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Adding an Out-of-Pocket Spending Limit to Traditional Medicare

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Introduction

Medicare beneficiaries can receive services through traditional Medicare (TM) or through Medicare Advantage (MA), in which private plans contract with Medicare to provide covered services. Though Medicare Parts A, B, and D benefits are fairly comprehensive, TM enrollees lack a cap on out-of-pocket spending, unlike in most commercial plans (such as employer-based coverage) available to people under age 65. This can result in very high expenses for enrollees with significant health problems. There is, however, an out-of-pocket cap in MA. In 2022, MA enrollees faced maximum caps of $7,550 for in-network expenses and $11,300 for both in- and out-of-network expenses combined. The out-of-pocket cap in MA and the absence of one in TM may be a factor contributing to the accelerated growth in MA enrollment and the decline in TM enrollment since 2018.

The originally proposed Build Back Better Act included a provision capping out-of-pocket spending for prescription drugs for Medicare Part D enrollees at $2,000.[1] This brief analyzes the implications of introducing a $5,000 cap on overall spending by TM enrollees and spending by specific payers, including Medicare, beneficiary out-of-pocket, supplementary coverage plan, and Medicaid spending. Although such a cap would be more ambitious than currently proposed legislation, a uniform cap on cost-sharing expenditures across Parts A, B, and D has been previously discussed as a possible way to reform Medicare and make the program more affordable for enrollees (Cubanski et al. 2016; Davis et al. 2005; Davis, Schoen, and Guterman 2013; Garrett et al. 2019). We also analyze two variations on this policy: One option would combine a $2,000 cap on cost sharing for prescription drugs with the $5,000 cap on all services. The second would set the spending cap at the same amount as the in-network cap on cost sharing in MA. We model these policy options as taking effect in 2023.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute has undertaken US Health Reform—Monitoring and Impact, a comprehensive monitoring and tracking project examining the implementation and effects of health reforms. Since May 2011, Urban Institute researchers have documented changes to the implementation of national health reforms to help states, researchers, and policymakers learn from the process as it unfolds. The publications developed as part of this ongoing project can be found on both the Robert Wood Johnson Foundation's and Urban Institute Health Policy Center's websites.

We estimate the following:

- In 2023, 4.5 million TM enrollees, or about 12 percent of such enrollees, will incur more than $5,000 in cost-sharing expenditures for Medicare services. In some cases, beneficiaries pay these expenses out of pocket. In other cases, supplementary insurance (e.g., Medigap or employer-sponsored insurance) or Medicaid pays some or all cost-sharing expenses over $5,000.
- The estimated average cost sharing in 2023 for Medicare beneficiaries with spending above the $5,000 cap is $10,500. Thus, a $5,000 cap is expected to reduce per capita cost-sharing payments by about $5,500.
- A $5,000 spending cap will increase Medicare spending for TM enrollees by about $39 billion (or 7.8 percent) relative to current law in 2023. This would likely require an increase in Parts B and D premiums to finance the new policy.
- Supplementary plan spending is estimated to fall by $12.3 billion under a $5,000 spending cap. This could apply downward pressure on Medigap premiums, potentially benefiting many enrollees currently unable to afford either excessive Medicare cost sharing or supplementary plan coverage or both.
- Because of the lower average out-of-pocket price for Medicare services for enrollees with high cost-sharing expenditures, total spending on Medicare services for TM enrollees (including program spending and beneficiary cost sharing) is estimated to increase by $14 billion, or 2.3 percent, relative to current law in 2023.

A spending cap of $5,000 would pay for expenses now paid out of pocket and provide direct relief to beneficiaries. Under the policy, payments made by supplementary insurance plans for these expenses beyond the proposed cap would be paid by Medicare instead of the supplemental insurer. We estimate that this would generate substantial savings for supplementary plans and potentially lead to lower premiums for Medigap plans. Enrollees in such plans would benefit from the lower premiums, or they could decide to drop supplementary coverage altogether if their primary motivation for having it was protection against large expenditures. Medicaid programs would also no longer bear expenses beyond

the proposed cap, which would result in lower state expenditures for enrollees dually covered by Medicare and Medicaid (hereafter "dual enrollees"). Federal Medicaid spending for these enrollees would also fall, offsetting some of the increased federal Medicare spending. In this paper, we estimate the additional costs of the $5,000 cap policy, both per capita and overall, and show the savings in out-of-pocket expenditures, reductions in supplementary insurance payments, and reductions in Medicaid expenditures relative to current law.

Medicare is a complicated program with complex cost-sharing rules. Medicare Part A provides hospital insurance; it has a large deductible for hospital stays ($1,556 in 2022). It also has additional cost sharing after 60 days of hospitalization and cost sharing for skilled nursing facilities after 20 days of use. Part B covers medical services such as visits to physicians. Part B had a deductible of $233 per year in 2022 and requires 20 percent cost sharing on all services. Part D provides coverage for prescription drugs provided through private plans. Part D has a complicated set of deductibles and cost sharing that can vary by plan. In addition to Parts A, B, and D, Medicare also offers Part C, or Medicare Advantage, which allows people to select private insurance plans. These plans offer all the services covered in Parts A and B and, in some cases, are integrated with Part D plans. If MA plans submit premiums below an established benchmark, they can offer additional benefits such as reduced cost sharing. Since 2011, federal regulations have required that MA plans cap out-of-pocket spending (the maximum cap for in-network services was $7,550 in 2021, and it increases with inflation), but plans can offer lower out-of-pocket maximums.

There are several effects that we do not measure in this analysis. First, we do not account for potential shifts in MA or Medigap enrollment. With the introduction of an out-of-pocket cap, some people may move from MA to TM. People choose MA plans for many reasons, but if the primary motivation is the out-of-pocket spending limit, some people could move back to TM. Similarly, an out-of-pocket cap could incentivize some TM enrollees to drop their Medigap plans if their primary motivation for having such coverage was protection from large expenditures. On the other hand, Medigap premiums may fall considerably in response to the introduction of an out-of-pocket spending cap, which may encourage enrollees to keep their Medigap plans or encourage other beneficiaries to newly enroll in such plans. Annual premiums paid to Medigap plans have been estimated to average about $1,779 (Cabral and Mahoney 2019). Thus, applying downward pressure on Medigap plans through the introduction of a $5,000 spending cap could result in significant savings to beneficiaries that are not estimated here.

Second, the TM benchmarks used for MA bidding could increase because covering expenditures above the cap would add to Part A and Part B expenditures, which could increase MA spending. In implementing the policy, Medicare could hold benchmarks fixed at their current levels and let MA plans compete with an enhanced TM option. If benchmarks were allowed to increase, MA plans would be allowed to offer additional benefits and attract TM beneficiaries.

Finally, the introduction of a cap on out-of-pocket expenditures in TM could lead MA plans to lower their out-of-pocket caps to better compete with improved TM benefits. This would be particularly likely if the cap on TM expenditures is lower than the caps offered by MA plans.

Methods

We use the Urban Institute's Medicare policy simulation model, MCARE-SIM, to estimate 2023 Medicare, supplemental, Medicaid, and out-of-pocket spending for Parts A, B, and D services among TM enrollees. MCARE-SIM uses data from the 2015–18 Medicare Current Beneficiary Survey (MCBS) and projects Medicare enrollment and spending estimates to 2023.

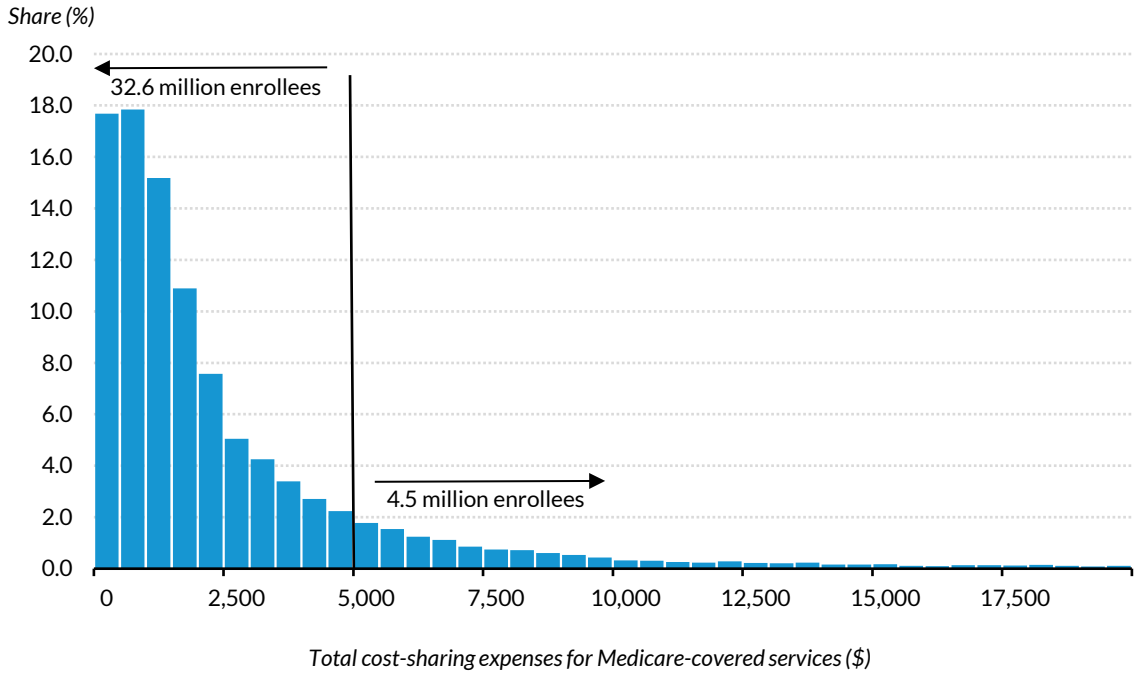
We estimate the costs of a $5,000 spending cap in 2023 for TM enrollees in three steps (see the appendix for more detail). We first estimate 2023 TM enrollment by applying demographic- and program-specific growth rates to 2015–18 MCBS data. The second step determines 2023 TM spending under current law, aligning MCBS-reported spending with administrative benchmarks and projecting to 2023. We apply cost-sharing rules for TM enrollees in Parts A, B, and D to determine cost-sharing obligations and then allocate them to beneficiaries or supplemental plans based on reported enrollment in Medicaid, Medigap, or other supplemental coverage. Our third step estimates the effects of a $5,000 cap on overall spending, spending by payer, and spending by service type. After identifying beneficiaries with cost-sharing obligations over $5,000, we credit cost-sharing paid by supplemental plans back to Medicare. We also credit beneficiary out-of-pocket spending back to Medicare, first adjusting beneficiaries' total spending to reflect the greater use of services associated with lower cost-sharing requirements.

Findings

The distribution of spending on cost sharing for Medicare-covered services is highly skewed. Most Medicare beneficiaries have expenses below $5,000, but some have a high cost-sharing burden. Figure 1 shows the skewed distribution of per capita spending for Medicare-covered services by supplementary insurance, by Medicaid, and paid out of pocket by beneficiaries. The figure shows that 32.6 million people have expenditures of $5,000 or less. The remaining 4.5 million have expenditures above $5,000. Of these, 3.0 million have expenditures between $5,000 and $10,000, 800,000 have expenditures between $10,000 and $15,000, and 800,000 have expenditures over $15,000.

FIGURE 1

Distribution of per Capita Cost-Sharing for Medicare Services for Traditional Medicare Enrollees, 2023



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Source: MCARE-SIM estimates for 2023 using the 2015–18 Medicare Current Beneficiary Survey.
Notes: Per capita estimates reflect the sum of supplementary insurance, employer-sponsored insurance, Medicaid, and beneficiary out-of-pocket payments for Medicare-covered services. Spending on cost sharing for Medicare services excludes payments for insurance premiums. The distribution presents all spending among fee-for-service beneficiaries with total cost-sharing expenditures below $20,000.

Enrollees with cost sharing greater than $5,000 have high overall Medicare spending and high overall cost sharing. Table 1 separates expenditure data for enrollees whose cost sharing is above $5,000 and for those whose cost sharing is at or below $5,000. Of those with cost-sharing expenditures above $5,000, we estimate that overall spending is $76,900 on average, with Medicare paying $66,400. Average cost sharing amounts to $10,500, spread across supplementary insurance, Medicaid, and out-of-pocket outlays. Among payers responsible for cost-sharing payments, supplementary plans (i.e., employer-sponsored insurance or Medigap coverage) pay the largest share, about $5,300 per enrollee. This is followed by Medicaid spending for dual enrollees at about $2,700. For TM enrollees with cost-sharing spending greater than $5,000, out-of-pocket spending amounts to $2,500 on average.

For enrollees with cost-sharing spending at or below $5,000, total spending for Medicare-covered services averages $7,400. Of this, Medicare pays $6,100. Average cost-sharing expenses, including out-of-pocket, supplementary plan, and Medicaid spending, amount to $1,300. Of this, enrollees pay $400 out of pocket.

TABLE 1

Per Capita Current-Law Spending for Traditional Medicare Enrollees, 2023

	Enrollees with cost-sharing spending above $5,000	Enrollees with cost-sharing spending at or below $5,000
Total spending for Parts A, B, and D services ($)	**76,900**	**7,400**
Medicare	66,400	6,100
Cost-sharing payments	10,500	1,300
Out of pocket	2,500	400
Supplementary plan	5,300	700
Medicaid	2,700	200
Estimated number of enrollees (millions)	**4.5**	**32.6**

Source: MCARE-SIM estimates for 2023 using the 2015–18 Medicare Current Beneficiary Survey.
Notes: Estimates reflect the sum of supplementary insurance, employer-sponsored insurance, Medicaid, and beneficiary out-of-pocket payments for Medicare-covered services. Spending on cost sharing for Medicare services excludes payments for insurance premiums. Totals exclude drug manufacturer discount spending for Part D. All spending estimates have been rounded to the nearest $100. Spending components may not sum to total because of rounding.

A $5,000 cap would reduce the cost-sharing burdens of high spenders by about 50 percent. Table 2 shows the estimated impact of a $5,000 cap on per capita spending. Across all TM beneficiaries, per capita Medicare expenditures would increase by $1,000, or 7.8 percent, relative to current law, while cost sharing would fall by $700, or 27.6 percent. Thus, on balance, total spending per capita for Medicare-covered services would increase by $400 (after rounding), or 2.3 percent, among TM beneficiaries. This increase in overall spending reflects induced demand (that is, new spending induced by the prices beneficiaries face above the cap falling to zero).

Among TM enrollees with cost sharing above $5,000, average total Medicare spending would increase from $66,400 to $74,900 under the $5,000 cap; this is an increase in per capita expenditures of $8,500, or 12.9 percent. This increase would be partially offset by a reduction in cost-sharing payments of $5,500, or 52.6 percent. We estimate out-of-pocket spending will fall by 51.1 percent (saving beneficiaries in this spending group $1,300 on average), supplemental plan spending will fall by 50.8 percent, and Medicaid spending will fall by 57.6 percent. Facing lower prices for Medicare-covered services, TM beneficiaries with cost-sharing spending exceeding the cap will use more services, increasing total spending by 3.9 percent.

Lastly, table 2 shows that the policy has no impact on enrollees with cost-sharing spending at or below $5,000 because the cap does not apply. Under a $5,000 spending cap, these enrollees are not exposed to any changes in the average price for services, and, as a result, their use of services is unchanged.

TABLE 2

Per Capita Spending for Traditional Medicare Enrollees under Current Law and under the $5,000 Spending Cap, 2023

	Per capita spending under current law	Per capita spending under $5,000 cap	Difference $	Difference %
All enrollees				
Total spending for Parts A, B, and D services ($)	15,900	16,300	400	2.3
Medicare	13,500	14,500	1,000	7.8
Cost-sharing payments	2,500	1,800	-700	-27.6
Out of pocket	700	500	-200	-22.4
Supplementary plan	1,300	900	-300	-26.5
Medicaid	500	300	-200	-37.6
Estimated number of enrollees (millions)	37.1	37.1		
Enrollees with cost-sharing expenses above $5,000				
Total spending for Parts A, B, and D services ($)	76,900	79,900	3,000	3.9
Medicare	66,400	74,900	8,500	12.9
Cost-sharing payments	10,500	5,000	-5,500	-52.6
Out of pocket	2,500	1,200	-1,300	-51.1
Supplementary plan	5,300	2,600	-2,700	-50.8
Medicaid	2,700	1,100	-1,600	-57.6
Estimated number of enrollees (millions)	4.5	4.5		
Enrollees with cost-sharing expenses at or below $5,000				
Total spending for Parts A, B, and D services ($)	7,400	7,400	0	0
Medicare	6,100	6,100	0	0
Cost-sharing payments	1,300	1,300	0	0
Out of pocket	400	400	0	0
Supplementary plan	700	700	0	0
Medicaid	200	200	0	0
Estimated number of enrollees (millions)	32.6	32.6		

Source: MCARE-SIM estimates for 2023 using the 2015–18 Medicare Current Beneficiary Survey.

Notes: Per capita estimates reflect the sum of supplementary insurance, employer-sponsored insurance, Medicaid, and beneficiary out-of-pocket payments for Medicare-covered services. Spending on cost sharing for Medicare services excludes payments for insurance premiums. Totals exclude drug manufacturer discount spending for Part D. All spending estimates have been rounded to the nearest $100. Spending components may not sum to total because of rounding. Percent changes are based on unrounded spending estimates.

The cap's largest impact is the reduction in cost-sharing expenses for Part B services. Table 3 breaks down the data for high spenders (with cost-sharing expenditures above $5,000) in table 2 into spending by Parts A, B, and D services. Figure 2 presents the change in Parts A, B, and D spending for high spenders under the proposed $5,000 cap relative to current law. On a per capita basis, a $5,000 cap results in an estimated increase in Medicare Part A spending of $1,900. Cost sharing for Part A services falls by $1,300 per capita relative to current law. The net increase in per capita TM spending on Part A services is $600, or 1.6 percent.

The largest dollar increases in spending are in Part B. With the $5,000 cap, Medicare spending increases by $5,100 per capita, whereas cost sharing for Part B services falls by $3,900; thus, the net increase in new per capita spending is $1,200, or 3.4 percent. The drop in cost-sharing spending for Part B services is spread across beneficiary out-of-pocket, supplementary plan, and Medicaid spending, but the decline is largest for supplementary insurance.

For Part D, per capita Medicare spending among TM enrollees increases by $1,500 relative to current law, and out-of-pocket spending declines by $300. The net increase in per capita drug spending is $1,200, or 22.3 percent. This relative increase in overall spending is significantly higher than the changes in spending for Parts A and B services for two reasons. First, based on elasticity studies, we model beneficiaries as having a larger response to changes in the price of prescription drugs than they would have for changes in the price of hospital and physician or outpatient services. Second, following policy rules for Part D, we do not model supplementary plans as providing cost-sharing protection for prescription drugs, meaning *all* Part D beneficiaries who reach the $5,000 cap would experience a change in the out-of-pocket price for prescription drugs and increase their use of prescription drugs in response.

TABLE 3

Per Capita Spending under Current Law and under the $5,000 Spending Cap among Traditional Medicare Enrollees with Current-Law Cost-Sharing Spending above $5,000, by Payer and Medicare Service, 2023

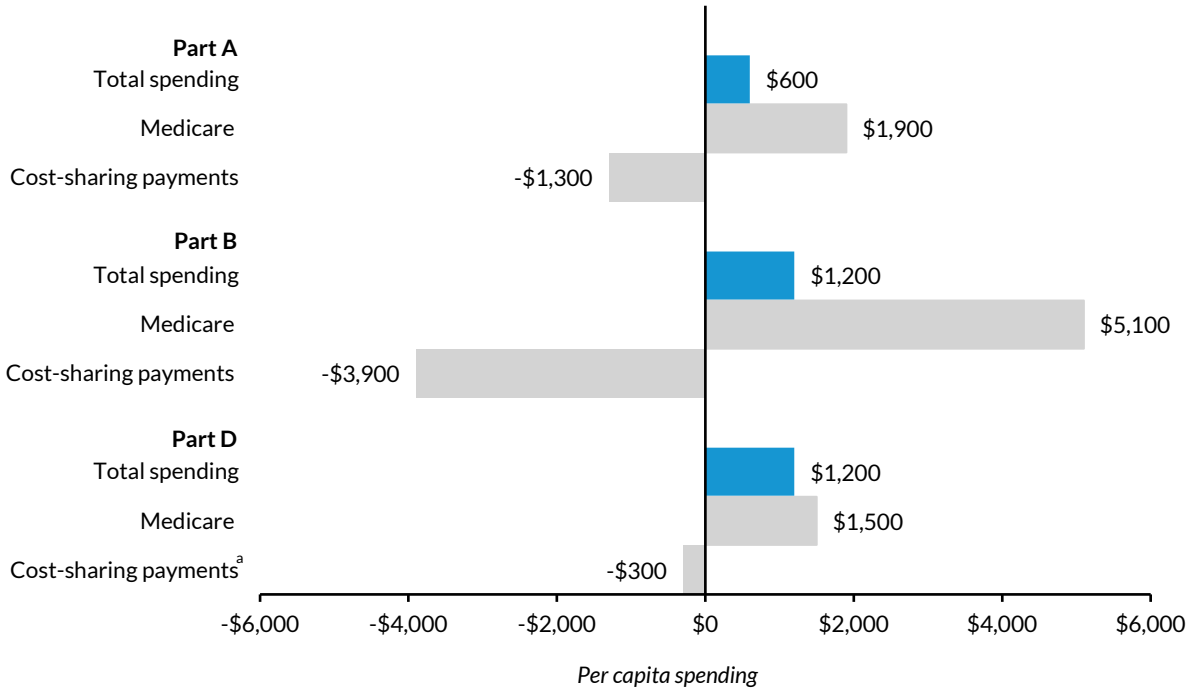
	Per capita spending under current law	Per capita spending under $5,000 cap	Difference	
			$	%
Part A				
Total spending ($)	*36,100*	*36,700*	*600*	*1.6*
Medicare	33,500	35,400	1,900	5.8
Cost-sharing payments	2,600	1,200	-1,300	-52.5
Out of pocket	500	200	-300	-54.7
Supplementary plan	1,200	600	-500	-46.8
Medicaid	900	400	-500	-58.5
Part B				
Total spending ($)	*35,500*	*36,700*	*1,200*	*3.4*
Medicare	28,300	33,400	5,100	18.0
Cost-sharing payments	7,200	3,300	-3,900	-53.9
Out of pocket	1,300	600	-700	-56.3
Supplementary plan	4,200	2,000	-2,100	-51.7
Medicaid	1,800	800	-1,000	-57.1
Part D				
Total spending ($)	*5,300*	*6,500*	*1,200*	*22.3*
Medicare	4,600	6,100	1,500	32.6
Cost-sharing payments[a]	700	400	-300	-39.6
Estimated number of enrollees (millions)	**4.5**	**4.5**		

Source: MCARE-SIM estimates for 2023 using the 2015–18 Medicare Current Beneficiary Survey.

Notes: Per capita estimates reflect the sum of supplementary insurance, employer-sponsored insurance, Medicaid, and beneficiary out-of-pocket payments for Medicare-covered services. Spending on cost sharing for Medicare services excludes payments for insurance premiums. Totals exclude drug manufacturer discount spending for Part D. A small amount of cost sharing for drug spending accrues to employer-sponsored insurance plans that provide coverage in the catastrophic range, but this amount is omitted from the table. All spending estimates have been rounded to the nearest $100. Spending components may not sum to total because of rounding. Percent changes are based on unrounded spending estimates.
[a] All cost-sharing payments under Part D are allocated to beneficiary out-of-pocket payments.

FIGURE 2

Change in per Capita Spending under $5,000 Spending Cap Relative to Current Law, among Traditional Medicare Enrollees with Current-Law Cost-Sharing Spending above $5,000, by Payer and Medicare Service, 2023



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Source: MCARE-SIM estimates for 2023 using the 2015–18 Medicare Current Beneficiary Survey.
Notes: Per capita estimates reflect the sum of supplementary insurance, employer-sponsored insurance, Medicaid, and beneficiary out-of-pocket payments for Medicare-covered services. Spending on cost sharing for Medicare services excludes payments for insurance premiums. Totals exclude drug manufacturer discount spending for Part D. A small amount of cost sharing for drug spending accrues to employer-sponsored insurance plans that provide coverage in the catastrophic range, but this amount is omitted from the figure. All spending estimates have been rounded to the nearest $100. Spending components may not sum to total because of rounding. Percent changes are based on unrounded spending estimates.
[a] All cost-sharing payments under Part D are allocated to beneficiary out-of-pocket payments.

Adding the cap would increase total Medicare spending by $38.8 billion in 2023. Table 4 shows changes in aggregate spending related to the cap. Aggregate TM expenditures would increase by $39 billion annually, or 7.8 percent, relative to current law. Cost-sharing payments would fall by $25 billion, or 27.6 percent. Out-of-pocket spending would fall by $6 billion, payments by supplementary insurance

plans would fall by $12 billion, and Medicaid expenditures would fall by $7 billion. The reduced out-of-pocket payments would directly help enrollees. The reduction in supplementary insurance payments should substantially reduce Medigap premiums, also helping enrollees. The drop in Medicaid expenditures would benefit both the federal and state governments. Overall, total spending on Parts A, B, and D services among TM enrollees would increase by $14 billion, or 2.3 percent.

TABLE 4

Total Expenditures for Traditional Medicare Enrollees under Current Law and under the $5,000 Spending Cap, by Payer, 2023

	Expenditures under current law	Expenditures under $5,000 cap	Difference	
			$	%
Spending for Parts A, B, and D services ($billions)	**592**	**605**	**14**	**2.3**
Medicare	500	539	39	7.8
Cost-sharing payments	91	66	-25	-27.6
Out of pocket	26	20	-6	-22.4
Supplementary plan	46	34	-12	-26.5
Medicaid	19	12	-7	-37.6
Estimated number of enrollees (millions)	**37.1**	**37.1**		

Source: MCARE-SIM estimates for 2023 using the 2015–18 Medicare Current Beneficiary Survey.
Notes: Totals exclude drug manufacturer discount spending for Part D. All spending estimates have been rounded to the nearest billion. Spending components may not sum to total because of rounding. Percent changes are based on unrounded spending estimates.

The largest aggregate increases in Medicare spending would be for Part B services; likewise, the greatest drop in cost sharing would be for Part B services. Table 5 shows the changes in aggregate expenditures by program Part. Relative to current law, Medicare spending on Part A services would increase by $9 billion, or 4.2 percent, among TM enrollees. This has implications for the Medicare Hospital Insurance Trust Fund, which finances the Part A program. Cost sharing for these services would fall by $6 billion, or 40.7 percent. Overall, Part A spending for TM enrollees and related cost sharing would increase by $3 billion, or 1.2 percent.

As noted, the cap would again have the biggest impact on Part B. Medicare spending for Part B services for TM enrollees would increase by $23 billion, or 9.7 percent, relative to current law. This would be financed by some combination of general revenues and higher Part B premiums paid by enrollees. Cost sharing for Part B services would fall by $18 billion, or 27.2 percent. Overall spending on Part B services and related cost sharing would increase among TM enrollees by $6 billion, or 1.8 percent.

Part D Medicare spending for TM enrollees would increase by $7 billion, or 13.1 percent. This would also likely be financed by higher premiums or general revenues. Out-of-pocket spending would drop by $1 billion. Thus, total spending on Part D services and related cost sharing would increase by $5 billion (after rounding), or 8.5 percent.

TABLE 5

Total Expenditures for Traditional Medicare Enrollees under Current Law and under the $5,000 Spending Cap, by Payer and Medicare Service, 2023

	Total expenditures under current law ($billions)	Total expenditures under $5,000 cap ($billions)	Difference	
			$billions	%
Part A				
Total spending	223	226	3	1.2
Medicare	208	217	9	4.2
Cost-sharing payments	15	9	-6	-40.7
Out of pocket	3	2	-1	-41.0
Supplementary plan	7	5	-2	-34.5
Medicaid	5	2	-2	-49.7
Part B				
Total spending	305	310	6	1.8
Medicare	240	263	23	9.7
Cost-sharing payments	64	47	-18	-27.2
Out of pocket	11	8	-3	-28.7
Supplementary plan	39	29	-10	-24.7
Medicaid	14	9	-5	-33.1
Part D				
Total spending	64	69	5	8.5
Medicare	52	59	7	13.1
Cost-sharing payments[a]	12	10	-1	-11.4

Source: MCARE-SIM estimates for 2023 using the 2015–18 Medicare Current Beneficiary Survey.

Notes: Totals exclude drug manufacturer discount spending for Part D. All spending estimates have been rounded to the nearest billion. Spending by Parts may not add to total spending because of rounding. Percent changes are based on unrounded spending estimates.

[a] All cost-sharing payments under Part D are allocated to beneficiary out-of-pocket payments.

Policy Alternatives

In table 6, we consider two policy alternatives. First, we estimate the impact of including a $2,000 Part D out-of-pocket cap in combination with the $5,000 overall TM cap. The $2,000 Part D out-of-pocket cap was initially proposed in the Build Back Better legislation and may have continued support under an updated reconciliation bill. Second, we estimate the impact of setting the cap on overall TM cost-sharing expenditures at the MA in-network out-of-pocket maximum ($7,550 in 2022). Introducing the out-of-pocket maximum in TM at parity with the MA in-network out-of-pocket maximum is a viable alternative, especially if lawmakers are concerned that a lack of parity in the two caps could introduce undue incentives for enrollees to switch coverage between TM and MA.

TABLE 6

Estimated Effects of the $5,000 Cap and Two Policy Alternatives on the Number of Affected Beneficiaries and Spending Relative to Current Law, 2023

	$5,000 cap on Medicare cost sharing (main policy)	$5,000 cap on Medicare cost sharing + $2,000 Part D cap	$7,550 cap on Medicare cost sharing
Number of affected beneficiaries (millions)	**4.5**	**4.7**	**2.5**
Change in per capita spending among affected beneficiaries ($)			
Total	3,000	3,400	3,200
Medicare	8,500	8,800	9,900
Cost-sharing payments	-5,500	-5,500	-6,700
Out of pocket	-1,300	-1,300	-1,500
Supplementary plan	-2,700	-2,600	-3,200
Medicaid	-1,600	-1,500	-2,000
Change in overall expenditures ($billions)			
Total	14	16	8
Medicare	39	41	25
Cost-sharing payments	-25	-26	-17
Out of pocket	-6	-6	-4
Supplementary plan	-12	-12	-8
Medicaid	-7	-7	-5

Source: MCARE-SIM estimates for 2023 using the 2015–18 Medicare Current Beneficiary Survey.
Notes: Per capita spending estimates are rounded to the nearest hundred. Estimates of overall expenditures are rounded to the nearest billion. Spending components may not sum to total because of rounding. Similarly, because of rounding, products of per capita estimates and total affected beneficiaries may not yield estimated total expenditures, and changes in Medicare spending and cost-sharing spending may not sum to changes in total spending.

Adding a $2,000 cap on cost sharing for prescription drugs covered by Part D to the $5,000 overall cost-sharing cap would benefit a small number of additional enrollees relative to the $5,000 overall cap alone. This is because most TM enrollees with high drug expenditures already have total cost sharing exceeding $5,000 and are already accounted for under the main policy. However, among all beneficiaries affected by the policy (i.e., those who incurred either $5,000 in total cost sharing or $2,000 in Part D cost sharing or both), total spending and Medicare spending per capita would increase by $3,400 and $8,800, respectively, relative to current law. Under this alternative policy, changes in per capita cost-sharing expenses relative to current law are similar to such changes under the main policy.

We find that this alternative policy would increase overall spending by $16 billion relative to current law, or about $2 billion more than the estimated increase in total spending under the main policy. The increase in total spending relative to the main policy reflects the behavioral response to markedly lower prices for Part D drugs, the category of services we model as being the most price sensitive. We estimate that this policy alternative would raise Medicare program costs by $41 billion relative to current law. Like the changes in per capita estimates, changes in total cost-sharing expenditures are similar under this policy alternative and the main policy.

Setting the TM cost-sharing cap at $7,550 (the current MA in-network out-of-pocket cap) would benefit 2 million fewer enrollees and would raise Medicare spending by $14 billion less than the main policy. Introducing the TM cost-sharing cap at exactly the MA in-network out-of-pocket cap would benefit fewer enrollees than the main policy; just an estimated 2.5 million TM enrollees have cost-sharing totals exceeding $7,550. Consequently, this policy would increase total spending by about $8 billion and increase Medicare spending by $25 billion relative to current law. Finally, a $7,550 cap would reduce overall out-of-pocket spending by $4 billion, reduce supplementary plan spending by $8 billion, and reduce Medicaid spending by $5 billion. As expected, this policy generates smaller differences in spending relative to current law than the main policy does.

Discussion

Medicare spending is highly skewed. More than 9 percent of TM beneficiaries have cost-sharing expenses exceeding $5,000. These enrollees have average total Medicare expenditures of about $76,900, so they are clearly a group with very serious health problems. Of that amount, Medicare pays about $66,400. The remainder, about $10,500, is paid out of pocket or paid by supplementary health insurance or Medicaid.

A policy that would cap cost sharing at $5,000 would increase per capita TM spending by $1,000, or 7.8 percent, on average relative to current law. But it would reduce cost sharing for the enrollees with the greatest health care needs by about 53 percent. For high-spending enrollees, it would reduce spending now paid out of pocket by about 51 percent, reduce supplementary plan spending by about 51 percent, and reduce Medicaid spending by about 58 percent. The reduction in out-of-pocket spending would help enrollees directly. The reductions in supplementary health insurance payments would reduce the need to purchase such policies or dramatically reduce their premiums. The reduction in Medicaid spending would offset some of the federal cost of the cap and generate savings for state governments.

A cap on TM cost-sharing payments would cost $39 billion in 2023, an increase in TM spending of 7.8 percent relative to current law. Medicare spending for Part A services would increase by $9 billion, or about 4.2 percent, relative to current law. Part A does not require most beneficiaries to pay premiums and is instead almost entirely financed by the Medicare Hospital Insurance Trust Fund, which, in turn, is financed primarily by payroll taxes. Thus, a $5,000 cap would likely require an increase in payroll taxes, unless another financing source is provided. However, the Medicare Hospital Insurance Trust Fund is already projected to be depleted by 2026 under current law; any increase in payroll taxes (or other funding source) must be levied on top of those increases in revenues (or spending cuts) needed to keep the trust fund solvent.

Medicare Part B spending for TM enrollees would increase by $23 billion, or 9.7 percent, under a $5,000 cap. Part D Medicare spending would increase by $7 billion, or 13.1 percent. Parts B and D spending is financed through a combination of enrollee premiums and general federal revenues. Therefore, the increased spending for Part B and Part D services under the $5,000 cap would likely

result in an increase in enrollee premiums for Parts B and D services. Other possibilities could include changes in deductibles or coinsurance in ways that would provide offsetting savings. Finally, per capita TM spending for Part A and Part B services would rise by 7.1 percent (data not shown), which would place upward pressure on the TM spending benchmarks against which MA plans bid; this would potentially enable MA plans to provide more benefits to enrollees or provide savings to MA enrollees in the form of premium rebates.

As modeled for 2023, the $5,000 spending cap would directly affect 12 percent of TM beneficiaries. But over time the percentage of enrollees who would benefit would grow considerably, unless the cap is indexed to Medicare cost growth. Even in the near term, all Medicare beneficiaries, not just the high spenders, would benefit from the reduced costs of supplementary insurance.

Appendix. Detailed Methods

We use the Urban Institute's Medicare policy simulation model, MCARE-SIM, to estimate 2023 Medicare, supplemental insurance, Medicaid, and out-of-pocket spending for Part A, Part B, and Part D services among TM enrollees. MCARE-SIM uses data from the 2015–18 MCBS and projects Medicare enrollment and spending estimates to 2023. The MCBS provides nationwide information on demographic characteristics, use of medical services, medical expenditures, health status, access to health care, and sources of supplemental insurance coverage for Medicare enrollees.

We estimate the costs of a $5,000 spending cap in 2023 for TM enrollees in three steps. We first estimate 2023 TM enrollment. To do so, we reweight enrollee groups in a combined 2015–18 MCBS analytic file to match 2019 MA and TM enrollment by Part A, Part B, and Part D, reported in Centers for Medicare & Medicaid Services (CMS) program statistics.[2] We apply population growth rates for each age group and racial or ethnic group, calculated from 2010 estimates and projected 2030 estimates from the Urban Institute's Mapping America's Futures database.[3] To determine the share of enrollees with TM coverage, we further apply MA growth rates derived from enrollment numbers reported in 2019 CMS program statistics and projected MA enrollment reported in the Congressional Budget Office's 2021 Medicare baseline report.[4]

The second step determines 2023 TM spending under current law. MCARE-SIM adjusts MCBS-reported Medicare spending to align with total expenditures reported in the 2019 CMS program statistics for Parts A and B services and adjusts Part D spending to align with 2019 per capita averages reported in the Medicare Trustees report (Medicare Trustees 2020). Medicare spending is then projected to 2023 by applying per capita spending growth rates for Parts A, B, and D reported in the Medicare Trustees report's expanded and supplementary materials.[5]

To determine total Medicare cost-sharing payments, we apply cost-sharing rules for TM enrollees in each Part. Because CMS has not yet published the 2023 cost-sharing rules, we project these rules based on the growth rates in deductibles, copayments, and out-of-pocket spending thresholds (for Part D) between 2019 and 2022. For inpatient stays in 2023, enrollees are predicted to pay a $1,626 deductible. For stays longer than 60 days, we apply a $406 copayment per day. For skilled nursing

facility stays, we apply a $203 copayment per day after the first 20 days. We estimate that the Part B deductible will rise to $252 by 2023. Beyond the deductible, enrollees are estimated to pay 20 percent coinsurance for all Part B services. Finally, for Part D enrollees ineligible for the Low-Income Subsidy, we model cost sharing for prescription drugs based on a projected $504 deductible, after which 25 percent coinsurance applies until costs reach the catastrophic coverage range (after accruing $7,853 in out-of-pocket spending, including drug manufacturer discounts). Beyond the catastrophic range, we apply a coinsurance rate of 5 percent on all drug expenditures. Part D enrollees who receive the Low-Income Subsidy are expected to pay a nominal copayment of $3 for each prescription drug fill.

To allocate cost-sharing payments, we identify enrollees with any Medicaid or supplementary plan coverage. For dual enrollees, we allocate all cost-sharing expenses to Medicaid. The dominant Medigap plan has long been Plan F, which provides full coverage for cost sharing for Parts A and B services. We model supplementary plans as providing Plan F–level benefits; that is, if an enrollee reports having supplementary plan coverage (and no Medicaid coverage), all cost-sharing expenses are allocated to the supplementary plan. Finally, if enrollees report having neither Medicaid coverage nor coverage through a supplementary plan, all cost-sharing expenses are allocated as beneficiary out-of-pocket payments.

Our third step estimates the effects of a $5,000 cap on overall spending, spending by payer, and spending by service type. We first identify all enrollees estimated to have cost-sharing payments exceeding $5,000 in 2023 under current law. Expenditures exceeding the cap paid by Medicaid, by supplemental plans, or out of pocket are allocated back to the Medicare program. These are categorized as Part A, B, or D services based on the ratio of cost-sharing expenditures by service to total cost-sharing expenditures across all services. Further, for beneficiaries that had out-of-pocket spending for Medicare services above $5,000, the policy lowers the average consumer-facing price for services (i.e., where the price is operationalized as the ratio of out-of-pocket to total spending). We apply service-specific price elasticities to estimate the increase in spending for services resulting from the decrease in price (i.e., induced demand). However, the $5,000 cap does not result in higher expenditures for Part A or Part B services for enrollees with supplemental insurance or Medicaid coverage, because these enrollees' cost sharing is already covered by the secondary plan, so the cap does not change their out-of-pocket liability.

Notes

[1] Build Back Better Act, H.R. 5376 (2021).

[2] "CMS Program Statistics," Centers for Medicare & Medicaid Services, updated April 1, 2022, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics.

[3] "Mapping America's Futures," Urban Institute, updated December 1, 2017, https://apps.urban.org/features/mapping-americas-futures/.

[4] "Medicare Baseline Projections," Congressional Budget Office, July 2021, https://www.cbo.gov/system/files/2021-07/51302-2021-07-medicare.pdf.

[5] "Trustees Report and Trust Funds," Centers for Medicare & Medicaid Services, updated January 26, 2022, https://www.cms.gov/OACT/TR/2021.

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