible	Single $250 annual deductible for all services. Exemptions for primary care (if registered with a primary care practice), preventive care, and prescriptions.	Hospital: $1,216 per episode. Part B: $147 per year.
Hospital cost-sharing	None.	$304 per day for days 61 to 90.
Physician cost-sharing	$20 primary care/$40 specialist visit/$50 emergency department (except for accidents and other urgent care).	20% open-ended; includes doctors for hospitalizations.
Other Part B services	10% coinsurance (therapy and durable medical equipment).	20% coinsurance.
Home health	None.	None.
Skilled nursing home	$80 per day for days 21–100.	$152 per day for days 21–100.
Prescription drugs	No deductible. Low/no cost-sharing for essential medications, low-cost for generics; 25% coinsurance for nonpreferred brand. Reference pricing.	Varies. Standard deductible $310; cost-sharing 25% multiple tiers.
Out-of-pocket limit	$3,400 annually for all covered services, including drugs.	None.
Illustrative value incentives*	No deductible for primary care if beneficiary is registered with a practice; $10 per-visit cost-sharing for those enrolled in primary medical home practice. No deductible if referred by medical home or using high-value medical groups or networks. Out-of-pocket limit lowered to $2,000 for patients using certified high-value accountable care network or care team.	None.
Monthly premium**	Estimated $85 a month, including prescription drugs, plus Part B at $104.90.	Part B: $104.90 monthly. Part D: $37 monthly average.

* For a discussion of Medicare Essential's value-based design and value-incentives, see K. Davis, C. Schoen, and S. Guterman, "Medicare Essential: An Option to Promote Better Care and Curb Spending Growth," *Health Affairs,* May 2013 32(5):900–9.

** Premium estimate of Medicare Essential premium for 2014 assumes that all beneficiaries with Medigap and Medicare with incomes above 200 percent of poverty participate and that beneficiaries with employer-sponsored health insurance and Medicare Advantage remain with their current coverage.

New Protections for Low-Income Beneficiaries

Aligning Medicare's low-income protections with the ACA's reforms for people under 65 would require an expansion of premium subsidies on a sliding scale relative to income and a reduction of cost-sharing up to 200 percent of poverty. An illustrative option could include:

- Expansion in eligibility for Part B premium subsidies from 135 percent of the federal poverty level to 200 percent based on a sliding scale using ACA contribution rates.
- For those with incomes between 100 percent and 200 percent of poverty and not eligible for Medicaid, reduced cost-sharing for Medicare benefits and a new annual limit on out-of-pocket costs.
- For all beneficiaries with incomes below poverty, full Part B premium subsidies and minimal cost-sharing for Medicare services through Medicaid. (Those wishing to do so could opt to receive the more limited assistance available to beneficiaries just above poverty.)
- Elimination of the asset test for all beneficiaries. Following the ACA, annual income alone would determine eligibility for premium subsidies and reduced cost-sharing.

For illustrative purposes, we have specified the benefits to include: a unified deductible of $250 a year, no separate deductible for hospital care, low copayments for visits, reduced coinsurance

for other Part B benefits, and an out-of-pocket limit of $2,000 for Parts A and B services. This design seeks to be in the actuarial value range for subsidized benefits for low-income adults in health plans offered in the ACA's insurance marketplaces.[15]

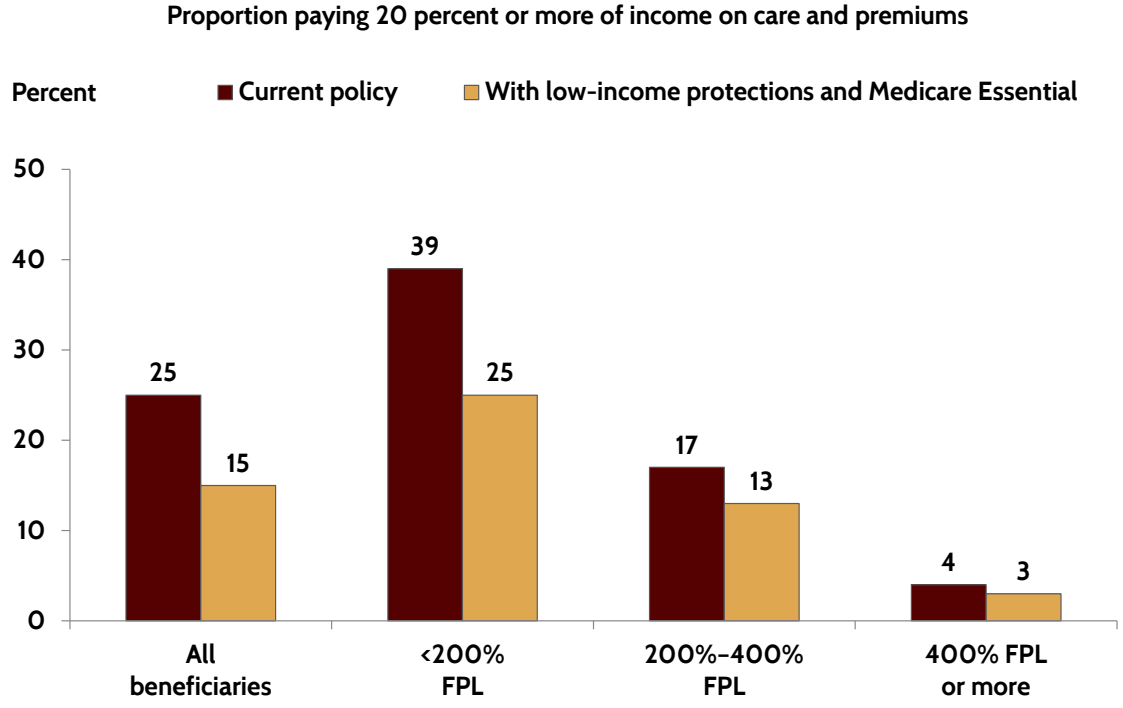
To streamline the application process, Medicare, rather than Medicaid, would administer and fund the expanded premium and cost-sharing subsidies for newly eligible beneficiaries who do not qualify for full Medicaid. There would be just a single application to fill out. The policies would use the same definition of income and draw on existing federal administrative systems.

Impact of Illustrative Policies

The combination of Medicare Essential with expanded low-income provisions would represent an attractive new integrated option for beneficiaries with higher incomes and supplemental private coverage. The estimated monthly cost, including drugs, would be more affordable than what is currently available in the Medigap marketplace, largely as a result of lower administrative costs. If all current higher-income beneficiaries with Medigap, as well as all those with Medicare only, were to participate in such an option, an estimated 4 million of them would have lower costs.

If all beneficiaries who are income-eligible received the expanded low-income help, we estimate that the combination of Medicare Essential and the new low-income provisions would reduce from 25 percent to 15 percent the proportion of beneficiaries now paying 20 percent of their income or more on health care and premiums (Exhibit 4). Not surprisingly, those with incomes below 200 percent of poverty would experience the biggest difference: the proportion of these individuals spending at least a fifth of their income would drop from 39 percent to 25 percent. But even beneficiaries with incomes between 200 percent and 400 percent of poverty would benefit from Medicare Essential, with the proportion paying 20 percent or more dropping from 17 percent to 13 percent.

Exhibit 4. Impact of Two Policies (2014)



Source: Analysis of 2010 Medicare Current Beneficiary Survey, projected to 2014; modeled illustrative policies.

The share of beneficiaries who would remain underprotected reflects the limits of Medicare's benefit package, which excludes important high-cost services such as hearing aids, dental care, and long-term care services and supports.[16]

SUMMARY AND DISCUSSION

Medicare's current fragmented benefit design and inadequate subsidies for low-income beneficiaries result in particularly high out-of-pocket cost burdens for beneficiaries living below 200 percent of poverty. The cost burden puts their access to care at risk as well as their ability to afford care, causing many to forgo other necessities or go into debt.

Expanding eligibility for low-income subsidies well beyond the poverty level will be necessary to provide financial protection for those most at risk. Doing so would promote equity and mirror the ACA's provisions for the under-65 population, thereby smoothing transitions for people as they enter the Medicare program. To streamline enrollment and lower administrative costs, eligibility for premiums and cost-sharing help could be determined through a website with a single application.

As a companion policy, Medicare Essential could be designed so that the premium fully finances the enhanced benefits at no cost to the federal budget. Medigap policies currently incur high administrative costs, averaging 20 percent of premiums.[17] Medicare Essential would likely be particularly attractive for beneficiaries currently buying Part D and Medigap policies, as they would realize substantial premium savings from lower overhead costs and having an integrated plan with prescription drugs. Since recent reforms prohibit Medigap policies from first-dollar coverage, Medicare Essential would be competitive with private supplemental policies, all of which include at least some cost-sharing.[18]

To the extent that a substantial share of beneficiaries now purchasing Part D plans opt for Medicare Essential, Part D pharmacy benefit managers (PBMs) would need to be selected by Medicare to administer the drug benefit to retain their markets. Some PBMs would likely be displaced. As this market is already highly concentrated and leading PBM groups now compete to participate in integrated plans for the under-65 population, this transition should be possible with only modest disruption in drug-pricing arrangements. By integrating the pharmacy benefit, Medicare would in the future be able to use its purchasing power, as well as follow value-based design principles, to ensure access to effective and essential medications.

Cost-sharing for all covered services could be structured to encourage beneficiaries to seek high-value care. Enabling such a flexible benefit design would strengthen Medicare's already significant role in providing a national platform to improve health system performance on behalf of the entire population. This leverage depends on Medicare being given the authority to adjust cost-sharing based on the value of services, as recommended by the Medicare Payment Advisory Commission (MedPAC) in a recent report.[19] Over time, if the value-based approach spurred delivery system innovation, potential savings would accrue to families, public programs, and private employers.[20]

In contrast to premium-support proposals, which would shift financial risk to beneficiaries if medical costs rise above some target rate, an approach like Medicare Essential would strengthen Medicare's ability to address costs over time.[21] That's because it uses payment incentives for providers and incentives for patients to choose lower-cost, higher-quality care. By offering an integrated benefit option, traditional Medicare would provide new competition for the Medicare Advantage private plan market.

Enhancing traditional Medicare's core benefits in this way would begin to phase out Part A and Part B cost-sharing and revamp Medicare's core benefits with an out-of-pocket maximum. However, an additional monthly premium would be needed to avoid high cost-sharing. In contrast, MedPAC examined a more integrated design with an out-of-pocket maximum and the restriction that the Part B premium could not increase. This constraint resulted in a $500 deductible, a $750 per hospital admission copayment, and a $5,000 annual out-of-pocket maximum.[22] Faced with such cost-sharing, beneficiaries would likely continue to buy supplemental coverage for fear of incurring high costs if they become sick.

Federal Budget Costs

Although Medicare Essential could be designed to be self-financing, federal spending would be necessary to pay for expanded low-income premium and cost-sharing subsidies. We estimate an annual cost of over $10 billion if all income-eligible beneficiaries participated.[23] To reduce federal budget outlays, low-income provisions could initially be limited to 150 percent of the poverty level. Policies could also be phased in, beginning with expanding premium subsidies to 150 percent of poverty as recommended by MedPAC.[24] Or phasing could start with reduced cost-sharing up to 135 percent of poverty.

Some of the options listed by the Congressional Budget Office (CBO) or recommended by MedPAC could be adopted to finance federal costs. For example, CBO estimates that either expanding Part D rebates for low-income beneficiaries or increasing alcohol and cigarette taxes would yield more than $100 billion in federal savings or revenues over a decade.[25] Simplifying enrollment and avoiding the need to supplement Medicare would also yield administrative savings that could be redeployed to improve benefits.

Together, the policy options we describe could offer the potential for future savings that would accrue not only to Medicare beneficiaries, but to the nation as a whole.

NOTES

1 K. Davis and C. Schoen, *Health and the War on Poverty: A Ten Year Appraisal* (Washington, D.C.: Brookings Institution, 1978).

2 D. Blumenthal, K. Davis, and S. Guterman, "Medicare at 50: Origins and Evolution," *New England Journal of Medicine,* Jan 29, 2015 372(5):479–86.

3 M. Moon, I. L. Hollin, L. H. Nicholas, C. Schoen, and K. Davis, *Serving Older Adults with Complex Care Needs: A New Benefit Option for Medicare* (New York: The Commonwealth Fund, forthcoming July 2015).

4 S. Sheingold, A. Shartzer, and D. Ly, *Variations and Trends in Medigap Premiums* (ASPE, DHHS, Dec. 2011), http://aspe.hhs.gov/health/reports/2011/medigappremiums/index.pdf.

5 Medicare Payment Advisory Commission, "Chapter 4: Financial Assistance for Low-Income Medicare Beneficiaries," *Report to the Congress—Medicare and the Health Care Delivery System* (Washington D.C.: MedPAC, June 2014). The chapter describes Medicare's three savings programs: the Qualified Medicare Beneficiary (QMB) program, the Service Limited Medicare Beneficiary (SLMB) program, and the Qualified Individual (QI) program, which is limited and temporary.

6 Ibid.

7 C. Schoen, S. Hayes, and P. Riley, *The Affordable Care Act's New Tools and Resources to Improve Health and Care for Low-Income Families Across the Country* (New York: The Commonwealth Fund, Oct. 2013).

8 We analyzed the 2010 Medicare Current Beneficiary Survey projected to 2014 for all estimates of out-of-pocket burdens under current policy and with the specified reforms. See the Study Methods and Data box for further details.

9 The high cost burden if low income reflects premiums as well as lack of supplemental protection. Few low-income beneficiaries have employer-sponsored supplements and an estimated 15 percent have no supplemental coverage. Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program* (Washington, D.C.: MedPAC, June 2014).

10 C. Schoen, M. M. Doty, R. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs,* Sept. 2011 30(9):1762–71.

11 R. Osborn, D. Moulds, D. Squires, M. M. Doty, and C. Anderson, "International Survey of Older Adults Find Short Comings in Access, Coordination, and Patient-Centered Care," *Health Affairs* Web First, Nov. 19, 2014.

12 K. Davis, C. Schoen, and S. Guterman, "Medicare Essential: An Option to Promote Better Care and Curb Spending Growth," *Health Affairs,* May 2013 32(5):900–9.

13 Authors' analysis based on the 2010 Medicare Current Beneficiary Survey. See the Study Methods and Data box for assumptions about participation in Medicare Essential.

14 For details about Medigap plans, see G. Jacobson, J. Huang, and T. Neuman, *Medigap Reform: Setting the Context for Understanding Recent Proposals* (Menlo Park, Calif.: Kaiser Family Foundation Jan. 2014).

[15] G. Claxton and N. Panchal, *Cost Sharing Subsidies in Federal Marketplace Plans* (Menlo Park, Calif.: Kaiser Family Foundation, Feb. 11, 2015). The ACA specifies low-income out-of-pocket limits can be no higher than $2,250 a year. This brief finds limits are much lower, averaging $881 for the near-poor and $1,700 for those with incomes between 150% and 200% of poverty. For simplicity, we used $2,000 for both groups.

[16] For detailed cost estimates by income group, see C. Schoen, C. Butorff, M. Andersen, and K. Davis, "On Medicare But at Risk: Policy Options to Expand Medicare's Low-Income Provisions to Improve Access and Affordability," under journal review, revised June 2015.

[17] Sheingold, Shartzer, and Ly, *Variations and Trends,* 2011.

[18] In April 2015 Congress repealed the Sustainable Growth Rate formula and enacted a reform package that includes a prohibition on Medigap plans covering the Part B deductible.

[19] Medicare Payment Advisory Commission, "Chapter 1: Reforming Medicare's Benefit Design," *Report to the Congress—Medicare and the Health Care Delivery System* (Washington, D.C.: MedPAC, June 2012), page 24.

[20] Davis, Schoen, and Guterman, "Medicare Essential," 2013.

[21] Premium support proposals would require beneficiaries to purchase health insurance from one of a number of competing plans, with the federal government paying part of the cost of coverage. The various proposals differ in how to set the federal contribution and how the contribution would change over time. All would make beneficiaries liable if costs went up faster than a specified rate.

[22] MedPAC, "Chapter 1," 2012, page 20.

[23] Schoen, Butorff, Andersen, and Davis, "On Medicare But at Risk," under journal review.

[24] MedPAC, "Chapter 4," 2014.

[25] Congressional Budget Office, *Options for Reducing the Federal Deficit* (Washington, D.C.: CBO, Nov 2014), https://www.cbo.gov/sites/default/files/cbofiles/attachments/49638-BudgetOptions.pdf. Requiring manufacturers to pay a minimum rebate on drugs covered under Part D for low-income beneficiaries would save $103 billion. Increasing taxes on alcoholic beverages to $16 per proof gallon would increase revenue by $66 billion and increasing the excise tax on cigarettes by 50 cents per pack would increase revenue by $35 billion.

STUDY METHODS AND DATA

We used the 2010 Medicare Current Beneficiary Survey (MCBS), inflated to 2014 and projected enrollment, to assess current financial burdens and the impact of the specified policy options. The 2010 Cost and Use files provide detailed information on out-of-pocket costs, including out-of-pocket spending on premiums and benefits not covered by Medicare and premiums paid for private plans. The nationally representative sample of beneficiaries has sufficiently robust sample sizes to examine subgroups by income.

In the analysis, we divided beneficiaries into poverty groups that correspond to current Medicare low-income policies and ACA thresholds for premium and cost-sharing subsidies. For married couples, the MCBS asks about costs only for the person interviewed but reports the couple's total income. Thus, estimates of out-of-pocket costs as a share of income understate burdens for married couples–the estimates miss premium and care costs for the spouse.

We used income reported in the MCBS compared with poverty thresholds to determine likely eligibility for expanded subsidies. In modeling the impact of expanding premium subsidies up to 200 percent of poverty, we assumed that all would be eligible except those with employer-based retiree coverage.

To assess the impact of provisions to reduce Medicare-related cost-sharing, we used information on total liability for Medicare-covered services and modeled the change in out-of-pocket costs with the specified change in benefit design for beneficiaries eligible to participate. We restricted participation to beneficiaries enrolled in traditional Medicare with Medicare only, Medigap, or Medicaid, excluding those with Medicare Advantage and employer-sponsored supplements. To simplify modeling, we assumed that all income-eligible beneficiaries with Medicare only, Medigap, and Medicaid above 100 percent to 200 percent of poverty would participate in the new low-income expansion for Medicare reduced cost-sharing. We modeled the impact of the specified reforms assuming full implementation and participation in 2014.

For Medicare Essential, we assumed only those with incomes above 200 percent of poverty would participate and pay the added premium. For simplicity, we assumed that all beneficiaries with incomes above 200 percent of poverty currently with Medicare only, Medigap, or Medicaid would participate. And beneficiaries with employer-sponsored insurance or Medicare Advantage would retain current coverage. We modeled just one year as if fully implemented in 2014. We did not model the potential dynamic longer-term impact on total spending if positive incentives succeeded in accelerating delivery system innovation to yield future cost savings.

Appendix Table 1. Distribution of Medicare Beneficiaries by Poverty and Coverage (estimated 2014)

	Medicare only	Medicaid	Employer	Medicare Advantage	Medigap	Total
People (millions)	5.2	8.9	20.0	10.7	7.9	52.7
			Poverty distribution–Share of each group			
<100% poverty	15.1%	54.6%	2.2%	7.5%	5.2%	13.8%
100%–134% poverty	20.1%	27.3%	4.0%	10.4%	10.3%	11.8%
135%–149% poverty	5.0%	3.9%	2.0%	5.1%	3.5%	3.5%
150%–199% poverty	17.0%	9.1%	8.2%	15.3%	11.6%	11.2%
200%–399% poverty	30.3%	4.7%	38.1%	39.9%	38.5%	32.2%
400%+ poverty	12.5%	0.5%	45.3%	21.7%	30.9%	27.6%

Source: Based on Medicare Current Beneficiary Survey 2010 distribution inflated to 2014 Medicare beneficiary count.

About the Authors

Cathy Schoen, M.S., is the executive director of The Commonwealth Fund Council of Economic Advisors. She is the former senior vice president for Policy, Research, and Evaluation at The Commonwealth Fund, as well as the former research director of the Fund's Commission on a High Performance Health System. Previously, Ms. Schoen was on the research faculty of the University of Massachusetts School of Public Health and directed special projects at the UMass Labor Relations and Research Center. During the 1980s, she directed the Service Employees International Union's research and policy department. Earlier, she served as staff to President Carter's national health insurance task force. Prior to federal service, she was a research fellow at the Brookings Institution. She has authored numerous publications on health policy and insurance issues, and coauthored the book *Health and the War on Poverty.* She holds an undergraduate degree in economics from Smith College and a graduate degree in economics from Boston College.

Karen Davis, Ph.D., is the Eugene and Mildred Lipitz Professor in the department of Health Policy and Management and director of the Roger C. Lipitz Center for Integrated Health Care at the Bloomberg School of Public Health at Johns Hopkins University. Dr. Davis has served as president of The Commonwealth Fund, chairman of the department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, and deputy assistant secretary for Health Policy in the department of Health and Human Services. She also serves on the board of directors of the Geisinger Health System and Geisinger Health Plan. She received her doctoral degree in economics from Rice University.

Christine Buttorff, Ph.D., is an associate policy researcher at the RAND Corporation. Her primary research interest is health insurance benefit design. Dr. Buttorff has worked on projects evaluating the impact of an opioid-prescribing guideline intervention in a worker's compensation pool, Medicare payment innovations, and insurance benefit design in the new exchanges. Prior to her dissertation work, she was a political reporter for a member station of National Public Radio, where she covered government and politics, as well as health care policy at the state and local levels. Dr. Buttorff received her Ph.D. from the Johns Hopkins School of Public Health in the Department of Health Policy and Management.

Martin S. Andersen, Ph.D., is an assistant professor in the Department of Economics at the University of North Carolina at Greensboro. Prior to joining the Greensboro faculty he was an assistant professor in the Department of Health Policy and Management at the Bloomberg School of Public Health at Johns Hopkins University. Dr. Andersen received his Ph.D. from the Harvard School of Public Health.

Editorial support was provided by Ann B. Gordon.

The
COMMONWEALTH
FUND

www.commonwealthfund.org