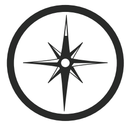

THIRD WAY

A Cost Cap for Nearly 7 Million Medicare Beneficiaries

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Takeaways

Nearly 7 million Medicare beneficiaries would have their health care costs capped under legislation introduced by Reps. Andy Kim (D-NJ), Dwight Evans (D-PA), and Lisa Blunt Rochester (D-DE).[1]

Medicare is supposed to be a safety net, but beneficiaries in the program don't have a critical protection: a limit on their out-of-pocket costs. It doesn't have to be this way. After all, Americans under age 65 with coverage through the Affordable Care Act (ACA) exchanges have a cap on their premiums based on their income and an out-of-pocket limit that protects them from high costs. If a Medicare beneficiary making $24,000 a year could get ACA coverage, they would pay a lower premium than they would through Medicare.[2]

Deductibles and copayments are also a big problem for seniors and people with disabilities who have Medicare coverage. Average out-of-pocket costs for Medicare beneficiaries were over $2,100 in 2016. If you add that cost to a beneficiary's monthly premium, the individual is paying close to $4,500 a year in health care costs.[3] For a beneficiary making $24,000 a year, that's more than 18% of their annual income. More than 18 million Medicare beneficiaries have incomes of less than $24,000 a year.[4]

A federal program, the Medicare Savings Program (MSP), is supposed to provide financial assistance for premiums and out-of-pocket health costs for low-income Medicare beneficiaries. But it has major gaps. At least half a million people who were eligible for the program were not enrolled in 2017. Additionally, the program doesn't provide any guaranteed assistance to Medicare beneficiaries with incomes greater than $16,700.[5]

The Kim-Evans-Blunt Rochester legislation addresses those gaps and cap costs for low-to-moderate income Medicare beneficiaries.[6] The bill proposes to raise income eligibility for the MSP and encourage states to enroll more beneficiaries.[7] According to our analysis, it would cap the costs for 6.8 million beneficiaries.[8]

Specifically, the bill aims to do the following:

- Eliminate premium and out-of-pocket costs for beneficiaries with incomes under $16,700, which is 135% of the federal poverty level (FPL). This provision would help more than 2 million low-income seniors.

- Eliminate premium costs for the 4.4 million eligible beneficiaries making less than $24,280, which is 200% of FPL.
- Ease restrictions on the amounts of assets a Medicare beneficiary can keep and still qualify for assistance through MSP.
- Provide funding to states to make MSP enrollment automatic through a program call Fast Lane Eligibility.

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

	POTENTIAL MEDICARE SAVINGS PROGRAM ENROLLMENT INCREASE
United States	**6,815,000**
Alabama	178,700
Alaska	7,500
Arizona	211,900
Arkansas	118,100
California	620,700
Colorado	82,700
Connecticut	38,800
Delaware	26,400
District of Columbia	17,100
Florida	521,000
Georgia	224,600
Hawaii	19,900
Idaho	35,300
Illinois	225,700
Indiana	200,100
Iowa	61,900
Kansas	58,400
Kentucky	113,900
Louisiana	110,500
Maine	35,800
Maryland	81,600
Massachusetts	114,500
Michigan	209,200
Minnesota	88,500
Mississippi	112,200
Missouri	156,600
Montana	23,600
Nebraska	38,300
Nevada	51,900
New Hampshire	24,500
New Jersey	136,900
New Mexico	50,900
New York	546,600
North Carolina	224,900
North Dakota	21,100
Ohio	250,000
Oklahoma	89,400
Oregon	124,100
Pennsylvania	298,400
Rhode Island	22,300
South Carolina	120,900
South Dakota	20,200
Tennessee	154,400
Texas	424,400
Utah	34,300
Vermont	19,300
Virginia	131,400
Washington	114,100
West Virginia	81,100
Wisconsin	126,500
Wyoming	14,000

Source: "Health Insurance Coverage Status and Type By Ratio of Income to Poverty Level in the Past 12 Months By Age." United States Census Bureau, American Community Survey, 2017, https://data.census.gov/cedsci/table?q=B27016&table=B27016&tid=ACSDT1Y2018.B27016&lastDisplayedRow=29. Accessed Oct. 30, 2019; "Eligibility for Medicare Savings Programs for Qualified Individuals (QIs)." Kaiser Family Foundation, 2018, https://www.kff.org/other/state-indicator/eligibility-for-medicare-savings-programs-for-qualified-individuals-qis/. Accessed Oct. 30, 2019; Moon, Marilyn, Friedland, Robert, and Lee Shirey. "Medicare Beneficiaries and Their Assets: Implications for Low-Income Programs." The Urban Institute, Center on Aging Society, and Kaiser Family Foundation, June 2002, Exhibit 3, https://www.urban.org/sites/default/files/publication/59826/1000249-Medicare-Beneficiaries-and-Their-Assets.PDF. Accessed Nov. 6, 2019; "State-Level Dual Status Codes, December 2017." Centers for Medicare and Medicaid Services, Dec. 2017, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MMEnrolleeStateandCountyEnrollmentSnapshotsQuarterly122018Data.xlsx. Accessed Oct. 30, 2019.

Methodology

To get the total number of beneficiaries who would benefit from this bill, we calculated three asset and income-adjusted population groups, added them together, and adjusted for growth in Medicare enrollment.

The first group is the number of eligible beneficiaries who were not enrolled in the MSP program in 2017, the second group is the number of income-eligible beneficiaries who would become eligible upon passage of HR 4761 through increased asset requirements, and the third group is the number of newly eligible people when both income and assets are increased.

The first income and asset-adjusted group was calculated in the following ways: Medicare enrollment for below 100%, and between 100% and 137% of FPL were asset adjusted based on Exhibit 3 of the Urban-Kaiser study (2002) by adding the asset scenarios shaded black and white to get 74% and 54%, respectively. We used those asset scenarios because they most closely matched CPI-adjusted asset levels in 2019. Medicare enrollment for the 100%-137% FPL population was adjusted from 137% of FPL to 135% of FPL to match the eligibility for the MSP program. States, where asset levels are higher than the federal floor, were adjusted based on that state's asset limit. Those two categories were added and adjusted for states in the few cases where income limits were higher than the federal floor (note: Alaska and Hawaii have higher FPLs but were not adjusted in any way in our data analysis; enrollment in these states would likely be higher than our analysis predicts). We then found the total number of income and asset eligible people who were not enrolled in MSP. Due to the lack of data for calculating an asset adjustment by income level, there are several states that had MSP enrollment numbers that appeared higher than the total eligible populations for those states. Those states were excluded when calculating the total number of eligible beneficiaries who were not enrolled in 2017.

The second income and asset adjusted group was calculated in the following way: The legislation increases asset limits from $7,800 to more than $25,000. In order to model this, we assumed this corresponded to a tripling of our base scenario's asset test ("black and white" above $4,000 to $12,000). In order to do this, we doubled the enrollment increase for the scenario shaded dark grey, which has an asset limit of $8,000. This resulted in asset adjustments of 14% fewer beneficiaries for under 100% FPL and 18% fewer for 100%-135% FPL. States with higher asset tests were excluded from this calculation, as we assumed all individuals were asset eligible in the first calculated value.

The final income and asset adjusted group was calculated in the following way: These are the added values for 137%-200% of FPL from the Census Bureau data, with states that had higher income levels either excluded (Connecticut and DC) or raised accordingly (Indiana and Maine). The asset adjustment was calculated in a similar fashion to the previous asset adjustments (black, white, and dark grey scenarios for the 136-175% data assuming similar asset rates up to 200% FPL). These three totals were added and the total possible enrollment data in MSP was adjusted from 2017 numbers to 2019 numbers using the growth in Medicare enrollment of 5.2% (CBO May 2019) to get the total number of Medicare beneficiaries who could currently benefit from the legislation. Numbers were then rounded to the nearest 100. Full calculations available upon request.

ENDNOTES

1. United States, Congress, House. Helping Seniors Afford Health Care Act. Congress.gov, https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/HR4671ih_10.15.2019.pdf. 116th Congress, 2nd session.
2. ACA premium cap for 200% of FPL is $1,588 in 2019. Medicare Part B premiums are $1,626 for 2019.
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5. "Eligibility for Medicare Savings Programs for Qualified Individuals (QIs)." Kaiser Family Foundation, 2018, https://www.kff.org/other/state-indicator/eligibility-for-medicare-savings-programs-for-qualified-individuals-qis/. Accessed 30 Oct. 2019.
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8. "Health Insurance Coverage Status and Type By Ratio of Income to Poverty Level in the Past 12 Months By Age." United States Census Bureau, American Community Survey, 2017. https://data.census.gov/cedsci/table?q=B27016&table=B27016&tid=ACSDT1Y2018.B27016&lastDisplayedRow=29. Accessed 30 Oct. 2019; "Eligibility for Medicare Savings Programs for Qualified Individuals (QIs)." Kaiser Family Foundation, 2018, https://www.kff.org/other/state-indicator/eligibility-for-medicare-savings-programs-for-qualified-individuals-qis/. Accessed 30 Oct. 2019; Moon, Marilyn, Friedland, Robert, and Lee Shirey. "Medicare Beneficiaries and Their Assets: Implications for Low-Income Programs." The Urban Institute, Center on Aging Society, and Kaiser Family Foundation, June 2002, Exhibit 3, https://www.urban.org/sites/default/files/publication/59826/1000249-Medicare-Beneficiaries-and-Their-Assets.PDF. Accessed 6 Nov. 2019; "State-Level Dual Status Codes, December 2017." Centers for Medicare and Medicaid Services, Dec. 2017, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MMEnrolleeStateandCountyEnrollmentSnapshotsQuarterly122018Data.xlsx. Accessed 30 Oct. 2019.