

U.S. Health Reform—Monitoring and Impact

A Unified Cost-Sharing Design for Medicare: Effects on Beneficiary and Program Spending

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By Bowen Garrett, Anuj Gangopadhyaya, Adele Shartzter, Diane Arnos



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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org.

EXECUTIVE SUMMARY

Medicare covered more than 59 million people, or 18 percent of the U.S. population, in 2018. Medicare Part A covers inpatient hospital expenses, and a voluntary Part B program covers physician visits and outpatient care. Since 2006, an optional Part D benefit has provided prescription drug coverage. Medicare beneficiaries may elect to enroll for these services, by part, under the traditional fee-for-service Medicare program or receive their Parts A and B benefits (and optionally Part D) through managed care plans under Medicare Part C (Medicare Advantage).

Each of these four parts has different rules regarding beneficiary financial obligations. In 2019, Medicare Part A has a deductible of \$1,364 per hospital episode. Part B has an annual deductible of \$185 per year and 20 percent coinsurance on most covered services. There is no upper limit on the out-of-pocket expenses beneficiaries may need to pay under Parts A and B. Though cost sharing under Part D varies by plan, no plan can charge a deductible of more than \$415. This complex array of cost-sharing responsibilities can leave beneficiaries confused and exposed to very high out-of-pocket spending on health care.

Most fee-for-service beneficiaries supplement their Medicare benefits with other sources of insurance including Medigap policies, retiree health benefits, or Medicaid. Cost sharing is generally lower, on average, in Medicare Advantage plans, and regulations provide that beneficiaries in those plans pay no more than \$6,700 out of pocket per year for Parts A and B services.

In this report, we examine a potential reform to Medicare that would:

- simplify coverage for fee-for-service beneficiaries;

- streamline cost-sharing obligations under a uniform deductible for Parts A, B, and D services;
- create an out-of-pocket maximum to protect beneficiaries from high financial burdens.

Our model policy would simplify the cost-sharing requirements of Parts A, B, and D by introducing a \$500 copay for inpatient stays, a \$500 combined deductible across the three parts (hospital copay would apply toward the deductible), a common 25 percent coinsurance rate for Parts B and D, and a \$6,700 annual limit on out-of-pocket obligations. We chose these parameters to substantially reduce the cost of inpatient services while maintaining a disincentive for excessive hospital care and to unify cost sharing for Part B services with Part D. We also sought to avoid dramatically increasing or decreasing the government's Medicare outlays. Our main scenario raises the coinsurance rate for Part B services from 20 percent to 25 percent to help offset the program costs of substantially reducing the financial burdens for those with high medical spending with the out-of-pocket maximum set to the current Medicare Advantage level.

In addition to simplifying cost-sharing and providing more financial protection to beneficiaries, a more unified cost-sharing design within traditional Medicare would promote greater competition with Medicare Advantage plans and potentially reduce demand for Medigap supplemental coverage while maintaining incentives against unnecessary or low-value medical care.

We assess the potential impacts of the model policy on beneficiary and program spending using Urban Institute's new MCARE-SIM microsimulation model. The current version of the MCARE-SIM model is built using enrollee-level data

from the 2015 Medicare Current Beneficiary Survey, which includes information on demographic characteristics, source of supplemental coverage (if any), health status, use of medical services, and medical expenditures. We model the effects of the unified benefit design relative to current policy as if it were implemented in 2020. The analysis excludes Medicare Advantage enrollees (who are already in plans sharing features with the model policy) and focuses on fee-for-service enrollees in Parts A and B, including those enrolled and not enrolled in Part D. In addition to accounting for how spending would change by payer (Medicare, Medicaid, other supplemental, beneficiary out-of-pocket spending) under the model policy compared with current law, the MCARE-SIM model calculates a behavioral response on spending levels resulting from changes in cost sharing (i.e., induced demand). All else equal, reduced cost sharing would induce a modest increase in a beneficiary's total spending level, consistent with empirical literature. The current version of the model holds supplemental coverage fixed across scenarios, though we might expect the model policy to affect the demand for supplemental plans. The model policy could also affect beneficiary decisions to enroll in Medicare Advantage, which we do not currently address.

Projected to 2020, the findings present the estimated effects of the model policy change for 39.4 million traditional Medicare enrollees. The main findings are as follows:

- Overall, per capita spending on covered services (total of Parts A, B, and D) would increase from \$16,611 to \$16,965. Medicare program spending would increase by \$791 per enrollee (from \$13,862 to \$14,652), while out-of-pocket costs would decline by \$212 (from \$1,056 to \$844), and third-party payments (including supplemental plan payments and Medicaid) would decline by \$225. The aggregate share of costs that Medicare covers would increase from 83.4 percent to 86.4 percent.
- Beneficiaries with no supplemental or Medicaid coverage (about 30 percent of all fee-for-service enrollees) would see the largest changes in their total spending and out-of-pocket costs. Average spending on covered services would increase from \$13,693 to \$14,457 (5.6 percent) for those with no supplemental coverage, while out-of-pocket costs would decrease by \$428 on average (from \$2,399 to \$1,971, or 17.8 percent).
- The model policy would substantially reduce the Medicaid program's liabilities for covering Medicare cost sharing for dually eligible enrollees. Average Medicaid spending for this group would fall by \$848, or 26.6 percent, from \$3,190 to \$2,342.
- By income group, rates of having supplemental coverage and the sources of that coverage vary. Among those without supplemental coverage, beneficiaries in all income groups experience reductions in out-of-pocket spending under the model policy compared with current law, ranging from 13.8 percent to 19.5 percent.
- Among enrollees without supplemental coverage, all age groups experience reductions in their average out-of-pocket costs, with the most substantial reductions occurring for those over age 75 (approximately 23 percent).
- Though the new policy structure reduces out-of-pocket costs on average, these costs would increase for some beneficiaries under the policy. Overall, 89 percent of enrollees would experience a decline in out-of-pocket spending or an increase of no more than 5 percent under the model structure, while 5 percent would experience an increase in out-of-pocket spending of 15 percent or more.
- Of more than 900,000 enrollees with \$6,700 or more in out-of-pocket expenses under current law, more than half would see their costs decline by 30 percent or more, and more than 30 percent would see their costs decline by 15 percent to 30 percent. But a substantial portion of enrollees with \$3,000 to \$6,699 in out-of-pocket costs would experience increases of 15 percent to 30 percent.
- Compared with current law, our model policy would increase aggregate expenditures by and on behalf of traditional Medicare beneficiaries by 2.1 percent. Medicare program spending for fee-for-service beneficiaries, projected to be \$546.2 billion in 2020, would increase by \$31.2 billion. Beneficiary out-of-pocket spending would decrease by \$8.3 billion, Medicaid spending would decrease by \$6.9 billion, and spending by supplemental coverage would fall by \$1.9 billion.

This report also presents findings for five additional scenarios that consider the effects of the model policy under alternative parameters: (1) no out-of-pocket maximum, (2) out-of-pocket maximum of \$5,000, (3) out-of-pocket maximum of \$3,300, (4) a \$750 deductible, and (5) 20 percent coinsurance for Parts B and D. Holding other elements of the policy constant, reducing the out-of-pocket maximum below \$6,700 would further decrease average spending by beneficiaries and supplemental coverage and correspondingly increase Medicare expenditures. Total

spending would increase somewhat as well, because of the increased use of care at lower effective prices.

Though changes in Medicare cost-sharing would likely affect premiums for Parts A (for the few who pay premiums for Part A), B, and D, we do not estimate those changes but note the likely magnitude of the effects. The savings accruing to supplemental coverage under the model policy would

likely lower premiums for Medigap and employer-sponsored retiree coverage. The modeled policy change could also affect the bids and payments of Medicare Advantage plans and alter beneficiary decisions to enroll in Medicare Advantage, which we have not modeled. In future work, we aim to address such limitations as we expand the MCARE-SIM model's capabilities.

INTRODUCTION

Since its creation in 1965, Medicare has been an essential source of health insurance coverage for seniors, and soon thereafter it also began covering people under age 65 with disabilities. Medicare was modeled after private insurance designs in the 1960s, which were primarily oriented toward protecting against high hospital bills. Initially, Medicare included Part A coverage for inpatient hospital expenses and a voluntary Part B program for physician visits and other outpatient care. Medicare has changed in size and scope over time, covering more than 59 million people, or 18 percent of the U.S. population, in 2018 and adding additional benefits beyond those established at the program's beginning.¹ Since 2006, Medicare has covered prescription drugs through a separate and optional Part D benefit. Medicare beneficiaries may elect to receive their Parts A and B benefits (and Part D, if they choose) through managed care plans under Medicare Part C, also known as Medicare Advantage.

Each of these four parts of Medicare has different rules regarding beneficiary financial obligations. For 2019, Medicare Part A has a deductible for inpatient hospital care of \$1,364 per episode, and Medicare Part B has an annual deductible of \$185 per year and 20 percent coinsurance on most covered services. There is no limit on beneficiary out-of-pocket expenses for Parts A and B services in fee-for-service (FFS) Medicare. Medicare Part D has different stages of cost sharing depending on utilization and plan benefit structure, but in 2019 no plan can charge a deductible of more than \$415. For most enrollees, Part D catastrophic coverage becomes effective after they incur about \$2,400 in out-of-pocket spending on prescription drugs in 2019, above which they continue to pay 5 percent of their drug costs with no limit.² This complex array of cost-sharing responsibilities can leave beneficiaries confused and exposed to very high out-of-pocket spending on health care.

Consequently, most FFS Medicare beneficiaries supplement their Medicare benefits with other sources of insurance. Some beneficiaries (26 percent) purchase Medigap policies,³ which are standardized plans designed to fill Medicare's coverage

gaps. About half of beneficiaries with Medigap are enrolled in Plan F, which is popular primarily because it offers full first-dollar coverage for all Medicare-covered services under Parts A and B (including the Part B deductible).⁴ Medicaid is another important source of supplemental coverage for Medicare beneficiaries who meet Medicaid's various income and other eligibility requirements. In addition, some Medicare beneficiaries obtain retiree supplemental coverage through a former employer, which helps reduce or eliminate their out-of-pocket obligations. Beneficiaries who enroll in Medicare Advantage plans through Part C can face variable cost-sharing requirements based on the plan's benefit structure. But cost sharing is generally lower, on average, in Medicare Advantage plans than in FFS Medicare, and regulations provide that beneficiaries in Medicare Advantage plans pay no more than \$6,700 out of pocket each year for Parts A and B services.

In this report, we examine a potential reform to Medicare that has two primary goals: simplify coverage for FFS beneficiaries and create an out-of-pocket maximum to enhance Medicare's protection against high financial burdens. The policy we model would streamline the cost-sharing requirements for Parts A, B, and D for FFS beneficiaries by introducing a \$500 combined deductible for services under all three parts; a \$500 copay for inpatient stays (which, if incurred, applies toward the combined deductible); 25 percent coinsurance for Parts B and D; and a \$6,700 out-of-pocket maximum that applies to all three parts. Other cost-sharing requirements, such as those that apply to skilled nursing facility stays, home health, and hospice, would not change. We chose these parameters to substantially reduce the cost of inpatient services while maintaining a disincentive for excessive hospital care and unifying cost sharing for Part B services with Part D. Our model policy raises the coinsurance rate for Part B services from 20 percent to 25 percent (in the main scenario). It also eliminates catastrophic drug coverage in Part D to help offset the program costs of substantially reducing the financial burdens for those with high medical spending with the out-of-pocket maximum set to the current Medicare Advantage level (\$6,700).

We assess the potential impacts of such a policy using the Urban Institute’s new MCARE-SIM microsimulation model, designed to model the effects of Medicare policies and potential reforms on beneficiaries and program finances. Our analysis builds on previous proposals to reform traditional Medicare (TM) that simulated expected out-of-pocket costs for different types of Medicare beneficiaries and considered different out-of-pocket maximum amounts.^{5,6,7,8,9} We discuss

how our findings relate to earlier studies’ findings in section 2 of the Appendix.

In addition to simplifying cost-sharing and improving financial protection for beneficiaries, a more unified cost-sharing design within FFS Medicare would promote competition with Medicare Advantage plans and potentially reduce demand for Medigap supplemental coverage while maintaining incentives against unnecessary or low-value medical care.

A UNIFIED COST-SHARING DESIGN

The new cost-sharing design we examine has several major components: a uniform \$500 combined deductible across Parts A, B, and D; a \$500 copay for each inpatient hospital stay; 25 percent coinsurance for Parts B and D services; and a \$6,700 annual maximum out-of-pocket limit on expenses. We treat the \$500 hospital copay as applicable toward the combined deductible. Going forward, we refer to this design as the “model policy.” We model the effects of this design relative to current policy as if it were implemented in 2020.

In Table 1, we compare the out-of-pocket responsibilities for inpatient hospitals, physician services, and prescription drugs under the new policy with expected coverage under current rules in 2020, as projected by Medicare Trustees, for beneficiaries without supplemental coverage or Medicaid. For beneficiaries with supplemental coverage or Medicaid, these cost-sharing rules describe the spending for Medicare-covered services that is the responsibility of a third-party payer or the beneficiary.

Table 1. Comparison of Deductible and Cost-Sharing Rules of New Unified Cost-Sharing Policy to Traditional Medicare Coverage (2020)

	Out-of-pocket or third-party payment liabilities in traditional Medicare FFS (2020 rules)	New unified cost-sharing policy (model policy)
Inpatient hospital		
Deductible	\$1,424 per episode	\$500 annual (combined)
Cost sharing	\$356/day for days 61–90; \$712 for up to 60 lifetime reserve days; all costs after reserve days	\$500 per episode
Physician/outpatient services		
Deductible	\$193 annual	\$500 annual (combined)
Cost sharing	20%; 0% for certain preventive services	25%; 0% for certain preventive services
Prescription drugs^a		
Deductible	\$435	\$500 annual (combined)
Cost sharing	25% up to \$6,350 ^b in total out-of-pocket spending; ~5% in catastrophic benefit	25%
Out-of-pocket spending		
Annual limit	No limit	\$6,700 ^c

Source: “Expanded Supplementary Tables and Figures,” in 2018 Medicare Trustees report: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html>.

Notes: FFS = fee-for-service.

^aUnder current law, the donut hole in Medicare Part D will be fully phased out in 2020. Accordingly, the donut hole is eliminated in our estimates of current law spending for 2020 and under the model policy.

^b\$6,350 total out-of-pocket includes payments for drug rebates. This equals about \$2,774 in beneficiary out-of-pocket payments for prescription drugs.

^cAlternative out-of-pocket limits of \$5,000, \$3,300, and no limit are also modeled, as described in Tables 7 and 8.

Under current law, beneficiaries in FFS traditional Medicare who do not have any supplemental or Medicaid coverage will face separate deductibles for inpatient hospital services under Part A (\$1,424 per episode in 2020; Table 1), Part B physician services (\$193), and Part D prescription drugs. The Part D deductibles vary based on the plan's specific benefit package, but the standard Medicare Part D benefit will include a deductible of about \$435 in 2020. Beneficiaries have no additional copayments for the first 60 days of a hospital stay under current law, but a daily cost-sharing requirement applies for longer hospital stays (projected to be \$356 per day for stays of 61 to 90 days and \$712 per day for stays beyond 90 days). Under our model policy, a Medicare beneficiary would have lower out-of-pocket responsibility for inpatient stays, facing a maximum out-of-pocket charge of \$500 compared with \$1,424 under current law.

To help finance the increased generosity for Part A services and implementation of an out-of-pocket limit, our main model policy also raises the coinsurance for Parts B and D

services. For Part B services, the coinsurance rate is higher under the new approach (25 percent versus 20 percent under current law). Our model policy similarly applies a 25 percent coinsurance on Part D drugs throughout the spending schedule and eliminates the catastrophic range, subject to the out-of-pocket maximum. The Affordable Care Act phases out the “donut hole” in the Medicare prescription drug benefit, where most beneficiaries face the full cost of their drugs before catastrophic coverage provisions take effect. In 2015 (the year of our data source), Medicare coverage of costs in the donut hole had been phased in only partially, but by 2020 the coinsurance rate will be a uniform 25 percent. To reflect rules that will be in place in 2020 under current law, we fill in the donut hole applicable to the 2015 data by applying a 25 percent coinsurance in the donut hole range for prescription drug spending. There is no cap on out-of-pocket expenses under current law for TM beneficiaries who do not have supplemental coverage, so our proposed \$6,700 out-of-pocket maximum is a new benefit that would reduce spending for beneficiaries with substantial health care needs.

DATA AND METHODS

The MCARE-SIM simulation model is primarily based on data from the 2015 Medicare Current Beneficiary Survey (MCBS). Survey respondents are Medicare beneficiaries enrolled in traditional FFS Medicare or Medicare Advantage for at least one month of 2015, including those under age 65 with disabilities and those residing in facilities. The survey includes information on sociodemographic characteristics, sources of supplemental insurance coverage, health status, access to health care, use of medical services, and medical expenditures. The MCBS allows for estimation of population statistics for those continuously or ever enrolled in the year and can be adjusted to reflect average monthly enrollment.

In addition to its survey data, the MCBS cost and use file contains administrative data on service utilization, Medicare outlays, and out-of-pocket liability for covered services linked to individual survey respondents, with an initial sample size of about 10,000 respondents. For this analysis, we generally use reported Medicare outlays and service utilization from the cost and use file to calculate third-party and out-of-pocket spending based on cost-sharing rules for 2020 (including the standard Part D benefit).

Beneficiary Coverage and Analysis Sample Restrictions

For this analysis, the MCARE-SIM model is restricted to FFS beneficiaries enrolled in Parts A and B, including those enrolled and not enrolled in Part D. Because we seek to model the implications of a uniform combined benefit for

this population, we exclude Medicare Advantage enrollees because they already have a combined benefit through their managed care plans. Enrollees are excluded from the analysis if they report only Medicare Advantage coverage throughout the calendar year (the primary reason for exclusion) or indicate that Medicare is not their primary payer. With these restrictions, we retain 64 percent of the original sample with cost and use data ($n = 6,406$). This translates into a population of approximately 32.3 million full-year-equivalent enrollees in 2015 (64 percent of all enrollees and 92 percent of all FFS enrollees). To benchmark to administrative totals (discussed below), we focus on full-year-equivalent enrollment. But for tabulations, we report enrollment as the number of people ever enrolled in the year.¹⁰ The 32.3 million full-year-equivalent enrollees estimate translates to 33.9 million ever enrolled in 2015 and an estimated 39.4 million ever enrolled in 2020.¹¹

Treatment of Supplemental Coverage

To determine the supplemental coverage status of TM enrollees, we use self-reported monthly coverage variables from the MCBS survey file to determine if enrollees have additional Medigap, retiree, or Medicaid coverage. Though TM beneficiaries with no supplemental coverage face a patchwork of out-of-pocket responsibilities that can be quite substantial, Medicare beneficiaries who have supplemental coverage through Medigap or an employer's retiree plan have more limited cost sharing under current

law. Medigap Plan F is the most prevalent Medigap plan and offers the most comprehensive protection against out-of-pocket expenses. Employer-sponsored retiree coverage also protects against out-of-pocket expenses, but there is little published information about the benefit structure of retiree supplemental plans. Because it is the most common supplemental plan, we assume that all Medicare beneficiaries with supplemental coverage through Medigap or a retiree health plan have a benefit structure like Plan F, with no deductibles or coinsurance for Parts A and B.¹² Medigap has not covered prescription drugs since 2006, and we do not have detailed information about retiree drug coverage benefits.¹³ We assume these Medicare beneficiaries have a standard Part D plan without a donut hole but with their employer or Medigap plan covering the 5 percent coinsurance beneficiaries face in the catastrophic range, which in 2020 occurs when enrollees incur at least \$2,774 in out-of-pocket expenditures for prescription drugs. Enrollees with employer-sponsored retiree coverage and/or supplemental coverage, but no Medicaid coverage, are designated as “FFS beneficiaries with supplemental coverage.” Our analysis does not permit enrollees to switch supplemental coverage plans under the modeled policy; therefore, beneficiary supplemental coverage status is held fixed.

Our assumptions likely overstate the generosity of supplemental coverage for those with Medigap or retiree health insurance, but we expect that to mainly affect enrollees’ level of out-of-pocket costs under current law, not the change in those costs under the modeled policy. Though most Medigap enrollees have coverage for all Medicare cost-sharing requirements, many Medigap enrollees must pay the Part B deductible and some are in plans that require copayments for certain services or have a higher deductible. Even so, Medigap plans generally offer more extensive coverage than our model cost-sharing structure, so out-of-pocket costs for those enrollees would not likely change under the proposal. Retiree plans also provide more extensive coverage than TM, including a limit on out-of-pocket spending, but they often reduce what retirees pay rather than cover all their out-of-pocket costs.¹⁴ Among enrollees with retiree insurance who face higher cost sharing, our proposal may affect out-of-pocket costs more than we have estimated, but we do not expect the differences to be substantial.

For low-income beneficiaries who meet the eligibility requirements, Medicaid coverage offers protection against out-of-pocket costs for Parts A and B services. Medicare beneficiaries who have full Medicaid benefits or are Qualified Medicare Beneficiaries thus have no deductibles or coinsurance requirements for those services. We assume

all TM beneficiaries with Medicaid are also enrolled in the Part D low-income subsidy, which limits their cost sharing to low copayments for brand-name and generic drugs (averaging about \$3 per prescription in 2015).¹⁵

Aligning 2015 Enrollment and Spending Data to Administrative Benchmarks

Weighted enrollment totals from the MCBS are already close to administrative benchmarks, but we adjust them slightly to fully align with enrollment totals reported in 2015 Centers for Medicare & Medicaid Services program statistics for all Medicare beneficiaries and all FFS beneficiaries by part.¹⁶ We also slightly adjust FFS enrollees’ Medicare expenditures to match 2015 Centers for Medicare & Medicaid Services program statistics per enrollee expenditures for FFS enrollees for Parts A and B services.¹⁷ We adjust Medicare Part D expenditures to match 2015 Part D expenditures reported by the Medicare Payment Advisory Commission (MedPAC).¹⁸

Projecting Enrollment and Expenditure Data to 2020

We calculate population growth rates from 2015 to 2020 by age group and race/ethnicity using estimates reported in the Urban Institute’s Mapping America’s Futures database.¹⁹ We scale the MCBS’s survey weights with these growth rates to obtain projected population counts for 2020. Finally, we use per beneficiary Medicare spending estimates for 2015 and the projected 2020 spending estimate from the 2018 Medicare Trustees Report to calculate growth rates for expenditures by part.²⁰ We apply these expenditure growth rates to Medicare program payments, then use Medicare 2020 cost-sharing rules to determine non-Medicare and total payments under current law, prior to applying model policy rules.

Spending by Service Type

The MCARE-SIM model requires specifying total expenditures for all Medicare-covered services used by FFS beneficiaries throughout the year. To examine the policy impact on Medicare and Medicaid financing and other payers’ payment liabilities, we categorize expenditures as either Medicare spending or non-Medicare spending. We separate payments into those categories for Parts A, B, and D services. We base our calculations of non-Medicare FFS payments (combined payments made by Medigap, employer-sponsored insurance, Medicaid plans, and beneficiaries out of pocket) on reported Medicare spending, accounting for beneficiary coverage, service utilization, Medicaid and supplemental plan coverage, and program deductible/cost-sharing rules. We describe our methods for imputing spending under current law by service type in section 1 of the Appendix.

Though the MCBS reports non-Medicare payments in the cost and use file, those amounts often differ considerably from our estimates based on Medicare spending after applying rules for beneficiary cost sharing and supplemental coverage. Because MCBS-reported Medicare spending for FFS beneficiaries is likely most accurate, we use Medicare spending, beneficiary coverage, and beneficiary service utilization to determine non-Medicare payment liabilities as described below, rather than the MCBS-reported amounts for non-Medicare spending. We further use information on supplementary plan types (if any), Medicaid coverage, and Part D low-income subsidy benefits to determine beneficiary out-of-pocket spending.

Computing Spending Amounts Under the New Policy

Under our model policy, beneficiaries are required to pay a \$500 combined deductible. In practice, the first \$500 of service spending could come from either Parts A, B, or D services, depending on the order in which service expenses are incurred during the calendar year. For modeling purposes, we simplify calculations by assigning deductible payments to service types within the deductible range in the same proportion as the observed individual share of Parts A, B, and D spending relative to total spending incurred during the calendar year.

Similarly, we allocate payments for services after enrollees exceed the \$6,700 out-of-pocket limit. In practice, service spending beyond the out-of-pocket maximum would depend

on the order in which these services were used over the year. We assign out-of-pocket payments beyond the \$6,700 limit to service type by assuming the share of Parts A, B, and D out-of-pocket spending relative to total out-of-pocket spending is held constant. We identify enrollees whose spending surpasses the out-of-pocket limit and reallocate the excess funds to Medicare program spending. We distribute spending beyond the \$6,700 limit by part such that it preserves the ratio of each part's out-of-pocket spending to total out-of-pocket spending.

Induced Demand Responses

We estimate the enrollee response to changes in pricing introduced by the policy in three steps. We first identify the average price of services under current law, by Parts A, B, and D, specified as the ratio of out-of-pocket spending to total spending. We next identify the new implied ratio of out-of-pocket spending to total spending under the model policy if enrollees had no change in utilization, which is the new effective price for Parts A, B, and D services under the model policy. Relying on evidence from the literature, we apply a -0.1 elasticity for Part A services, a -0.2 elasticity for Part B services, and a -0.3 elasticity for Part D services to derive new total utilization and spending measures under the model policy.²¹

Once we have determined the new spending level for enrollees resulting from the price change, we reapply the model policy cost-sharing rules to determine the allocation of Medicare and non-Medicare spending.

FINDINGS

Effects on Per Capita Spending Overall and by Payer and Part

Table 2 compares per capita projected 2020 spending under current law and the model policy and shows the allocation across Medicare program spending, beneficiary out-of-pocket payments, and payments from supplemental coverage, both in aggregate and for each Medicare part. Overall, per capita spending on covered services (total of Parts A, B, and D shown at the top of Table 2) would increase slightly under the proposal (from \$16,611 to \$16,965), but Medicare spending would increase by \$791 while out-of-pocket costs and third-party payments (including supplemental plan payments and Medicaid) would decline

by \$212 and \$225, respectively. The aggregate share of costs that Medicare covers would increase from 83.4 percent (\$13,862 out of \$16,611) to 86.4 percent (\$14,652 out of \$16,965) under the proposal.

In aggregate, most changes in per capita spending for Medicare would occur for Part A services, largely reflecting the proposed reduction in the hospital deductible. Average per capita Medicare spending on Part A would increase by \$451 (from \$5,617 to \$6,068), whereas out-of-pocket spending would decline by \$80 and third-party payments would fall by \$253. The high share of savings accruing to third-party payers primarily results from the high share of enrollees who have supplemental insurance covering all their Part A costs.

Table 2. Per Capita Spending of Medicare Fee-for-Service Beneficiaries, by Type of Medicare-Covered Services

2020 estimates				
	Current law	Model policy	Change	(%)
Parts A,B,D total	\$16,611	\$16,965	\$354	(2.1)
Medicare spending	\$13,862	\$14,652	\$791	(5.7)
Out-of-pocket spending	\$1,056	\$844	-\$212	(-20.1)
Supplemental plan or Medicaid	\$1,694	\$1,469	-\$225	(-13.3)
Part A total	\$6,190	\$6,308	\$118	(1.9)
Medicare spending	\$5,617	\$6,068	\$451	(8.0)
Out-of-pocket spending	\$146	\$65	-\$80	(-55.0)
Supplemental plan or Medicaid	\$427	\$175	-\$253	(-59.1)
Part B total	\$7,856	\$7,919	\$63	(0.8)
Medicare spending	\$6,180	\$6,221	\$41	(0.7)
Out-of-pocket spending	\$412	\$404	-\$8	(-2.0)
Supplemental plan or Medicaid	\$1,264	\$1,294	\$30	(2.4)
Part D total	\$2,564	\$2,738	\$173	(6.8)
Medicare spending	\$1,616	\$1,898	\$282	(17.5)
Out-of-pocket spending	\$498	\$374	-\$123	(-24.8)
Subsidy payments	\$448	\$465	\$17	(3.7)
ESI payments	\$2	\$0	-\$2	(-100.0)
<i>Estimated number of enrollees</i>	<i>39,405,000</i>	<i>39,405,000</i>		

Source: Urban Institute’s MCARE-SIM model, based on the 2015 Medicare Current Beneficiary Survey.

Notes: ESI = employer-sponsored insurance. Enrollment measured by the number of beneficiaries ever enrolled in a calendar year. Part A spending includes hospital inpatient, skilled nursing facility, home health services (for beneficiaries who had any inpatient utilization), and hospice care. Part B spending includes outpatient physician and other medical services, ambulatory surgical services, durable medical equipment, and home health services (for beneficiaries who had no inpatient utilization). Total Medicare spending reports the sum of Parts A, B, and D Medicare spending and Part D subsidy payments.

For Part B services, by contrast, the model policy would yield only small net changes in Medicare spending, out-of-pocket costs, and third-party payments. That result reflects the offsetting effects of the proposed limit on out-of-pocket costs, which increases Medicare’s costs, and the higher coinsurance rate on Part B services before that limit is reached, which reduces Medicare’s costs. Similarly, for Part D services, beneficiaries with high drug costs under current law may experience dramatic changes in out-of-pocket spending because of the increased coinsurance rate in the catastrophic range, from 5 percent to 25 percent; however, again, these individuals may also benefit from the policy because of the newly introduced \$6,700 out-of-pocket limit. How much a person spends out of pocket for prescription drugs depends

on the mix of their different types of health service spending under current law. We estimate that for Part D services, the proposal increases Medicare per capita spending by \$282 and reduces out-of-pocket spending by about \$123, on average.

Table 3 shows how the model policy’s effects would differ depending on enrollees’ type of supplemental coverage. As expected, beneficiaries with no supplemental or Medicaid coverage (who account for about 30 percent of the affected FFS enrollees) would see the largest changes in their total spending and out-of-pocket costs. Average spending on covered services would increase by \$764 (5.6 percent) for these beneficiaries, while average out-of-pocket costs would decrease by \$428 (17.8 percent). Correspondingly, per capita Medicare payments would increase by \$1,192 for this group.

Table 3. Per Capita Spending for Medicare Fee-for-Service Beneficiaries, by Supplemental Coverage and Medicaid Status

2020 estimates				
Fee-for-service coverage type	Current law	Model policy	Change	(%)
All FFS beneficiaries				
Total spending	\$16,611	\$16,965	\$354	(2.1)
Medicare spending	\$13,862	\$14,652	\$791	(5.7)
Out-of-pocket spending	\$1,056	\$844	-\$212	(-20.1)
Supp. plan or Medicaid	\$1,694	\$1,469	-\$225	(-13.3)
<i>Estimated number of enrollees</i>	<i>39,405,000</i>	<i>39,405,000</i>		
Without supplemental coverage				
Total spending	\$13,693	\$14,457	\$764	(5.6)
Medicare spending	\$11,295	\$12,487	\$1,192	(10.6)
Out-of-pocket spending	\$2,399	\$1,971	-\$428	(-17.8)
Supp. plan or Medicaid	\$0	\$0	\$0	
<i>Estimated number of enrollees</i>	<i>11,830,000</i>	<i>11,830,000</i>		
With Medigap or retiree coverage				
Total spending	\$14,349	\$14,479	\$130	(0.9)
Medicare spending	\$11,661	\$12,047	\$386	(3.3)
Out-of-pocket spending	\$594	\$436	-\$158	(-26.6)
Medigap or retiree plan	\$2,095	\$1,996	-\$99	(-4.7)
<i>Estimated number of enrollees</i>	<i>19,388,000</i>	<i>19,388,000</i>		
With Medicaid coverage				
Total spending	\$26,181	\$26,475	\$294	(1.1)
Medicare spending	\$22,782	\$23,951	\$1,169	(5.1)
Out-of-pocket spending	\$209	\$182	-\$27	(-13.1)
Medicaid spending	\$3,190	\$2,342	-\$848	(-26.6)
<i>Estimated number of enrollees</i>	<i>8,187,000</i>	<i>8,187,000</i>		

Source: Urban Institute's MCARE-SIM model, based on the 2015 Medicare Current Beneficiary Survey.

Notes: FFS = fee-for-service. Supp. = supplemental. Enrollment measured by the number of beneficiaries ever enrolled in a calendar year.

For enrollees with Medigap or retiree coverage, who account for about half of the affected population, the estimated changes in total spending and its components (Parts A, B, and D) would be modest. We expected the small change in out-of-pocket spending estimated for this group because these beneficiaries' out-of-pocket costs are limited by their supplemental insurance coverage for Parts A and B. Surprisingly, however, average costs incurred by their supplemental insurance plans would be reduced only modestly under the proposal, from \$2,095 to \$1,996, a difference of only \$99 (4.7 percent). Relative to all FFS enrollee groups, these enrollees, on average, use Part A

services the least (\$4,796 in total Part A expenditures relative to the \$6,308 average for the whole sample) and have the highest share of Part B expenditures relative to total expenditures (data not shown). Thus, Medigap and retiree plans gain the least from the reduced inpatient hospital deductible and are most affected by the increase in cost sharing for Part B services. Overall out-of-pocket spending decreases by an average of \$158 (26.6 percent) for this group; this difference comes entirely from changes in out-of-pocket spending for Part D services (not shown in table), because those are not covered by supplemental insurance.

By contrast, the proposal would substantially reduce the Medicaid program's liabilities for covering Medicare cost sharing for dually eligible enrollees. Medicaid spending for this group would fall by \$848 per capita. This partly reflects the higher likelihood of dual enrollees being hospitalized, which means that the proposed reduction in Medicare's hospital deductible is more likely to benefit them.²² Their higher rate of hospitalization also helps explain why their spending on Medicare services overall is much higher, about \$26,181 per enrollee, compared with roughly \$14,000 for the other two groups under current law.

Effects on FFS Enrollees by Income and Age

Because the proposed changes in cost sharing would most strongly affect enrollees who lack supplemental coverage, examining how those effects differ by enrollees' economic and demographic characteristics provides a useful perspective.

Table 4 shows that FFS enrollees in the middle of the income distribution are more likely to have neither supplemental nor Medicaid coverage, accounting for about 34 percent of this enrollee group. In contrast, lower-income enrollees are more likely to qualify for Medicaid, and higher-income enrollees are more likely to have retiree coverage or a Medigap plan.²³

Among those without supplemental coverage (right panel of Table 4), out-of-pocket costs decrease under the proposal for enrollees across the income distribution, with reductions ranging from 13.8 percent to 19.5 percent. Among those with income above 400 percent of the federal poverty level, out-of-pocket spending declines by \$482 (18.3 percent), from \$2,642 to \$2,159. The corresponding increase in Medicare program spending per capita to offset reduced out of pocket spending ranges from \$844 to \$1,394 and is greatest for those with income between 200 and 400 percent of the federal poverty level.

Table 4. Coverage Shares and Medicare Versus Out-of-Pocket Spending for Medicare Fee-for-Service Beneficiaries, by Income Group

2020 estimates												
Income group	% of enrollees	All Medicare FFS Beneficiaries			Subset of Medicare FFS Beneficiaries Without Supplemental Coverage or Medicaid							
		% with Medigap or retiree coverage	% with Medicaid coverage	% without supp. or Medicaid coverage	Medicare spending (\$)				Out-of-pocket spending (\$)			
					Current law	Model policy	Change (%)		Current law	Model policy	Change (%)	
<100% FPL	16	13	67	20	9,982	10,866	884	(8.9)	1,960	1,689	-271	(-13.8)
100%–200% FPL	25	39	26	34	9,340	10,183	844	(9.0)	2,046	1,762	-284	(-13.9)
200%–400% FPL	29	62	4	34	11,919	13,313	1,394	(11.7)	2,509	2,019	-490	(-19.5)
>400% FPL	31	70	1	30	12,347	13,669	1,322	(10.7)	2,642	2,159	-482	(-18.3)
All beneficiaries	100%	49%	21%	30%	11,295	12,487	1,192	(10.6)	2,399	1,971	-428	(-17.8)

Source: Urban Institute's MCARE-SIM model, based on the 2015 Medicare Current Beneficiary Survey.

Notes: FFS = Fee-for-service. Supp. = supplemental. FPL = federal poverty level. Enrollment measured by the number of beneficiaries ever enrolled in a calendar year.

Table 5 presents the distribution of effects by age group. Of enrollees under age 65, who generally qualify for Medicare because of a disability, only 12 percent have some form of private supplemental coverage. Though most of these enrollees qualify for Medicaid (56 percent), those who do not would be unlikely to have access to retiree coverage (because they are less likely to have worked and retired with an employer-based

supplemental plan because of their disability) and may have difficulty affording the premium of a Medigap plan. However, accounting for both Medicaid and private supplemental coverage, enrollees under age 65 are about as likely as other beneficiaries to have coverage beyond Medicare. Among those ages 65 and older, about 23 to 33 percent lack supplemental or Medicaid coverage, with only modest differences by age group.

Table 5. Coverage Shares and Medicare Versus Out-of-Pocket Spending for Medicare Fee-for-Service Beneficiaries, by Age Group

2020 estimates

Age group	% of enrollees	All Medicare FFS Beneficiaries			Subset of Medicare FFS Beneficiaries Without Supplemental Coverage or Medicaid							
		% with Medigap or retiree coverage	% with Medicaid coverage	% without supp. or Medicaid coverage	Medicare spending (\$)				Out-of-pocket spending (\$)			
					Current law	Model policy	Change (%)		Current law	Model policy	Change (%)	
<65	15	12	56	32	12,877	14,286	1,409	(10.9)	\$2,500	\$2,018	-482	(-19.3)
65–74	48	53	14	33	8,245	8,999	754	(9.1)	\$1,948	\$1,706	-242	(-12.4)
75–84	25	62	14	23	13,724	15,526	1,803	(13.1)	\$3,003	\$2,326	-676	(-22.5)
85+	13	51	20	29	18,412	20,227	1,815	(9.9)	\$3,237	\$2,481	-757	(-23.4)
All beneficiaries	100%	49%	21%	30%	11,295	12,487	1,192	(10.6)	\$2,399	\$1,971	-428	(-17.8)

Source: Urban Institute’s MCARE-SIM model, based on the 2015 Medicare Current Beneficiary Survey.
 Notes: FFS = fee-for-service. Enrollment measured by the number of beneficiaries ever enrolled in a calendar year.

Among those without supplemental coverage (right panel of Table 5), all age groups would see reductions in their average out-of-pocket costs, with the most substantial reductions occurring for those over age 85 (\$757, or 23.4 percent) and those between ages 75 and 84 (\$676, or 22.5 percent). Beneficiaries younger than 65 who are not Medicaid eligible typically qualify for Medicare on the basis of disability. We find that this group has lower total inpatient spending and higher total outpatient spending, on average, than the full sample; their reduced out-of-pocket spending is driven by the \$190 average reduction (52 percent) in Part A spending and a \$138 average reduction (9.2 percent) in Part B spending (not shown in table). Out-of-pocket costs would change the least for beneficiaries between ages 65 and 75, who likely recently gained eligibility based on age and are therefore younger and healthier than other enrollees.

Distribution of Changes in Out-of-Pocket Spending

Though the new policy structure reduces out-of-pocket costs on average, some beneficiaries would experience increased out-of-pocket costs under the policy. Table 6 shows ranges of percent increases or decreases in out-of-pocket costs by spending under current law. Overall, 89 percent of enrollees would experience a decline in out-of-pocket spending or an increase of no more than 5 percent under the proposed structure, while a small fraction

(5 percent) would experience an increase in out-of-pocket spending of 15 percent or more.

Nearly everyone with less than \$500 in out-of-pocket costs under current law would see his or her out-of-pocket costs stay the same or decline. Of more than 900,000 enrollees with more than \$6,700 in out-of-pocket expenses under current law, more than half would see their costs fall by 30 percent or more, and more than 30 percent would see their costs decline by 15 percent to 30 percent. Out-of-pocket costs would increase by 30 percent or more under the new policy for only 3 percent of all beneficiaries.

For individuals with out-of-pocket costs ranging from \$500 to \$999, most would see their costs decline, but 9 percent would experience some notable (i.e., more than 5 percent) increase. A substantial portion of enrollees with \$1,000 to \$6,699 in out-of-pocket costs under current law would experience increases of 5 percent to 30 percent. This result is driven by (1) individuals with substantial Part B spending for which the coinsurance rate increases from 20 percent to 25 percent under the policy and (2) the increase in Part D coinsurance from 5 percent to 25 percent in the catastrophic range. We report detailed findings for changes in out-of-pocket spending by part in Appendix Table 4.

Table 6. Change in Out-of-Pocket Spending

2020 estimates										
OOP payments under current law (\$)	Share (%) of Beneficiaries Experiencing							All beneficiaries		
	Spending reduction				Spending increase			Estimated number of enrollees	%	% with reduced out-of-pocket payments
	30% or more	15%–30%	5%–15%	+/- 5% change	5%–15%	15%–30%	30% or more			
0–99	9	2	38	51	0	0	1	5,355,000	14	48
100–499	54	4	27	10	1	0	3	17,583,000	45	86
500–999	25	19	32	15	2	2	5	6,886,000	17	76
1,000–2,999	4	14	22	32	22	4	2	6,853,000	17	40
3,000–4,999	3	20	27	3	32	8	7	1,354,000	3	50
5,000–6,699	7	19	8	20	24	14	8	469,000	1	34
6,700+	58	31	8	3	0	0	0	905,000	2	97
All beneficiaries	32%	9%	28%	20%	6%	2%	3%	39,405,000	100	69

Source: Urban Institute’s MCARE-SIM model, based on the 2015 Medicare Current Beneficiary Survey.

Notes: OOP = out-of-pocket. Spending and enrollment estimates are for 2020. Enrollment measured by the number of beneficiaries ever enrolled in a calendar year.

Effects on Per Capita Spending Under Alternative Model Policy Parameters

Table 7 illustrates the impact of changing the out-of-pocket limit and other model policy parameters on per capita spending among FFS enrollees without supplemental or Medicaid coverage and, separately, for all FFS beneficiaries. In addition to our main scenario with the \$6,700 out-of-pocket limit, we also estimate effects on spending with no limit, a \$5,000 limit, and a \$3,300 limit on out-of-pocket spending. For these alternative policy scenarios, we hold constant the other elements of the policy (i.e., the \$500 hospital copayment, the \$500 deductible, 25 percent coinsurance for Part B services, and the 25 percent coinsurance for Part D services in the catastrophic range). We also consider the implications of two additional policy scenarios: (1) raising the uniform deductible to \$750 and (2) maintaining coinsurance rates for Part B at 20 percent (as under current law) and reducing that for Part D services to 20 percent. Both scenarios maintain the \$6,700 out-of-pocket limit specified in the main model policy. We present details on policy specifications across these five additional scenarios in Appendix Table 3. We focus on how findings for the alternative policies differ from the main model policy specification.

For FFS beneficiaries with no supplemental or Medicaid coverage, we estimate that Medicare would pay less with no out-of-pocket maximum (Policy Alternative 1) relative to the main model policy (\$11,129 with no out-of-pocket maximum, compared with \$12,487 under the main model policy), and the beneficiaries would pay more on average (\$2,477 with no out-of-pocket maximum, compared with \$1,971 under the model policy). Relative to the model policy with no cap, the \$6,700 cap alone reduces average out-of-pocket spending per enrollee by more than \$500. Comparing Policy Alternative 1 with the main model policy for all beneficiaries, we find that the difference in out-of-pocket spending is more muted (\$1,019 versus \$844), but without a cap, spending by supplemental coverage or Medicaid is substantially higher (\$1,885 versus \$1,469). Medicare program spending is substantially lower under Policy Alternative 1 without the cap than under the model policy and is even slightly lower than under current law. This is because the cost implications of the other elements of the model policy roughly balance out. Though hospital cost sharing is lower, the beneficiaries would face higher cost sharing for Part B services and for prescription drugs in the Part D catastrophic range.

Table 7. Impact of Policy Alternatives on Per Capita Spending, by Payment Source

2020 estimates							
	Per Capita Spending (\$)						
	Current law	Model policy	Policy Alternative 1: Model policy with no OOP limit	Policy Alternative 2: Model policy with \$5,000 OOP limit	Policy Alternative 3: Model policy with \$3,300 OOP limit	Policy Alternative 4: Model policy with \$750 deductible	Policy Alternative 5: Model policy with 20% coinsurance
Subset of Medicare FFS beneficiaries without supplemental coverage or Medicaid							
Medicare spending	11,295	12,487	11,129	12,959	13,720	12,263	12,797
Out-of-pocket	2,399	1,971	2,477	1,811	1,567	2,096	1,807
Total	13,693	14,457	13,606	14,770	15,287	14,359	14,603
All FFS beneficiaries							
Medicare spending	13,862	14,652	13,697	14,998	15,581	14,476	14,944
Out-of-pocket	1,056	844	1,019	784	689	894	775
Supplemental or Medicaid	1,694	1,469	1,885	1,335	1,119	1,554	1,305
Total	16,611	16,965	16,600	17,117	17,388	16,925	17,024

Source: Urban Institute’s MCARE-SIM model, based on the 2015 Medicare Current Beneficiary Survey.

Notes: OOP = out-of-pocket. FFS = fee-for-service. Model policy refers to policy implementing a uniform \$500 deductible, 25 percent coinsurance rates for Part B and D services, and a \$6,700 out-of-pocket limit. “Model policy with \$750 deductible” replaces the \$500 uniform deductible with a \$750 uniform deductible. “Model policy with 20 percent coinsurance” uses a 20 percent coinsurance for Parts B and D services, rather than a 25 percent coinsurance rate.

As expected, applying lower out-of-pocket limits of \$5,000 and \$3,300 (Policy Alternatives 2 and 3, respectively) further reduces beneficiary out-of-pocket spending below that of the model policy. These policy scenarios also increase Medicare program spending relative to the model policy. For beneficiaries with no supplemental coverage, average out of pocket spending falls to \$1,811 with a \$5,000 limit (Policy Alternative 2) and \$1,567 with a \$3,300 limit (Policy Alternative 3). With reduced out-of-pocket spending for beneficiaries, both Medicare spending per beneficiary and total average spending per beneficiary would be higher, because lower effective prices tend to increase utilization of services. Similar patterns apply when we look at all FFS beneficiaries, but payments by supplemental coverage and Medicaid are lower with the lower caps (\$1,335 under Policy Alternative 2 and \$1,119 under Policy Alternative 3, compared with \$1,469 under the main model policy).

We consider two other variations of the main model policy holding the out-of-pocket limit fixed at \$6,700. For FFS beneficiaries without supplemental or Medicaid coverage, raising the deductible from \$500 to \$750 (Policy Alternative 4) results in lower average Medicare spending than under our main policy (\$12,263 versus \$12,487). Out-of-pocket spending for this group is 6 percent higher than under the main policy (\$2,096 versus \$1,971). We observe similar patterns in these comparisons looking across all FFS beneficiaries; spending

by supplemental or Medicaid programs increases relative to the main policy (\$1,554 versus \$1,469). Average total per beneficiary spending slightly decreased relative to the main policy (\$16,925 versus \$16,965), reflecting the small decrease in generosity driven by the increased uniform deductible.

Policy Alternative 5 establishes coinsurance rates for Parts B and D services at 20 percent while maintaining the \$6,700 out-of-pocket limit and the \$500 uniform deductible, as proposed under the main policy. Relative to the main model policy, we find such a policy would lower average per beneficiary out-of-pocket spending from \$844 to \$775 (8 percent) and lower supplemental or Medicaid spending from \$1,469 to \$1,305 (11 percent), while increasing Medicare program spending from \$14,652 to \$14,944 (2 percent). Average total per beneficiary spending would slightly increase relative to the main policy (\$17,024 versus \$16,965), reflecting the small increase in overall Medicare generosity driven by the decreased coinsurance rates for Parts B and D services.

Effects of Policy Alternatives on Aggregate Spending by Payer

Table 8 shows the aggregate change in total expenditures for TM enrollees, by payer, under the model policy relative to current law, as well as the spending impacts under the five policy alternatives. Compared with current law, our primary policy (with a \$6,700 limit) would lead to a 2.1 percent overall

increase in total spending by and on behalf of Medicare beneficiaries. Total Medicare program spending for FFS enrollees would increase by 5.7 percent, or \$31.2 billion, in 2020. Beneficiary out-of-pocket spending would decrease by 20.1 percent, Medicaid spending for FFS dual enrollees would decrease by 26.6 percent, and spending via private supplemental coverage would decrease by 4.7 percent.

Under an alternative specification of the model policy with no out-of-pocket limit (Policy Alternative 1), total spending would decrease by 0.1 percent relative to current law. Medicare program spending would decrease by \$6.5 billion (1.2 percent), and out-of-pocket expenditures would decrease by \$1.5 billion (3.5 percent). On the other hand, relative to current law, Medicaid and supplemental spending would increase in aggregate by \$1.4 billion (5.2 percent) and \$6.2 billion (15.2 percent), respectively, because these programs would cover the additional cost sharing (relative to current law) required under this alternative and insulate beneficiaries from high out-of-pocket costs. Medicaid, Medigap, and retiree coverage plans are penalized by the increased coinsurance to Part B services when this is not accompanied with an out-of-pocket limit, and those effects are not fully offset by the reduced cost sharing in Part A.

When we apply out-of-pocket limits that are lower than the primary specification (\$5,000 and \$3,300), we find increases in total spending of \$20.0 billion and \$30.6 billion, respectively, relative to current law. With a \$5,000 limit, Medicare program spending would increase by \$44.8 billion, or about 8.2 percent. Medicare program spending would increase by 12.4 percent, or \$67.8 billion, with a \$3,300 limit. Spending by Medicaid and supplemental coverage, however, would be substantially less with out-of-pocket limits of \$5,000 or \$3,300. Table 8 also shows that the policy successfully reduces out-of-pocket spending under all the alternative specifications, and the lower the out-of-pocket limit, the greater the aggregate reduction in beneficiary out-of-pocket spending.

Under Policy Alternative 4, which maintains all elements of the model policy but increases the deductible from \$500 to \$750, total spending increases by \$12.4 billion relative to current law. Medicare spending increases overall by about 4.4 percent, Medicaid spending decreases by 23.4 percent, supplemental coverage increases by 1.5 percent, and out-of-pocket spending decreases by 15.3 percent. Except for the change in supplemental coverage, these changes in aggregate spending are in the same direction as changes under the model policy. However, changes under Policy Alternative 4 are smaller in magnitude than under the model policy.

Table 8. Change in Traditional Medicare Enrollees’ Total Expenditures, by Payment Source and Policy Alternative

2020 estimates, dollar amounts in millions					
	Total	Medicare	Medicaid	Supplemental	Out-of-pocket
Expenditures under current law	\$654,555	\$546,225	\$26,119	\$40,618	\$41,593
Model policy (\$6,700 limit)	+\$13,963 (+2.1%)	+\$31,160 (+5.7%)	-\$6,944 (-26.6%)	-\$1,912 (-4.7%)	-\$8,342 (-20.1%)
Policy Alternative 1 (no OOP limit)	-\$422 (-0.1%)	-\$6,495 (-1.2%)	+\$1,369 (+5.2%)	+\$6,162 (+15.2%)	-\$1,457 (-3.5%)
Policy Alternative 2 (\$5,000 OOP limit)	+\$19,959 (+3%)	+\$44,794 (+8.2%)	-\$9,035 (-34.6%)	-\$5,104 (-12.6%)	-\$10,697 (-25.7%)
Policy Alternative 3 (\$3,300 OOP limit)	+\$30,643 (+4.7%)	+\$67,752 (+12.4%)	-\$12,178 (-46.6%)	-\$10,481 (-25.8%)	-\$14,450 (-34.7%)
Policy Alternative 4 (model policy with \$750 deductible)	+\$12,363 (+1.9%)	+\$24,222 (+4.4%)	-\$6,112 (-23.4%)	+\$610 (+1.5%)	-\$6,357 (-15.3%)
Policy Alternative 5 (model policy with 20% coinsurance)	+\$16,265 (+2.5%)	+\$42,638 (+7.8%)	-\$8,894 (-34.1%)	-\$6,415 (-15.8%)	-\$11,065 (-26.6%)

Source: Urban Institute’s MCARE-SIM model, based on the 2015 Medicare Current Beneficiary Survey.

Notes: OOP = out-of-pocket. Model policy refers to policy implementing a uniform \$500 deductible, 25 percent coinsurance rates for Parts B and D services, and a \$6,700 out-of-pocket limit. “Model policy with \$750 deductible” replaces the \$500 uniform deductible with a \$750 uniform deductible. “Model policy with 20 percent coinsurance” uses a 20 percent coinsurance for Parts B and D services, rather than a 25 percent coinsurance rate.

The last scenario we consider (Policy Alternative 5) maintains all elements of the model policy but reduces coinsurance for Parts B and D services from 25 percent to 20 percent. Relative to current law, such a policy would increase total spending by 2.5 percent and Medicare spending by about \$42.6 billion (7.8 percent). Medicaid, supplemental, and out-of-pocket

spending would decline by 34.1 percent, 15.8 percent, and 26.6 percent, respectively. The direction of these changes relative to current law is the same as the model policy, but the magnitudes of these changes are greater, reflecting the impact of raising the Medicare generosity of Parts B and D services.

DISCUSSION

Microsimulation modeling using the new MCARE-SIM model of a Medicare benefit package with an out-of-pocket maximum; a unified deductible across Parts A, B, and D; consistent coinsurance across Parts B and D; and a reduced hospital inpatient copayment finds that the policy would reduce overall per capita out-of-pocket spending for FFS Medicare beneficiaries compared with that under current law. Per capita out-of-pocket expenditures across Parts A, B, and D would drop by 20.1 percent, on average, from \$1,056 in 2020 under current law to \$844 under our model policy. Under the policy, out-of-pocket spending would drop or remain about the same for 35.1 million of the 39.4 million Medicare FFS beneficiaries in our sample and 4.3 million would experience at least a 5 percent increase in out-of-pocket spending. Medicare program spending would increase by \$31.2 billion relative to current law in 2020.

The reductions in average out-of-pocket spending mask the differential effects of the model policy on beneficiaries, depending on the amount and type of their Medicare spending under current law and whether they have supplemental or Medicaid coverage. Beneficiaries who do not have supplemental or Medicaid coverage to provide cost-sharing relief under current law would see the greatest reductions in out-of-pocket spending under the model policy. Beneficiaries who have Medicaid or other supplemental coverage would see much smaller reductions in average out-of-pocket spending attributable to their prescription drug costs. Beneficiaries with supplemental coverage have much lower current-law out-of-pocket spending. With Medicare covering a greater share of service costs, Medicaid and supplemental coverage per capita spending on behalf of these beneficiaries would decline by 13.3 percent.

Our model policy would benefit Medicare enrollees who have high out-of-pocket spending under current law, particularly those with spending above the policy's \$6,700 out-of-pocket maximum. For beneficiaries with out-of-pocket spending below the maximum under current law, those with relatively high Part A out-of-pocket spending would save on out-of-pocket costs under the model policy because of the universal decrease in Part A cost sharing. Those beneficiaries who

have a higher proportion of their out-of-pocket spending concentrated on services under Parts B or D would tend to fare less well under the model policy. Compared with current law, the model policy has slightly higher cost sharing for Parts B and D (25 percent versus 20 percent for Part B services and 25 percent versus 5 percent for Part D expenditures in the catastrophic range) up to the out-of-pocket maximum. So, we find that the mix of services that comprise a beneficiary's current-law spending below the \$6,700 maximum affects whether the model policy would reduce or increase their out-of-pocket spending.

Holding other elements of the policy constant, reducing the out-of-pocket maximum below \$6,700 would further decrease average spending by beneficiaries and supplemental coverage and correspondingly increase Medicare expenditures. Total beneficiary expenditures would increase as well, because of the increased use of care at lower effective prices. We describe similar efforts in recent years to simulate the effects of reforming Medicare's benefit design in Appendix section 2.

Our analysis has several limitations. The savings accruing to supplemental coverage would likely lower premiums for Medigap and employer-sponsored retiree coverage. Though changes in the benefit package would likely affect premiums for Parts A, B, and D, we do not estimate those changes. The overall effect on Medicare's Part B costs was small (a 0.7 percent increase), so the change in Part B premiums would also be small (roughly \$3 to \$4). We estimate an 8 percent increase in Medicare Part A costs, which would likely increase Part A premiums by a similar percentage, but relatively few enrollees owe the Part A premium,²⁴ so the aggregate effect on beneficiaries would be small. Part D program costs, however, would increase by about 17.5 percent, and enrollee premiums as structured under current law cover about one-fourth of the program's cost. Changes in Medicare's benefits and costs for Parts A and B would also affect the bids of and payments for Medicare Advantage plans, but we have not estimated those effects. We do not specify in our analysis how the additional \$31.2 billion in Medicare spending would be financed. To offset program cost increases not automatically covered by premiums, policymakers could

modify taxes to raise revenue; create a new unified premium for TM coverage for Parts A, B, and D; or adopt various other revenue-generating proposals.

The savings accruing to supplemental coverage would likely lower premiums for Medigap and employer-sponsored retiree coverage. According to our analysis, the average effect on costs for retiree and Medigap plans was small (a 4.7 percent reduction), but those effects would likely vary by plan. With limited available data about Medigap and retiree benefits, we assume that Medicare beneficiaries with supplemental coverage all have benefits similar to Medigap Plan F. This does not reflect Medicare beneficiaries' various supplemental coverage benefits that are less generous than Plan F. Medicare's liability under our policy is unaffected by this assumption, but we likely overestimate savings for supplemental plans and underestimate those beneficiaries' out-of-pocket savings. Premiums are an important factor in

retirees' decisions about whether to purchase supplemental coverage;²⁵ lower premiums could increase take-up, but a more comprehensive Medicare benefit may reduce the need to purchase supplemental coverage. Likewise, changes to the benefit package in traditional Medicare (e.g., including the out-of-pocket cap) would affect whether some beneficiaries elect to enroll in Medicare Advantage. A future expansion of this analysis could incorporate premium effects and model changes in insurance purchasing decisions. Several other analyses of a reformed Medicare benefit included separate fixed-dollar copayments for primary care and specialist physician visits. Though this cost-sharing arrangement is common in private health plans and new Medigap policies, the MCBS does not include a direct measure that distinguishes primary and specialty care visits, and we did not attempt to produce an assignment rule for reported physician visits. However, we will consider such an approach in future work.

APPENDIX SECTION 1: METHODOLOGICAL DETAILS

Estimating Current-Law Spending by Service Type

Inpatient Spending

We use Medicare-reported spending for inpatient events and the number of inpatient days per event to determine non-Medicare payments for inpatient services. For those with nonzero Medicare payments, non-Medicare payments are designated as the full deductible per inpatient episode (\$1,424 in 2020) and the per day charge for very long stays, if applicable. As noted above, we assume that supplemental coverage plans, such as Medigap or employer-sponsored insurance, require neither deductibles nor cost sharing for Part A services. For beneficiaries reporting supplemental coverage and dual beneficiaries with Medicaid coverage, we specify no out-of-pocket liabilities for inpatient services.

Skilled Nursing Facility Spending

We use Medicare-reported spending for skilled nursing facility (SNF) events and the number of days per SNF event to determine non-Medicare payment liabilities for SNF services. Because Medicare pays in full for the first 20 days of a SNF event, events with fewer than 20 SNF days are imputed to have \$0 non-Medicare payment liability. For each day in the 21-to-100-day range, we apply a per day copayment (\$178 in 2020). Medicare does not cover daily charges for beneficiaries after they've incurred 100 days of SNF utilization. Payments for more than 100 days of SNF care are considered as not being paid by Medicare under current law. Similarly, we treat SNF utilization beyond 100 days as not covered under the model policy.

Home Health and Hospice Care

Medicare pays for home health and hospice care stays in full. Home health payments are categorized as Part A Medicare payments if the beneficiary has at least one inpatient event in the year; otherwise, home health payments are categorized as Part B Medicare payments. Hospice care payments are categorized as Part A Medicare payments.

Part B Spending

We combined all events from the cost files for medical providers and outpatient services to determine Medicare payments for Part B services. For these services, individuals are projected to pay a deductible of \$193 in 2020. Cost sharing for nearly all Part B services is 20 percent after the deductible.²⁶ For beneficiaries with nonzero Medicare expenses, we determine non-Medicare expenses as the sum of the deductible and 20 percent of all spending beyond the deductible. Typical supplemental coverage plans, such

as Medigap or employer-sponsored insurance, require no deductible and no cost sharing for Part B services. For beneficiaries identifying supplemental coverage and dual beneficiaries with Medicaid coverage, we specify no out-of-pocket liabilities for Part B services.

Part D Spending

Determining spending on Part D services is somewhat more complex. We first separate enrollees based on whether they identify enrollment in the low-income drug subsidy program (LIS), because different rules for cost sharing and Medicare payments apply for non-LIS and LIS enrollees. For TM beneficiaries not enrolled in Part D, we assume they would not enroll in Part D under the new policy and do not factor their drug spending into our analysis.

Non-LIS Enrollees

For non-LIS beneficiaries, we apply the standard drug-benefit deductible and cost-sharing schedule with some adjustments. For non-LIS beneficiaries reporting some Medicare Advantage enrollment, we scale Medicare Part D payments by the share of their Part D enrollment that is concurrent with their FFS enrollment.

In 2020, non-LIS enrollees reach the catastrophic coverage range when their total out-of-pocket spending reaches \$6,350, though manufacturers' payments of coverage gap discounts are credited toward that total, as discussed below. After reaching this threshold, Medicare generally pays for 95 percent of Part D payments and enrollees pay the remaining 5 percent. For non-LIS enrollees with employer-sponsored supplemental coverage, we allocate the 5 percent cost share in the catastrophic range to the supplemental plan, reflecting our assumption about wraparound drug coverage in this range.

For non-LIS enrollees who reach the former coverage gap (in 2020, when total drug costs reach \$4,020), manufacturer discounts for brand-name drugs are applied. For simplicity, we include these discount payments with costs financed by the Medicare program in our accounting; however, discount payments also count toward enrollee out-of-pocket Part D payments and therefore count toward reaching the catastrophic coverage range. Ignoring discount payments would overstate beneficiary out-of-pocket liability in the coverage gap range.²⁷ Appendix Table 1 describes payment rules for non-LIS Part D enrollees.

LIS Enrollees

There are two forms of federal payments for LIS enrollees: Medicare base payments (which cover the costs of the basic drug benefit) and LIS cost-sharing subsidy payments. To determine these amounts, we use the total reported drug costs and number of standardized prescription fills for Medicare claims reported in the MCBS. We apply a nominal \$3 copay for each fill to assess out-of-pocket payments.²⁸ For the base payments, Medicare pays 75 percent for each

drug payment in the initial coverage range, nothing in the donut hole range (all Medicare payments are LIS subsidy payments in this range), and 95 percent in the catastrophic range (which occurs for LIS enrollees when their total drug costs reach \$9,039 in a year). LIS subsidy payments are thus simply the difference between total drugs costs and the sum of Medicare and out-of-pocket payments. Appendix Table 2 describes the rules we use to determine costs for LIS enrollees.

Appendix Table 1. Payment Imputation Rules for Non-LIS Part D Enrollees

2020 rules				
Range in total drug costs	Total drug costs	Medicare	Out-of-pocket	Manufacturer discounts
\$0–\$435	Y	\$0	Y	\$0
\$436–\$4,020	Y	$0.75*(Y-435)$	$0.25*(Y-435)+435$	\$0
\$4,020	Y = \$4,020	\$2,689	\$1,331	\$0
\$4,021–\$9,789	Y	$0.15*(Y-4,020)+2,689$	$0.25*(Y-435)+435$	$0.62*(Y-4,020)$
\$9,789	Y = \$9,789	\$3,554	\$2,774	\$3,461
>\$9,789	Y	$0.95*(Y-9,789)+3,554$	$0.05*(Y-9,789)+2,774$	\$3,461

Source: Urban Institute calculations based on “Expanded Supplementary Tables and Figures,” in 2018 Medicare Trustees report: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html>.

Notes: LIS = Low-Income Subsidy drug coverage. Y is total calculated individual drug costs.

Appendix Table 2. Payment Imputation Rules for LIS Part D Enrollees

2020 rules				
Range in total drug costs	Total drug costs	Medicare	Out-of-pocket	Manufacturer discounts
\$0–\$435	Y	\$0	\$3 x number of fills	Y-(Medicare+OOP)
\$435–\$4,020	Y	$0.75*(Y-435)$	\$3 x number of fills	Y-(Medicare+OOP)
\$4,020	Y = \$4,020	\$2,689	\$3 x number of fills	Y-(Medicare+OOP)
\$4,021–\$9,039	Y	\$2,689	\$3 x number of fills	Y-(Medicare+OOP)
>\$9,039	Y	$0.95*(Y-9,039)+2,689$	\$3 x number of fills	Y-(Medicare+OOP)

Source: Urban Institute calculations based on “Expanded Supplementary Tables and Figures,” in 2018 Medicare Trustees report: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html>.

Notes: LIS = Low-Income Subsidy drug coverage. Y is total reported individual drug costs for LIS enrollees.

APPENDIX SECTION 2: OUR FINDINGS IN THE CONTEXT OF PREVIOUS LITERATURE

There have been similar efforts in recent years to simulate the effects of reforming Medicare's benefit design. Differences in the policy design and data time frame make directly comparing findings difficult, but these efforts have consistently found that an annual out-of-pocket maximum would provide additional financial protection to the small share of beneficiaries each year with high medical spending. These analyses also note that adjusting coinsurance and copayments below the out-of-pocket maximum has a differential impact on beneficiaries based on their supplemental coverage benefits and service use.

In its 2012 report to Congress, MedPAC recommended developing a benefit design that would include an out-of-pocket maximum, a common deductible for Parts A and B, cost sharing designed to encourage use of high-value services, and an additional charge on supplemental insurance (Medigap).²⁹ MedPAC notes that an out-of-pocket maximum would provide financial protection to the small percentage of beneficiaries who incur high costs; because different beneficiaries typically incur these costs in a given year, over time the policy would benefit a larger percentage of Medicare beneficiaries. MedPAC's illustrative benefit package for Parts A and B would keep overall beneficiary cost-sharing liability roughly equal, on average, to current law. Though our approach yielded an average decrease in beneficiary liability, we similarly sought to balance protection against high medical costs with overall program spending and constraints against overuse of services. The MedPAC policy (modeled by Actuarial Research Corporation, using 2009 Medicare claims) included a \$5,000 out-of-pocket maximum; a \$500 combined deductible; a \$750 hospital copayment per admission; fixed-dollar copayments for physician, outpatient hospital, SNF, and home health services; and 20 percent coinsurance for Part B drugs and durable medical equipment. As with our analysis, MedPAC concluded that the effects of their illustrative benefit package would vary by beneficiaries' use of services. Their overall increase in Medicare program spending was lower than ours (1.0 percent versus 5.7 percent), in part because our policy yields a net decrease in average beneficiary out-of-pocket spending.

In "Medicare Essential: An Option to Promote Better Care and Curb Spending Growth," Davis, Schoen, and Guterman proposed a benefit that would combine Parts A, B, and D with an annual \$3,400 out-of-pocket maximum and \$250 annual deductible, fixed copayments for physician services, and 25 percent coinsurance for nonpreferred-brand prescription

drugs.³⁰ They also assumed an efficiency gain from value-based care, contributing to overall program savings over their ten-year time frame. Their policy would be financed with a budget-neutral premium, which they estimate would cost \$111 per month. As in our analysis, Davis, Schoen, and Guterman find that employer retiree plans and Medicaid would benefit under their policy while Medicare spending would initially increase.

More recently, a Commonwealth Fund report by Schoen, Buttorff, and Willink modeled a policy with a \$3,500 annual out-of-pocket maximum for Parts A and B services and hospital inpatient copayments of \$350 (or \$100).³¹ As in our analysis, the authors note the substantial relief for Medicare beneficiaries without supplemental or Medicaid coverage along with the savings for Medicaid, Medigap, and employer supplemental plans. The authors find that this policy would cost \$36 to \$44 per beneficiary per month, assuming no behavioral effect of lower cost sharing on total spending. We estimate that an out-of-pocket limit of \$3,300 (close to their \$3,500 limit) increases total spending by 4.7 percent, which translates to \$61 per beneficiary per month. Their policy parameters and modeling approach differ from ours. For example, they assess the effect of adding an out-of-pocket limit and lower hospital copayments without the additional Parts B and D changes included in our policy (our cost estimate would be even higher if we retained current-law 20 percent coinsurance for Part B services). Also, we assume lower cost sharing will induce somewhat higher medical spending consistent with the Rand Health Insurance Experiment and other research. Dollar for dollar, imposing an out-of-pocket maximum may have a smaller induction effect than lowering deductibles or coinsurance, but even so, some induction is warranted. Our induction method includes a higher price elasticity for prescription drugs than hospital or physician services, so policies that include drug spending in the out-of-pocket maximum could lead to greater induced demand than policies with an out-of-pocket maximum for Parts A and B only.

A 2016 Kaiser Family Foundation report by Cubanski, Neuman, Levinson, et al. describes four options to reform Medicare's benefit design,³² each of which includes an annual out-of-pocket maximum and a uniform deductible for Parts A and B services. Option 1 (the closest to our policy) includes a single \$650 deductible and a \$6,700 annual out-of-pocket maximum, as well as modifications to cost-sharing requirements. The other options lower the deductible and

out-of-pocket maximum, add financial support for low-income beneficiaries, and means-test the deductible and out-of-pocket maximum. The options include limitations on Medigap's ability to cover deductibles and do not address Part D services, key differences from our policy. Compared with our analysis, they find a lower share would experience reduced out-of-pocket spending in Option 1 (40 percent versus 69 percent in our analysis) but find a similar share with a minimal change (25 percent versus 20 percent in our analysis). As

they note based on their findings across the four options, estimates of changes in spending and impact on beneficiaries are sensitive to the specific policies modeled. The report also highlights that policies could be structured to increase financial protection against catastrophic expenses, add financial protection for low-income beneficiaries, reduce the need for supplemental coverage, and produce savings for the federal government or third-party payers, but these objectives cannot be achieved simultaneously.

Appendix Table 3. Comparison of Deductible and Cost-Sharing Rules of New Unified Cost-Sharing Policy to Other Policy Alternatives

	Model Policy	Policy Alternative 1: Model policy with no OOP limit	Policy Alternative 2: Model policy with \$5,000 OOP limit	Policy Alternative 3: Model policy with \$3,300 OOP limit	Policy Alternative 4: Model policy with \$750 deductible	Policy Alternative 5: Model policy with 20% coinsurance for Parts B and D services
Inpatient hospital						
Deductible	\$500 annual (combined)	\$500 annual (combined)	\$500 annual (combined)	\$500 annual (combined)	\$750 annual (combined)	\$500 annual (combined)
Cost-sharing	\$500 per episode	\$500 per episode	\$500 per episode	\$500 per episode	\$500 per episode	\$500 per episode
Physician/outpatient services						
Deductible	\$500 annual (combined)	\$500 annual (combined)	\$500 annual (combined)	\$500 annual (combined)	\$750 annual (combined)	\$500 annual (combined)
Cost-sharing	25%; 0% for certain preventive services	25%; 0% for certain preventive services	25%; 0% for certain preventive services	25%; 0% for certain preventive services	25%; 0% for certain preventive services	20%; 0% for certain preventive services
Prescription drugs^a						
Deductible	\$500 annual (combined)	\$500 annual (combined)	\$500 annual (combined)	\$500 annual (combined)	\$750 annual (combined)	\$500 annual (combined)
Cost-sharing	25%	25%	25%	25%	25%	20%
Out-of-pocket spending						
Annual limit	\$6,700	N/A	\$5,000	\$3,300	\$6,700	\$6,700

Notes: OOP = out-of-pocket. N/A = not applicable.

^aUnder current law, the donut hole in Medicare Part D will be fully phased out in 2020. Accordingly, the donut hole is eliminated in our estimates of current law spending for 2020 and under the model policy.

Appendix Table 4. Change in Out-of-Pocket Spending by Part

2020 estimates									
	Share of Beneficiaries Experiencing							All beneficiaries	
	Spending reduction			+/- 5% change	Spending increase			N	%
	30% or more	15%–30%	5%–15%		5%–15%	15%–30%	30% or more		
OOP payments under current law (\$)									
0–99	9	2	38	51	0	0	1	5,355,000	14
100–499	54	4	27	10	1	0	3	17,583,000	45
500–999	25	19	32	15	2	2	5	6,886,000	17
1,000–2,999	4	14	22	32	22	4	2	6,853,000	17
3,000–4,999	3	20	27	3	32	8	7	1,354,000	3
5,000–6,699	7	19	8	20	24	14	8	469,000	1
6,700+	58	31	8	3	0	0	0	905,000	2
All beneficiaries	32%	9%	28%	20%	6%	2%	3%	39,405,000	100
Part A OOP payments under current law (\$)									
0–99	0	0	0	99	0	0	1	37,531,000	95
100–499									
500–999									
1,000–2,999	98	0	0	1	0	0	0	1,418,000	4
3,000–4,999	84	14	2	0	0	0	0	178,000	<1
5,000–6,699	87	3	10	0	0	0	0	111,000	<1
6,700+	94	4	2	0	0	0	0	166,000	<1
All beneficiaries	5%	0%	0%	95%	0%	0%	1%	39,405,000	100
Part B OOP payments under current law (\$)									
0–99	0	0	0	100	0	0	0	29,247,000	74
100–499	2	3	4	10	8	23	50	3,377,000	9
500–999	0	1	0	2	8	25	63	2,634,000	7
1,000–2,999	2	1	1	1	12	74	9	2,980,000	8
3,000–4,999	9	1	5	4	12	69	0	634,000	2
5,000–6,699	13	8	15	11	28	24	0	231,000	1
6,700+	83	15	2	0	0	0	0	302,000	1
All beneficiaries	1%	1%	1%	75%	3%	11%	9%	39,405,000	100
Part D OOP payments under current law (\$)									
0–99	10	2	34	55	0	0	0	6,868,000	17
100–499	63	6	24	8	0	0	0	22,419,000	57
500–999	45	35	18	3	0	0	0	5,444,000	14
1,000–2,999	10	25	49	13	2	0	1	4,313,000	11
3,000–4,999	10	2	3	7	5	27	46	294,000	1
5,000–6,699	16	8	34	31	10	0	0	52,000	<1
6,700+	58	0	42	0	0	0	0	16,000	<1
All beneficiaries	45%	11%	27%	16%	0%	0%	0%	39,405,000	100

Source: Urban Institute’s MCARE-SIM simulation model, based on the 2015 Medicare Current Beneficiary Survey.

Notes: OOP = out-of-pocket. Enrollment measured by the number of beneficiaries ever enrolled in a calendar year.

ENDNOTES

1. According to Table II.B1 in the 2019 Medicare Trustees' report, 59.6 million people were enrolled in Medicare Part A in 2018, and a total of 59.9 million were enrolled in any component. See The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Baltimore: Centers for Medicare & Medicaid Services; 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf>. Accessed May 21, 2019.
2. The catastrophic threshold in Part D is set at \$5,100 in 2019, but drug manufacturer discounts are credited toward that amount, so a typical beneficiary would reach the threshold after paying about \$2,400 out of pocket.
3. Authors' calculations from 2015 Medicare Current Beneficiary Survey.
4. America's Health Insurance Plans. *State of Medigap 2018: Trends in Enrollment and Demographics*. Washington: America's Health Insurance Plans; 2018. https://www.ahip.org/wp-content/uploads/2018/06/State_of_Medigap18_FINAL.pdf. Accessed May 21, 2019. In this report, the enrollment figure for Plan F includes a high-deductible version of that plan; however, an earlier report indicates that purchases of the high-deductible version account for only a small percent of Medigap purchases. See the note below Table 5 in America's Health Insurance Plans Center for Policy and Research. *Trends in Medigap Enrollment and Coverage Options, 2013*. Washington: America's Health Insurance Plans; 2014. https://www.ahip.org/wp-content/uploads/2014/11/CPR_714_17_Trends-in-Medigap-Coverage-and-Enrollment_13.pdf. Accessed May 21, 2019.
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10. We do this because ever-enrolled totals are aligned with per capita and aggregate spending estimates when accounting for partial-year enrollees. We choose to capture partial-year Medicare spending for partial-year enrollees rather than annualizing spending for such enrollees, which would overstate the number of individuals reaching the out-of-pocket limit in addition to other features of the policy.
11. The growth rate reflects demographic trends, including a relatively high rate of growth for the population ages 65 and over of around 3 percent per year. Our current projections are driven by demographic factors. FFS enrollment may grow more slowly than we project if the Medicare Advantage penetration rate continues to rise. In the future, we will consider applying a differential trend for TM and Medicare Advantage enrollees.
12. Medigap Plan F provides full first-dollar coverage for Parts A and B services. Currently, the only plans with out-of-pocket limits for beneficiaries are Medigap Plans K and L, which reduce but do not eliminate beneficiary cost sharing. For details on Medigap plan characteristics, see Centers for Medicare & Medicaid Services. *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*. Baltimore: Centers for Medicare & Medicaid Services; 2017. <https://www.medicare.gov/sites/default/files/2018-07/02110-medicare-medigap-guide.pdf>. Accessed May 21, 2019.
13. Prior to 2006, some Medigap plans provided supplemental drug coverage. Once Part D was implemented, Medigap plans were prohibited from providing drug coverage. However, a grandfathering rule allowed beneficiaries with Medigap drug benefits to keep the plans they had. So, some 2015 enrollees in our data could still have these grandfathered plans. Our analysis only captures drug spending under Part D and how it changes under the model policy.
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15. Though we allocate payments made by the Part D low-income subsidy program as Medicare program payments, some of these expenses are ultimately financed by state Medicaid programs. See Schneider A. The "Clawback": State Financing of Medicare Drug Coverage. 2004. <https://www.kff.org/wp-content/uploads/2013/01/the-clawback-state-financing-of-medicare-drug-coverage.pdf>. Accessed May 21, 2019.
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22. We estimate that FFS dual enrollees average 0.47 inpatient stays relative to 0.23 and 0.22 stays for beneficiaries without Medicaid or supplemental coverage and beneficiaries with supplemental coverage, respectively.
23. It is unclear why 11 percent of enrollees with income greater than 400 percent of the federal poverty level report having Medicaid coverage. We find a similar share have Medicaid coverage when we limit to those with income greater than 600 percent of the federal poverty level. Measurement error in the income and/or Medicaid coverage measure could produce such a result, but further investigation is warranted.
24. Beneficiaries qualify for Part A enrollment without paying a premium if they have worked more than 40 quarters and paid Social Security taxes, or if they are the spouse of someone that qualifies for premium-free Part A. Among FFS individuals in the 2015 MCBS, 98.7 percent of beneficiaries did not pay a Part A premium.
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27. In 2019 and beyond, the discount amount is 70 percent. For non-LIS enrollees, about 89 percent of spending in the coverage gap range is for brand-name drugs. (See, for example, notes for Tables 10 through 19 of Medicare Payment Advisory Commission. *A Data Book: Health Care Spending and the Medicare Program*. Washington: Medicare Payment Advisory Commission; 2018. medpac.gov/docs/default-source/data-book/jun18_databookentirereport_sec.pdf?sfvrsn=0. Accessed May 21, 2019.) So, we estimate that the discounts cover about 62 percent ($0.70 * 0.89$) of total drugs costs in that range.
28. The \$3 figure is an approximate weighted average of the LIS copays for generic and brand-name drugs. LIS enrollees do not face any cost sharing once they reach the catastrophic threshold, so our approach slightly overestimates their total out-of-pocket costs.
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About the Authors and Acknowledgments

Bowen Garrett is a Senior Fellow, Anuj Gangopadhyaya and Adele Shartzter are Research Associates, and Diane Arnos is a Research Assistant in the Urban Institute's Health Policy Center.

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