THIRD WAY

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Capping Health Costs for Medicare Beneficiaries

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Despite how well Medicare has protected older and disabled Americans from devastating health costs, many beneficiaries still face high costs and cannot get the care they need. For example, Medicare doesn't protect beneficiaries with incomes above $12,880 from high out-of-pocket costs. Reps. Lisa Blunt Rochester (D-DE), Andy Kim (D-NJ), and Dwight Evans (D-PA) have proposed legislation for a comprehensive income-based cost cap for low-income seniors. It would make health care affordable for 6.4 million Medicare beneficiaries.

Josie Graham from San Francisco had to fight hard for her father's care after he was diagnosed with cancer. She was frustrated by many barriers until one week before he died. That's when he became eligible for hospice with no co-pays. She wrote, "the ease of accessing end-of-life care, services and

medical equipment through a home hospice program felt like receiving a magical key that unlocked doors we had tried to break down for years." [1]

Medicare has protected most older and disabled Americans from devastating health costs, but many beneficiaries fall through the cracks. Nearly 6 million Medicare beneficiaries with incomes of less than $23,000 spent about $5,000 or more on coverage and care in 2013-14 (the most recent survey available). [2] That's nearly a quarter of their income. And because protections from high costs vary by state, low-income beneficiaries in some areas spent one-third to one-half of their income on health care. [3]

We must do more to protect older and disabled Americans from high health care costs. Third Way has called for Congress to enact a cost cap that would limit premiums, deductibles, copayments, and other out-of-pocket costs for everyone based on their income—no matter where they get their insurance. [4] This idea builds off the Affordable Care Act (ACA), where everyone buying their own coverage through the exchanges now has a cap on their premiums and out-of-pocket costs under the American Rescue Plan. This means they won't pay more than a set amount on health care costs in a certain year, no matter what services they need.

As Congress works to extend the improved ACA cost cap through budget reconciliation, policymakers should also take the opportunity to cap costs for Medicare beneficiaries. Capping drugs costs in Medicare has received a lot of attention, but gaps in coverage for hospital and doctor costs also need to be addressed. Reps. Lisa Blunt Rochester (D-DE), Andy Kim (D-NJ), and Dwight Evans (D-PA) have proposed legislation for a comprehensive income-based cost cap for low-income seniors. [5] It would make health care affordable for 6.4 million Medicare beneficiaries. This policy brief explores why that effort is so important by outlining the gaps in Medicare coverage and how a cost cap would address those problems.

The Problem: Gaps in Coverage under Medicare

Typically, Medicare pays for 73% of an individual's health care costs without factoring in any other supplemental coverage (compared to 83-85% for typical employer plans). [6] Because of that, most beneficiaries have some source of supplemental coverage, which could be a Medigap plan, a Medicare Advantage plan, a prescription drug plan, a low-income supplement known as the Medicare Savings Programs (MSP), or various combinations.

One of the gaps in protection is that *Medicare doesn't have an out-of-pocket limit on health care costs for low- to moderate-income beneficiaries.* [7] This gap affects individuals who are not eligible for MSP. Currently, MSP provides supplemental coverage for beneficiaries with incomes up to 135% of the federal poverty level. This supplement covers a beneficiary's share of Medicare Part B premiums, which pays doctor bills. For beneficiaries living in poverty, it also covers out-of-pocket costs. Not only is the level to qualify for MSP very low (135% of the federal poverty level, which is $17,388), but too few people are enrolled (as shown in the chart below). [8] Specifically, half or more of eligible

beneficiaries are not enrolled or cannot enroll due to limits on enrollment slots. This results in a range of enrollment rates—from 29% of eligible participants in West Virginia to 78% of eligible participants in Maine. [9]

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Medicare Savings Program	Type of Assistance	Enrollment (Millions)	Participation Rate	Income Level to Qualify Based on Federal Poverty Level
QMB	Part A Premiums, Part B Premiums, Part B out-of-pocket costs	6.9	53%	100% or lower
SLMB	Part B Premiums	1.3	32%	101% to 120%
QI	Part B Premiums	0.6	15%	121% to 135%
QDWI	Part A Premiums	*	*	200% or lower

Notes: QMB: Qualified Medicare Beneficiary
SLMB: Specified Low-Income Medicare Beneficiary
QI: Qualifying Individual
QDWI: Qualified Disabled and Working Individuals

For the QMB, SLMB, and QI programs, recipients cannot have assets of more than $7,730 for an individual and $11,600 for a couple. For the QDWI program, the asset limits are $4,000 for an individual and $6,000 for a couple.

* less than 200 individuals

Source: United States, Congress, Medicaid and CHIP Payment and Access Commission, "Medicare Savings Programs: New Estimates Continue to Show Many Eligible Individuals Not Enrolled," Aug. 2017, https://tinyurl.com/y689gxq4. Accessed 3 Sept. 2021.

That gap in coverage has serious financial and health consequences for beneficiaries.

Financial Consequences

- High health care costs pushed more than 2 million older Americans into poverty in 2019. [10]
- Beneficiaries who are sick, lack supplemental coverage, and have an income of less than twice the poverty level face an average of $6,737 in medical bills each year. [11]
- Medicare beneficiaries who are newly-diagnosed with cancer and lack supplemental coverage have average out-of-pocket costs that were almost 24% of their household income. [12]
- One-in-ten of those diagnosed with cancer were crushed with out-of-pocket costs that consumed 63% of their total household income. [13]

Health Consequences

- Compared to the elderly in other high-income countries, older Americans are at least twice as likely not to get medical care because of costs. [14]
- Thirty-one percent of older Americans with high health care needs face obstacles to care due to cost compared to 2% to 19% in a study of 11 high-income countries. [15]
- Inadequate coverage for health costs is directly correlated with early death. [16]
- Older Americans are less likely to escape the poverty trap and chronic diseases and other health problems that poverty makes worse. [17]
- Black and Hispanic older Americans face more obstacles getting health care and more health care problems due to higher rates of poverty. [18]

The Solution: A Cost Cap for Medicare

Medicare beneficiaries should have protection from high premiums and out-of-pocket costs based on their income. Current cost protections for Medicare beneficiaries, however, are either missing or inadequate. For example, a beneficiary with an income of $16,389 (which is 135% of the poverty level) must pay as much as 17% of their income on out-of-pocket expenses, depending on how much care they need during a year. [19] In contrast, a beneficiary with a $48,500 income (400% of poverty) pays only 6%. The Blunt Rochester-Kim-Evans legislation would improve Medicare cost protections through the Medicare Savings Programs, which covers beneficiaries' hospital and doctor costs under Medicare Parts A and B as shown in the chart below. MSP is administered by the states as part of Medicaid.

Medicare Caps for Hospital & Doctor Costs

	Premium Contribution Cap		Out-of-Pocket Costs Cap	
Income as Percentage of Federal Poverty Level	Current Law	Proposed	Current Law	Proposed
100% or less	0%	0%	0%	0%
135%	10%	0%	17%	0%
200%	14%	7%	11%	11%
300%	9%	9%	8%	8%
400% or more	7% or less	7% or less	6% or less	6% or less

Notes: This chart applies to Medicare beneficiaries as individuals.

Caps outside of Medicare Savings Program are based on the average premium and out-of-pocket maximum for a Medigap plan (see endnote 19).

Source: Authors' calculations based on proposed legislation.

Specifically, the Blunt Rochester-Kim-Evans legislation would raise the Qualified Medicare Beneficiary eligibility from 100% to 135% of poverty as shown in the chart below. It would increase the Specified Low-Income Medicare Beneficiary eligibility from 120% to 200%. Beneficiaries above 200% of poverty would continue to use Medigap, Part D plans, and Medicare Advantage plans, which would be able to provide adequate cost caps with the addition of the provisions above. To increase participation rates, the proposal would provide grants to states for auto-enrollment under a program called Express Lane eligibility.

Proposed Changes to Medicare Savings Program

Medicare Savings Program	Type of Assistance	Current Income Level to Qualify Based on Federal Poverty Level	Proposed Income Level to Qualify Based on Federal Poverty Level
QMB	Part A Premiums, Part B Premiums, Part B out-of-pocket costs	100% or lower	135% or lower
SLMB	Part B Premiums	101% to 120%	200% or lower
QI	Part B Premiums	121% to 135%	replaced by SLMB
QDWI	Part A Premiums	200% or lower	no change

Notes: QMB: Qualified Medicare Beneficiary
SLMB: Specified Low-Income Medicare Beneficiary
QI: Qualifying Individual
QDWI: Qualified Disabled and Working Individuals

Under the proposal, the asset limits under the QMB and SLMB will be consistent with the Part D Low-Income Subsidy program.

Source: United States, Congress, House of Representatives. Helping Seniors Afford Health Care Act. Congress.gov, https://www.congress.gov/bill/117th-congress/house-bill/5040/, 117th Congress, 1st session, House Resolution 5040.

This legislation would help 6.4 million beneficiaries who fall into two groups. [20] The first group are 1.9 million beneficiaries with incomes under $17,388, which is 135% of the federal poverty level (FPL), who would no longer face Medicare Part B premiums for doctor care and out-of-pocket costs. Previously, these beneficiaries were only getting assistance with their premiums.

The second group are the 4.5 million seniors who weren't previously eligible. The new provision raises the income eligibility from $17,388 (135% FPL) to $25,769 (200% FPL). This group would no longer have to pay a monthly premium for Medicare Part B.

The potential for increased MSP enrollment for each state is shown below.

State-by-State Increase of Medicare Beneficiaries Receiving Financial Assistance Under the Blunt Rochester-Kim-Evans Legislation

	POTENTIAL MEDICARE SAVINGS PROGRAM ENROLLMENT INCREASE
United States	**6,447,100**
Alabama	179,300
Alaska	9,300
Arizona	211,200
Arkansas	84,000
California	572,300
Colorado	92,800
Connecticut	35,600
Delaware	26,300
District of Columbia	10,700
Florida	495,700
Georgia	207,100
Hawaii	20,800
Idaho	32,700
Illinois	209,900
Indiana	171,200
Iowa	62,000
Kansas	50,300
Kentucky	112,300
Louisiana	140,600
Maine	33,700
Maryland	81,400
Massachusetts	110,600
Michigan	203,600
Minnesota	84,100
Mississippi	107,900
Missouri	150,500
Montana	26,800
Nebraska	39,500
Nevada	53,000
New Hampshire	28,300
New Jersey	124,100

New Jersey	124,100
New Mexico	85,400
New York	437,300
North Carolina	221,400
North Dakota	21,400
Ohio	234,900
Oklahoma	88,100
Oregon	106,300
Pennsylvania	274,200
Rhode Island	19,200
South Carolina	116,200
South Dakota	17,700
Tennessee	147,900
Texas	423,300
Utah	33,100
Vermont	16,400
Virginia	130,100
Washington	107,400
West Virginia	71,800
Wisconsin	111,300
Wyoming	15,700

Source: Authors' calculations based on Hunter, Kaitlin and David Kendall. "A Cost Cap for Nearly 7 Million Medicare Beneficiaries: Methodology." Third Way, 22 Nov. 2019, www.thirdway.org/memo/a-cost-cap-for-nearly-7-million-medicare-beneficiaries. Accessed 3 Sep. 2021; "Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age." United States Census Bureau, American Community Survey, 2019, https://data.census.gov/cedsci/table?q=B27016&tid=ACSDT1Y2019.B27016&hidePreview=true&moe=false&tp=true. Accessed 3 Sep. 2021; "Eligibility for Medicare Savings Programs for Qualified Individuals (QIs)." Kaiser Family Foundation, 2018, www.kff.org/other/state-indicator/eligibility-for-medicare-savings-programs-for-qualified-individuals-qis/. Accessed 3 Sep. 2021; Moon, Marilyn, Robert Friedland, and Lee Shirey. "Medicare Beneficiaries and Their Assets: Implications for Low-Income Programs." The Urban Institute, Center on Aging Society and Kaiser Family Foundation, June 2002, Exhibit 3, www.urban.org/sites/default/files/publication/59826/1000249-Medicare-Beneficiaries-and-Their-Assets.PDF. Accessed 3 Sep. 2021; United States, Department of Health and Human Resources, Centers for Medicare and Medicaid Services, "MMCO Statistical & Analytic Reports 20 Jul. 2020: Annual Release (12/2007-12/2019)," www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics. Accessed 3 Sep. 2021.

Conclusion

Budget reconciliation provides an important opportunity to fill a big gap in protections for Medicare beneficiaries. The Blunt Rochester-Kim-Evans legislation fills that gap. It would bring the nation one step closer to everyone having access to affordable care through a cost cap.

Publication note: This report is an update of A Cost Cap for Medicare Beneficiaries and A Cost Cap for Nearly 7 Million Medicare Beneficiaries.

TOPICS

MEDICARE/MEDICAID 62

ENDNOTES

1. Torres, Stacy. "Why is American health care so inaccessible? It only got easy when my dad was dying." *USA Today*, 3 Aug. 2021. https://www.usatoday.com/story/opinion/voices/2021/08/03/health-care-easy-accessible-lifetime-not-just-hospice/5384133001/. Accessed 3 Sep. 2021.

2. Schoen, Cathy and Claudia Solis-Roman. "On Medicare But at Risk: A State-Level Analysis of Beneficiaries Who Are Underinsured or Facing High Total Cost Burdens." *The Commonwealth Fund*, May 10, 2016, https://www.commonwealthfund.org/publications/issue-briefs/2016/may/medicare-risk-state-level-analysis-beneficiaries-who-are. Accessed 3 Sep. 2021.

3. Schoen, Cathy and Claudia Solis-Roman. "On Medicare But at Risk: A State-Level Analysis of Beneficiaries Who Are Underinsured or Facing High Total Cost Burdens." *The Commonwealth Fund*, May 10, 2016, https://www.commonwealthfund.org/publications/issue-briefs/2016/may/medicare-risk-state-level-analysis-beneficiaries-who-are. Accessed 3 Sep. 2021.

4. Kendall, David, Gabe Horwitz, and Jim Kessler. "Cost Caps and Coverage for All: How to Make Health Care Universally Affordable. Third Way, 2 Feb. 2019, www.thirdway.org/report/cost-caps-and-coverage-for-all-how-to-make-health-care-universally-affordable. Accessed 3 Sep. 2021.

5. United States, Congress, House of Representatives. Helping Seniors Afford Health Care Act. *Congress.gov*, https://www.congress.gov/bill/117th-congress/house-bill/5040/, 117th Congress, 1st session, House Resolution 5040.

6. McArdle, Frank et al. "How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans? A 2012 Update." *Kaiser Family Foundation*, Apr. 2012, www.kff.org/health-reform/issue-brief/how-does-the-benefit-value-of-medicare/. Accessed 3 Sep. 2021.

7. Other gaps In health care cost protection for Medicare beneficiaries Included no cap on out-of-pocket drug costs and inadequate coverage for vision, dental, and hearing.

8. United States, Congress, Medicaid and CHIP Payment and Access Commission "Medicare Savings Programs: New Estimates Continue to Show Many Eligible Individuals Not Enrolled." Aug. 2017, www.macpac.gov/publication/medicare-savings-programs-new-estimates-continue-to-show-many-eligible-individuals-not-enrolled/. Accessed 3 Sep. 2021.

9. United States, Congress, Medicaid and CHIP Payment and Access Commission "Medicare Savings Programs: New Estimates Continue to Show Many Eligible Individuals Not Enrolled." Aug. 2017, www.macpac.gov/publication/medicare-savings-programs-new-estimates-continue-to-show-many-eligible-individuals-not-enrolled/. Accessed 3 Sep. 2021.

10. United States, Department of Commerce, Census Bureau. "The Supplemental Poverty Measure: 2019." Table 7, 15 Sep. 2020, www.census.gov/library/publications/2020/demo/p60-272.html. Accessed 3 Sep. 2021.

11. Schoen, Cathy, Karen Davis, and Amber Willink. "Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status." Appendix 5, *The Commonwealth Fund*, 12 May 2017, https://www.commonwealthfund.org/publications/issue-briefs/2017/may/medicare-beneficiaries-high-out-pocket-costs-cost-burdens-income. Accessed 3 Sep. 2021.

12. "Highest Out-of-Pocket Cancer Spending for Medicare Patients Without Supplement." Press Release, *JAMA Network*, 23 Nov. 2016. https://media.jamanetwork.com/news-item/highest-out-of-pocket-cancer-spending-for-medicare-patients-without-supplement/. Accessed 3 Sep. 2021.

13. "Highest Out-of-Pocket Cancer Spending for Medicare Patients Without Supplement." Press Release, *JAMA Network*, 23 Nov. 2016. https://media.jamanetwork.com/news-item/highest-out-of-pocket-cancer-spending-for-medicare-patients-without-supplement/. Accessed 3 Sep. 2021.

14. Osborn, Robin et al. "Older Americans Were Sicker and Faced More Financial Barriers to Health Care Than Counterparts in Other Countries." The Commonwealth Fund, 15 Nov. 2017, www.commonwealthfund.org/publications/journal-article/2017/nov/older-americans-were-sicker-and-faced-more-financial-barriers. Accessed 3 Sep. 2021.

15. Osborn, Robin et al. "Older Americans Were Sicker and Faced More Financial Barriers to Health Care Than Counterparts in Other Countries." The Commonwealth Fund, 15 Nov. 2017, www.commonwealthfund.org/publications/journal-article/2017/nov/older-americans-were-sicker-and-faced-more-financial-barriers. Accessed 3 Sep. 2021.

16. Woolf, SH, *et al.* " U.S. Health in International Perspective: Shorter Lives, Poorer Health." *National Research Council and the Institute of Medicine*, Ch. 4: Public Health and Medical Care Systems, 2013. https://www.ncbi.nlm.nih.gov/books/NBK154484/. Accessed 3 Sep. 2021.

17. Wedmedyk, Shaina. "Older Adults in Poverty Face Compounded Health Inequities." Association of State and Territorial Health Officials, 25 Aug. 2015, www.astho.org/StatePublicHealth/Older-Adults-in-Poverty-Face-Compounded-Health-Inequities/8-25-15/. Accessed 3 Sep. 2021.

18. Altman, Drew. "Seniors and Income Inequality: How Things Get Worse with Age." Kaiser Family Foundation, 11 Jun. 2015, www.kff.org/medicare/perspective/seniors-and-income-inequality-how-things-get-worse-with-age/. Accessed 3 Sep. 2021; Yamada, Tetsuji et al. "Access Disparity and Health Inequality of the Elderly: Unmet Needs and Delayed Healthcare." International Journal of Environmental Research and Public Health, 3 Feb. 2015, www.ncbi.nlm.nih.gov/pmc/articles/PMC4344691/. Accessed 3 Sep. 2021.

19. Authors' calculation based on the Blunt Rochester-Kim-Evans proposal and the average premium and out-of-pocket limit for Medigap Plan L. Although Plan L is not a common choice among beneficiaries, it is one of the few types of Medigap plans designed with a dollar amount for an out-of-pocket limit, which makes it suitable for the cost cap calculations.

20. Authors' calculations based on Hunter, Kaitlin and David Kendall. "A Cost Cap for Nearly 7 Million Medicare Beneficiaries: Methodology." Third Way, 22 Nov. 2019, www.thirdway.org/memo/a-cost-cap-for-nearly-7-million-medicare-beneficiaries. Accessed 3 Sep. 2021; "Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age." United States Census Bureau, American Community Survey, 2019, https://data.census.gov/cedsci/table?q=B27016&tid=ACSDT1Y2019.B27016&hidePreview=true&moe=false&tp=true. Accessed 3 Sep. 2021; "Eligibility for Medicare Savings Programs for Qualified Individuals (QIs)." Kaiser Family Foundation, 2018, www.kff.org/other/state-indicator/eligibility-for-medicare-savings-programs-for-qualified-individuals-qis/. Accessed 3 Sep. 2021; Moon, Marilyn, Robert Friedland, and Lee Shirey. "Medicare Beneficiaries and Their Assets: Implications for Low-Income Programs." The Urban Institute, Center on Aging Society and Kaiser Family Foundation, June 2002, Exhibit 3, www.urban.org/sites/default/files/publication/59826/1000249-Medicare-Beneficiaries-and-Their-Assets.PDF. Accessed 3 Sep. 2021; United States, Department of Health and Human Resources, Centers for Medicare and Medicaid Services, "MMCO Statistical & Analytic Reports 20 Jul. 2020: Annual Release (12/2007-12/2019)," www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics. Accessed 3 Sep. 2021.