

## Policy Options to Improve the Performance of Low Income Subsidy Programs for Medicare Beneficiaries

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### Introduction

One of the principal goals of health care reform is to provide affordable health insurance coverage to all Americans. The Patient Protection and Affordable Care Act (ACA) contains provisions that will provide premium and cost-sharing assistance to low-income families. ACA provides premium assistance to families with income up to 400 percent of the federal poverty level (FPL) and cost-sharing assistance up to 200 percent of FPL (H.R. 3590). Eligibility for this low-income assistance will not be dependent on an asset test.

These low-income subsidy provisions in ACA do not apply to people receiving insurance coverage through Medicare. Instead, Medicare only offers financial assistance to low-income beneficiaries with incomes up to 150 percent of FPL through Medicaid, the Medicare Savings Programs (MSPs), and the Medicare Part D Low-Income Subsidy (LIS).<sup>1</sup> Nonetheless, premiums and cost-sharing can still be burdensome for some low-income beneficiaries who either do not qualify or apply for these programs or have large health expenditures, because Medicare does not have a limit on out-of-pocket (OOP) spending.<sup>2</sup> In addition, current Medicare LIS programs can be complicated and confusing to many eligible beneficiaries, because the programs have different eligibility criteria resulting from differences in state rules and discrepancies between programs in how income and resources are computed. This confusion is evidenced by the low participation rates in some of these programs (Ebeler, Van de Water, and Demchack 2006; Government Accountability Office 2005). National health care reform could provide an opportunity to simplify and align these programs and to improve Medicare's performance in serving low-income beneficiaries.

This paper considers policy options to reform current Medicare low-income subsidies and extend low-income subsidies to beneficiaries up to 300 percent of FPL, more consistent with provisions in the health reform bill. Using the Urban Institute's Medicare Benefits Simulation Model, we analyze new LIS options, coupled with a Medicare cost-sharing structure that has a unified deductible, uniform coinsurance, and limits on OOP spending, and estimate their impacts on program spending and beneficiary OOP spending.

### Policy Options

Traditional Medicare includes Part A (hospital insurance), Part B (medical insurance), and Part D (prescription drug coverage).<sup>3</sup> One striking feature of traditional Medicare is that, for Part A and Part B covered services, there is no limit on OOP spending and cost-sharing; in some cases, even increases with utilization. For example, in the case of hospitalization, in 2009, beneficiaries paid an inpatient deductible of \$1,068, a copayment of \$267 for days between 61 and 90, \$534 for days between 91 and 150, and full costs beyond 150 days.

There are currently three mechanisms through which Medicare beneficiaries can qualify for assistance with premiums and cost-sharing: Medicaid, the three MSPs mentioned above, and the Medicare Part D LIS. Table 1 shows the eligibility standards and benefits of these programs in 2006 (the year covered by the data used in this paper). Full Medicaid covers services beyond Medicare, pays for Part B premiums (and Part A premiums, if applicable), and pays for all cost-sharing. Qualified Medicare beneficiaries (QMBs) receive premium and cost-sharing subsidies similar to those provided through Medicaid, but no additional services. The Specified Low-income Medicare Beneficiary (SLMB) and Qualified Individual (QI) programs pay Part B premiums for eligible beneficiaries who choose to enroll. The Part D LIS provides premium and cost-sharing assistance for prescription drug coverage. The eligibility criteria and benefits for Medicaid are largely determined by states, although federal law and regulations require states to cover certain low-income aged, blind, and disabled individuals. For the MSPs, the federal government sets the standards, but states have certain flexibility in determining the eligibility criteria and benefits. The Part D LIS program, on the other hand, is administered at the federal level by the Centers for Medicare & Medicaid Services and has uniform rules regarding eligibility and benefits in all states.

Recognizing the problems described above, various options have been suggested that would establish a unified annual Medicare deductible, uniform coinsurance, and limits on OOP spending

**Table 1: Current Program Eligibility Rules and Associated Benefits**

Program/Pathway		Income standards	Resource standards	Notes
Full Medicaid	SSI	74% of FPL for singles 82% of FPL for couples	\$2,000 for singles \$3,000 for couples	209(b) states may have more restrictive standards; participants receive full Medicaid benefits and are deemed eligible for full Part D LIS.
	SSP	State established	\$2,000 for singles \$3,000 for couples	
	Medically Needy	State established	State established	
	Poverty-related coverage	State established	State established	
	Long-term care-related coverage	State established	State established	
Medicare Savings Programs	QMB	100% of FPL	\$4,000 for singles \$6,000 for couples	Medicaid pays Part B premium (Part A premium if applicable) and cost-sharing; participants are deemed eligible for full Part D LIS.
	SLMB	120% of FPL	\$4,000 for singles \$6,000 for couples	Medicaid pays Part B premium; participants are deemed eligible for full LIS.
	QI	135 percent of FPL	\$4,000 for singles \$6,000 for couples	Medicaid pays Part B premium subject to a state spending cap; participants are deemed eligible for full Part D LIS.
	QDWI	200% of FPL	\$4,000 for singles \$6,000 for couples	Medicaid pays Part A premium for returned workers; participants are deemed eligible for full Part D LIS.
Part D Low Income Subsidies	Full LIS	135% of FPL	\$6,000 for singles \$9,000 for couples	Participants pay zero premium and deductible with reduced copayment and coinsurance.
	Partial LIS	150% of FPL	\$10,000 for singles \$20,000 for couples	Participants pay reduced premium and cost-sharing.

Source: Merlis (2005) and Bruen, Wiener, and Thomas (2003).

(Congressional Budget Office 2008); simplify and align eligibility criteria for low-income subsidy programs (Merlis 2005; Zuckerman, Shang, and Waidmann 2010a); and provide a comprehensive Medicare benefits option or Medicare Extra (Part E) (Davis et al. 2005). In fact, the Medicare Improvement for Parents and Providers Act of 2008 (H.R. 6331) took a major step toward coordinating the eligibility standards of MSPs with those of the Part D LIS.<sup>4</sup>

A reformed LIS schedule would make more sense if it were combined with comprehensive cost-sharing reforms that included a unified deductible, uniform coinsurance, and stop loss protection. These types of reforms were considered by Zuckerman et al. (2010b), and this paper builds on that work. The earlier paper estimated the impacts of reformed cost-sharing (e.g., a unified deductible, uniform coinsurance, and limits on OOP spending) on program spending and beneficiary OOP spending. The low-income subsidy options we propose in this paper would take as a baseline the following reformed cost-sharing: an annual unified deductible of \$1,000 for Part A and Part B covered services; a 20 percent coinsurance rate for Part A and Part B covered services, and a limit on OOP spending at \$5,000 for Part A, Part B, and Part D covered services. In addition, the deductible and “doughnut hole” in Part D would be eliminated.<sup>5</sup> Under ACA, the doughnut hole is gradually eliminated (as we do here), but the separate Part D deductible remains.

We analyze two low-income subsidy options (table 2).<sup>6</sup> Option 1 retains resource requirements (asset tests) for the current eligibility groups and applies those for the partial Part D LIS to newly eligible groups, while Option 2 eliminates the resource requirements as a condition of eligibility. In both options, we combine Medicaid and QMB, and these beneficiaries would neither pay premiums nor face cost-sharing under Medicare. Beneficiaries currently eligible for SLMB, QI, and Full or Partial Part D LIS would be combined into a single eligibility category; this group would not pay a premium and would have a deductible of \$150, a coinsurance rate of 5 percent, and a limit on OOP spending protection of \$1,000. Option 1 would also expand the LIS programs to beneficiaries up to 300 percent of FPL. Beneficiaries with income between 150 percent and 200 percent of FPL would pay one-third of full Part D and Part B (if applicable) premiums (\$1,448). Beneficiaries with income between 200 percent and 250 percent of FPL would pay two-thirds of full Part B and Part D premiums, and beneficiaries with income between 250 percent and 300 percent of FPL would pay full Part B and Part D (if applicable) premiums, while deductibles, coinsurance rates, and the limit on OOP spending gradually increase with income as well. By eliminating the resource requirements, Option 2 means that more beneficiaries would be eligible at each level of income. Under both Option 1 and Option 2, Medicaid would no longer play a role in the low-income subsidy of Medicare beneficiaries.<sup>7</sup>

**Table 2: Policy Options for Reforming Medicare Low Income Subsidy Programs**

Low Income Subsidy Option 1 (with Asset Test)	Low Income Subsidy Options 2 (No Asset Test)	Premium	Deductible (\$)	Part A Coinsurance	Part B Coinsurance	Stop Loss (\$)
Medicaid/QMB	Less than 100% FPL	Zero	0	0%	0%	0
SLMB/QI/FullRx/PartialRx	100-150% FPL	Zero	150	5%	5%	1000
150-200% FPL	150-200% FPL	1/3 of Full Premium	250	10%	10%	2000
200-250% FPL	200-250% FPL	2/3 of Full Premium	500	10%	10%	3000
250-300% FPL	250-300% FPL	Full Premium <sup>1</sup>	750	15%	15%	4000
Ineligible	More than 300% FPL	Full Premium	1000	20%	20%	5000

Low Income Subsidy 1: For beneficiaries with income between 150-300% FPL, an asset limit of \$10,000 for singles and \$20,000 for couples are also applied for eligibility.

Low Income Subsidy 2: This option eliminates the asset test for subsidies including the Part D low income subsidies.

<sup>1</sup> Medicare Part B premium was \$1,062 and premium for standard Part D benefit plan was \$386.4 in 2006.

Medicare Part D introduced the concept of true out-of-pocket (TrOOP) expenses. The basic idea is that Medicare cost-sharing paid by supplemental health insurance plans does not count toward the OOP limit in the drug benefit. In this paper, we consider options both with and without TrOOP: That is, we alternatively do and do not count cost-sharing paid by supplemental insurance plans (including Medicaid). Using the TrOOP provision would reduce Medicare spending and increase beneficiary OOP costs because the limit on OOP spending would not start until beneficiaries reached a higher level of spending. We simulate the impacts of Option 1 and Option 2 with and without the TrOOP provision.

## Data and Methods

In this paper, we use the Urban Institute's Medicare Benefits Simulation Model to simulate the effects of alternative LIS options on Medicare spending and beneficiary OOP spending. We provide a detailed description of the model construction in an [online appendix](#). A more concise description is presented here.

Constructing a baseline and simulating the impacts of various policy options to restructure Medicare require information on health care expenditures, as well as eligibility and participation in the LIS programs. To the best of our knowledge, no single data source collects sufficiently detailed information to generate estimates for all of these factors. The Urban Institute's Medicare Benefit Simulation Model relies on data from both the 2006 Health and Retirement Study (HRS) and the 2004 Medicare Current Beneficiary Survey (MCBS) to construct a baseline reflecting the Medicare benefit and cost-sharing structure in 2006 and simulate the impacts of alternative reform options.

The 2006 wave of the HRS is nationally representative of the noninstitutionalized population that is 53 years of age or older. The MCBS is a nationally representative

sample of both aged and disabled Medicare beneficiaries, regardless of institutional status. To align the HRS sample frame with the MCBS, we dropped beneficiaries residing in nursing homes and those less than 53 years of age before matching with HRS. Both the HRS and the MCBS collect detailed information on demographics and health status. However, the MCBS lacks the detailed income and asset information required for modeling eligibility, and the HRS lacks detailed information on health care utilization and expenditures to simulate the effects of reformed cost-sharing options. Our strategy is to combine these two data sources. For each respondent in the HRS, we find a statistical match from the MCBS and assign the expenditure profile of the matched MCBS respondent to the HRS respondent.

The match between the HRS and the MCBS is based on variables common to both data sets, including age, gender, race/ethnicity, education, region, urban/rural, supplemental coverage, self-reported health status, disability, chronic conditions (hypertension, cancer, heart disease, lung disease, diabetes, and stroke), and number of chronic conditions. Supplemental insurance was defined using the following categories: current employer-sponsored insurance (ESI) coverage, Medicaid coverage, retiree ESI coverage (also including private managed care, other private coverage, and TRICARE), Medicare managed care, Medigap coverage, and no supplemental coverage.<sup>8</sup> The entire expenditure profile of the matched MCBS respondent was assigned to the corresponding HRS respondent. As a result, we have both eligibility status and detailed health care spending for each individual in the matched HRS sample.

The matched HRS-MCBS data contain information to simulate eligibility for LIS programs at the beneficiary level and health care utilization and expenditures at the medical event level. Several adjustments were made to the matched data to reflect the structure of the Medicare program in 2006 that were not reflected in the source data from 2004. Specifically, we applied

current rules for the LIS programs, and simulated the presence of prescription drug coverage under Part D, a new benefit in 2006. Finally, we imputed Medigap premiums and retirees' share of premiums for employer-sponsored coverage, which are not routinely reported on the HRS or MCBS. All estimates were adjusted to 2006 dollars using the Consumer Price Index.

Given a 2006 baseline, we applied alternative cost-sharing rules and LIS programs to the expenditure profiles in the baseline to simulate their impacts on Medicare spending and beneficiary OOP spending. For beneficiaries with Medicaid as their supplemental coverage, we did not observe Medicaid payment rates and were required to assume Medicaid paid full cost-sharing under the alternatives outlined in Option 1 and Option 2. In reality, Medicaid generally would pay less under the baseline because Medicaid payment rates in most states are lower than Medicare payment rates.<sup>9</sup> Under reformed cost-sharing for Option 1 and Option 2, we assume cost-sharing for Medicaid based on bringing payment rates to Medicare levels. We did not incorporate the effects of changes in cost-sharing on spending for Medicare-covered services, including prescription drugs, in order to focus our analysis on changes in the distribution of spending between the program and beneficiaries.<sup>10</sup> Each simulation shows how Medicare spending, beneficiary cost-sharing, and other sources of spending would be altered by different reform options.

The study sample in this paper includes all beneficiaries except those who were institutionalized,

younger than 53 years of age, and with Medicare as secondary payer. The final sample consists of 10,636 individuals, representing 37.2 million Medicare beneficiaries, among whom about 6.0 million enrolled in Medicare Advantage. In the simulation, we assume that the benefit package for Medicare Advantage enrollees remains the same and there is no behavioral response to the reforms throughout the simulation. Although the focus of this paper is Medicare fee-for-service enrollees, we provide estimates for the premium subsidies to Medicare Advantage enrollees under the baseline and reform options.

## Results

We focus our attention on the results without the TrOOP provision and then briefly discuss the impacts of adding the TrOOP provision at the end of the section. Table 3 shows simulated Medicare and beneficiary OOP spending (cost-sharing, program premiums, and supplemental insurance premiums) under the baseline and alternative LIS options across all fee-for-service beneficiaries. All estimates in the table are averaged across beneficiaries with Medicaid, supplemental coverage through an employer, or Medigap and those without any supplemental coverage.

The top panel shows that, under the baseline, mean spending for Medicare-covered services was \$9,323 (in 2006 dollars), with \$6,808 paid by Medicare, \$722 paid by the beneficiary, and \$1,792 paid by other sources, including Medicaid and other supplemental insurers.

**Table 3: Simulated Effects of Alternative Low Income Subsidy Options,<sup>1</sup> in 2006 Dollars**

	Baseline	Without TrOOP <sup>2</sup>			With TrOOP		
		Reformed Cost-sharing	Option 1	Option 2	Reformed Cost-sharing	Option 1	Option 2
Spending for Covered Services at Point of Service	9,323	9,323	9,323	9,323	9,323	9,323	9,323
Medicare	6,808	6,816	7,158	7,370	6,028	6,468	6,716
Beneficiary	722	760	675	606	908	812	736
Other payers	1,792	1,747	1,490	1,347	2,387	2,044	1,872
Premium Contributions							
Medicare	265	221	420	525	264	465	572
Parts B/D low-income subsidies <sup>3</sup>	62	62	263	380	62	263	380
Part D employer subsidies	203	159	157	145	202	202	192
Beneficiary	1,496	1,537	1,462	1,301	1,711	1,627	1,451
Part B/D	1,020	1,020	973	861	1,020	973	861
Contributions to ESI supplemental	222	195	189	173	274	267	247
Medigap premium	254	322	300	267	417	387	343
Change in total Medicare spending	-	-36	505	822	-781	-140	215
Change in beneficiary OOP spending	-	79	-81	-311	401	221	-31

1 Fee-For-Services beneficiaries only.

2 True Out-Of-Pocket (TrOOP) expenses: expenses paid by supplemental insurance plans including Medicaid do not count toward the stop-loss limit.

3 In the simulations of Baseline and Reformed Cost-sharing, Medicare Savings Program subsidies (\$153 per FFS beneficiary) are not included in the Medicare premium contribution.

Source: Urban Institute 2006 Medicare Benefits Simulation Model.

The middle panel shows that through subsidies to employers and low-income beneficiaries, Medicare contributed \$265 per beneficiary to Part B and Part D premiums. The mean beneficiary share of Part B and Part D premiums was \$1,020, and beneficiary payments toward ESI and Medigap premiums averaged, across all fee-for-service beneficiaries, \$222 and \$254, respectively.

Reformed Medicare cost-sharing (Zuckerman et al. 2010b), combined with current LIS programs, would have relatively small impacts on Medicare spending, beneficiary cost-sharing, and other sources of spending (table 3, column 2, top panel). On average, reformed cost-sharing would reduce total Medicare spending (summation of changes in Medicare spending and Medicare premium subsidies) by \$36 per fee-for-service beneficiary (less than 1 percent) and increase beneficiary OOP spending (summation of changes premium contributions and point of service cost-sharing) by \$79 (less than 4 percent).

Compared to reformed cost-sharing under current low-income protections, Option 1 would increase Medicare spending for covered services by \$342 (to \$7,158), reducing beneficiary cost-sharing by \$85 and lowering other sources of spending by \$257 (table 3, column 3, top panel). These spending reductions would result in slightly lower beneficiary payments for ESI and Medigap premiums and slightly lower Part D employer subsidies. Including both the consolidation of MSP subsidies paid by Medicaid (\$153 per beneficiary on average; not shown) for dual eligibles and increases in Part D low-income subsidies for nondual beneficiaries, Option 1 would increase Medicare subsidies to low-income beneficiaries by \$201, from \$62 in the baseline

to \$263. Compared to the baseline, total Medicare spending, on average, would increase by \$505 per fee-for-service beneficiary, and beneficiary OOP spending would decrease by \$81.<sup>11</sup>

Option 2 (table 3, column 4)—which has the same LIS schedule as Option 1 but eliminates resource requirements—would make more people eligible for low-income subsidies. This would further increase Medicare spending, and reduce beneficiary cost-sharing and other sources of spending. Compared to Option 1, Option 2 would increase low-income premium subsidies by \$117 per fee-for-service beneficiary. On average, total Medicare spending would increase by \$822 (about 12 percent), and beneficiary OOP spending would decrease by \$311.

Tables 4 through 6 present the distributional effects of the LIS options by income, health status, and baseline spending, respectively. Table 4 shows that baseline Medicare spending decreases with income, ranging from \$8,924 for beneficiaries with income less than 100 percent of FPL to \$5,410 for beneficiaries with income more than 300 percent of FPL. Beneficiary cost-sharing is lowest for those with income less than 100 percent of FPL (\$562), although Medicare spending is highest among beneficiaries in this group; beneficiary cost-sharing is highest for those with income between 150 percent and 300 percent of FPL (\$805). In the baseline, however, low-income beneficiaries had a higher average cost-sharing to income ratio (beneficiary cost-sharing divided by income) than beneficiaries with incomes more than 300 percent of FPL. Option 1 (without TrOOP) would reduce cost-sharing for beneficiaries with incomes less than 100 percent of FPL from \$562 to \$477, a decrease of

**Table 4: Simulated Effects of Alternative Low Income Subsidy Options by Income,<sup>1</sup> in 2006 Dollars**

	Baseline	Without TrOOP <sup>2</sup>			With TrOOP		
		Reformed Cost-sharing	Option 1	Option 2	Reformed Cost-sharing	Option 1	Option 2
<b>Medicare spending</b>							
Less than 100% FPL	8,924	8,519	9,543	9,863	7,825	9,272	9,670
100-150% FPL	7,155	7,060	7,516	7,899	6,367	6,910	7,436
150-300% FPL	6,647	6,791	7,003	7,234	5,941	6,171	6,392
More than 300% FPL	5,410	5,569	5,569	5,569	4,743	4,743	4,743
<b>Beneficiary Cost Sharing</b>							
Less than 100% FPL	562	687	477	350	781	528	384
100-150% FPL	715	799	662	535	936	785	632
150-300% FPL	805	816	754	690	984	919	858
More than 300% FPL	718	704	704	704	866	866	866
<b>Premiums</b>							
Less than 100% FPL	816	835	798	614	902	862	672
100-150% FPL	1,399	1,458	1,346	1,063	1,624	1,501	1,205
150-300% FPL	1,698	1,751	1,643	1,474	1,954	1,836	1,651
More than 300% FPL	1,726	1,755	1,726	1,670	1,960	1,923	1,853

1 Fee-For-Services beneficiaries only.

2 True Out-Of-Pocket (TrOOP) expenses: expenses paid by supplemental insurance plans including Medicaid do not count toward the stop-loss limit.

Source: Urban Institute 2006 Medicare Benefits Simulation Model.

\$85. The reductions in beneficiary cost-sharing become gradually smaller moving up the income distribution.<sup>12</sup> Option 2 would reduce beneficiary cost-sharing by \$212, \$180, \$115, and \$14, respectively, for beneficiaries at each level of income presented.

Table 5 shows that Option 1 and Option 2 (without TrOOP) would reduce the cost sharing of beneficiaries in poor health by \$181 and \$271, respectively, compared to increases of \$48 and \$13 for those in excellent health. The reductions in premiums are smaller, in percentage terms, relative to cost sharing, because gains are averaged across all beneficiaries in calculating ESI and Medigap premiums. Table 6 shows that annual cost sharing under the baseline (top panel) ranged from \$10 in the bottom decile to \$2,892 in the top decile. Both Option 1 and Option 2 would provide greater protections for those with high cost-sharing. Option 1 would reduce cost-sharing in the top decile to \$2,119, a reduction of \$773, but increase it by \$36 to \$46, in the bottom decile; Option 2 would reduce cost-sharing in the top decile by \$996, but increase it by \$35 in the bottom decile. The bottom panel of Table 6 reports on the effects of the policy options on total out-of-pocket spending (including premiums) and the results are consistent with the findings for cost-sharing.

Adding the TrOOP provision means that payments from other sources such as Medigap, Medicaid, and ESI would not count toward the OOP spending limit. In all tables, the TrOOP provision would result in lower Medicare spending, higher beneficiary cost-sharing, and higher spending from other sources. This occurs because TrOOP delays the OOP spending protection from taking effect until the beneficiary reaches a higher

level of total Medicare spending. The TrOOP provision, however, would have larger impacts on beneficiaries in poor health and with high OOP spending, because these people have higher levels of spending and, as such, higher cost-sharing obligations. Part B and Part D premiums are not affected by TrOOP because the TrOOP provision would not change Part B and Part D premium subsidies.

## Discussion

A reformed LIS program would provide better protection to low-income beneficiaries and beneficiaries with the greatest health care needs. As the results show, low-income beneficiaries, beneficiaries in poorer health, and beneficiaries in the upper spending deciles benefit the most from these reform options. In addition, these reform options would greatly simplify the current system and could potentially increase program participation. For example, evidence suggests that eliminating resource requirements would increase participation in LIS programs (Glaun 2002; Hoover, Khatutsky, and Haber 2002).

An important aspect of reforming the LIS program is its implications for overall program spending. Without the TrOOP provision, Option 1 would increase total Medicare spending by \$504 per fee-for-service beneficiary while reducing Medicaid spending by \$238. Overall public spending would increase by \$266 per fee-for-service beneficiary.<sup>13</sup> All told, Option 1 would result in an increase in total public spending of about \$9.1 billion, or 2.4 percent of the \$376 billion Medicare spent in 2006.<sup>14</sup> Option 2 without TrOOP would

**Table 5: Simulated Effects of Alternative Low Income Subsidy Options by Health Status<sup>1</sup>, in 2006 Dollars**

	Baseline	Without TrOOP <sup>2</sup>			With TrOOP		
		Reformed Cost-sharing	Option 1	Option 2	Reformed Cost-sharing	Option 1	Option 2
<b>Medicare spending</b>							
Excellent	3,078	2,874	2,987	3,112	2,561	2,707	2,831
Very good	4,101	3,953	4,070	4,216	3,493	3,629	3,792
Good	5,674	5,629	5,860	6,055	5,001	5,270	5,478
Fair	8,961	9,071	9,584	9,884	8,073	8,725	9,084
Poor	13,693	14,105	15,029	15,302	12,298	13,606	13,992
<b>Beneficiary Cost Sharing</b>							
Excellent	446	511	494	459	560	540	506
Very good	562	595	567	520	675	646	597
Good	723	773	709	646	888	822	757
Fair	878	904	766	666	1,090	943	831
Poor	922	942	741	651	1,315	1,046	928
<b>Premiums</b>							
Excellent	1,679	1,738	1,661	1,506	1,946	1,857	1,686
Very good	1,656	1,708	1,644	1,484	1,908	1,835	1,660
Good	1,554	1,597	1,516	1,355	1,774	1,684	1,510
Fair	1,358	1,392	1,313	1,135	1,545	1,457	1,268
Poor	1,159	1,184	1,111	970	1,306	1,227	1,077

1 Fee-For-Services beneficiaries only.

2 True Out-Of-Pocket (TrOOP) expenses: expenses paid by supplemental insurance plans including Medicaid do not count toward the stop-loss limit.

Source: Urban Institute 2006 Medicare Benefits Simulation Model.

**Table 6: Simulated Beneficiary Spending by Deciles of Beneficiary Spending at the Baseline,<sup>1</sup> in 2006 Dollars**

<b>Beneficiary Cost Sharing</b>								
Decile	Baseline	Without TrOOP <sup>2</sup>			With TrOOP			
		Reformed Cost-sharing	Option 1	Option 2	Reformed Cost-sharing	Option 1	Option 2	
1	10	116	46	45	133	46	45	
2	86	178	74	71	215	74	71	
3	172	310	181	168	334	184	172	
4	269	385	281	255	417	297	270	
5	387	530	471	426	549	491	443	
6	520	601	565	514	641	605	554	
7	674	792	763	679	862	832	751	
8	902	1,010	966	869	1,181	1,134	1,031	
9	1,315	1,372	1,287	1,136	1,680	1,594	1,432	
10	2,892	2,308	2,119	1,896	3,070	2,862	2,589	

  

<b>Beneficiary Out-Of-Pocket Spending</b>								
Decile	Baseline	Without TrOOP			With TrOOP			
		Reformed Cost-sharing	Option 1	Option 2	Reformed Cost-sharing	Option 1	Option 2	
1	81	275	5	5	347	6	5	
2	1,026	1,188	834	700	1,248	870	734	
3	1,620	1,712	1,601	1,445	1,840	1,725	1,563	
4	1,794	1,898	1,809	1,623	2,040	1,950	1,756	
5	1,981	2,090	2,005	1,791	2,255	2,172	1,950	
6	2,197	2,294	2,223	1,994	2,516	2,446	2,213	
7	2,499	2,607	2,499	2,236	2,963	2,851	2,574	
8	2,893	3,129	2,993	2,646	3,621	3,472	3,089	
9	3,304	3,512	3,336	2,990	4,100	3,892	3,500	
10	4,789	4,279	4,074	3,636	5,259	5,008	4,494	

1 Fee-For-Services beneficiaries only.

2 True Out-Of-Pocket (TrOOP) expenses: expenses paid by supplemental insurance plans including Medicaid do not count toward the stop-loss limit.

Source: Urban Institute 2006 Medicare Benefits Simulation Model

increase total public spending by \$20 billion. Adding the TrOOP provision essentially eliminates Medicare's additional costs, but shifts costs to some beneficiaries. Option 1 with TrOOP would actually reduce total public spending by nearly \$11 billion, while Option 2 with TrOOP would have a very small impact on total public spending (an increase of \$0.7 billion).

The impacts on program costs vary by the design of the LIS program. In addition, higher participation and changes in supplemental insurance status could add program costs to certain options. There are several potential ways for the federal government to finance a reformed LIS program: (1) by requiring maintenance of effort by states that otherwise would see Medicaid spending reduced; (2) by redistributing costs across beneficiaries so that low-income beneficiaries and beneficiaries with the greatest health care needs receive better protection; (3) by raising additional revenue through, for example, a premium increase for high-income beneficiaries; or (4) by some combination of these methods.

Our results, however, do not take into account the impacts of the potential changes in program participation, primarily because of the lack of solid estimates on the magnitude of the impacts, given that the evidence was mostly drawn from case studies and

surveys that were intended to explain why eligible beneficiaries do not enroll (Glaun 2002; Hoover, Khatutsky, and Haber, 2002). In addition, we assume no behavioral response to the policy changes and, as a result, beneficiaries retain the same supplemental insurance status as in the baseline. This assumption helps us to simplify the modeling exercise. We recognize that some beneficiaries might switch to another supplemental status, which could alter our estimates. For example, with comprehensive reformed cost-sharing in Medicare and a restructured subsidy program, there may be less need for supplemental coverage such as Medigap, especially with the TrOOP provision under which cost-sharing paid by supplemental coverage does not count toward the limit on OOP spending. Some beneficiaries who currently enroll in Medicare Advantage to obtain lower cost-sharing and a limit on OOP spending may find the reformed fee-for-service program more attractive.

This paper, instead of simulating the impacts of a full range of LIS options, provides examples of the types of options that might be considered and a framework to evaluate these options. The method proposed here could help in striking a balance between program costs and providing adequate assistance to low-income Medicare beneficiaries.

## Endnotes

1. Medicaid and the MSPs provide premium assistance to beneficiaries up to 135 percent of FPL and cost-sharing assistance up to 100 percent of FPL, and the Medicare Part D LIS provides premium and cost-sharing assistance to beneficiaries up to 150 percent of FPL, conditioned on their meeting the corresponding resource requirements. All beneficiaries receive subsidies for the basic Medicare premiums.
2. Limits on OOP spending would be available in the health reform plans and in typical plans offered in the private insurance market.
3. Medicare Advantage (Part C) is required to cover all traditional benefits, but may have an enhanced benefit structure provided by private insurance companies.
4. The legislation uses the LIS asset standards for both LIS and MSPs as a way to expand eligibility for the MSPs and to potentially increase participation in the MSPs by reducing their administrative burden and costs.
5. “Doughnut hole” refers to the gap in Part D coverage after a beneficiary exceeds the initial coverage limit of \$2,830 (in 2010) in total expenditures up to the point where OOP expenditures reach \$4,550. For expenditures in this range, the beneficiary is responsible for the full cost of prescription drugs.
6. Option 1 and Option 2 incorporate legislative changes from the Medicare Improvements for Patients and Providers Act of 2008, while the baseline and reformed cost-sharing are based on program rules in 2006.
7. Alternatively, Medicare could require a maintenance of effort on the part of state Medicaid programs as a way of offsetting the costs of this enhanced Medicare low-income benefit.
8. If more than one type of supplemental coverage was identified, we assigned the type of supplemental coverage to the respondent based on a hierarchy that gave precedence to ESI and followed the order of coverage as shown in the text. For example, a respondent who reported ESI and Medicaid was assigned ESI.
9. Medicare pays providers according to its payment methods and rates. In principle, Medicaid pays the associated cost-sharing. However, the Balanced Budget Act of 1997 clarified that state Medicaid programs are not required to pay the full cost-sharing amount so long as their payment policies are written in their state plan. States are free to cap their liability so that providers receive no more than the state would have paid if the beneficiary only had Medicaid. For example, suppose that for a service with a Medicare payment rate of \$100, Medicare pays \$80 and beneficiary cost-sharing is \$20. If the Medicaid payment rate is \$75 (less than \$80), Medicaid pays zero coinsurance on behalf of the beneficiary; if the Medicaid payment rate is \$90, Medicaid pays \$10; if the Medicaid payment rate is \$100 (or greater than \$100), Medicaid pays \$20, the full cost-sharing (MEDPAC 2004).
10. We explored using standard actuarial induction techniques to estimate how the changes in beneficiary cost-sharing would alter spending for Medicare-covered services. However, since the change in cost-sharing associated with the various policy options was small, on average, induction would have also led to very small changes in average spending. Therefore, we chose to not include potential induction effects from this analysis.
11. In addition, a total of \$238 in Medicaid spending from the baseline would also be eliminated and covered under Medicare. This change is not shown in table 3. Other changes that would occur, for example, relate to private insurer costs and profits as well as general outlays, but those are not considered either.
12. For beneficiaries with incomes higher than 300 percent of FPL, reformed cost-sharing is slightly lower (\$704) than in the baseline (\$718), and remains at \$704 under Option 1 and Option 2 as the LIS options do not alter the cost-sharing of this group; total premiums under Options 1 and 2, however, are lower than those under reformed cost-sharing because Medigap and ESI premiums are based on average plan costs across all beneficiaries.
13. Although we assume that the benefit package for Medicare Advantage enrollees remains unchanged and therefore there are no changes in their cost-sharing, low-income Medicare Advantage enrollees could still be eligible for premium subsidies in Part B and Part D (if their Medicare Advantage plan does not provide prescription drug coverage). Under our simulation, Medicare Advantage enrollees would receive an increase of \$135 (an increase of \$244 for Medicare and a decrease of \$109 for Medicaid) per enrollee in premium subsidies.
14. Our sample represents 31.2 million noninstitutionalized fee-for-service enrollees and 6.0 million noninstitutionalized Medicare Advantage enrollees, and the total increase in public spending is calculated as 31.2 million multiplied by \$266 for fee-for-service beneficiaries and 6.0 million multiplied by \$135 for Medicare Advantage enrollees, or about \$9.1 billion in total.

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