Medicaid and Medicare:

Aging, Access and Affordability

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Introduction

Affordability is a cornerstone of any efficient and effective health care system. Discussions of healthcare affordability often center on the premiums – the upfront monthly cost of purchasing insurance. But equally important are the back-end deductibles, copays and coinsurance associated with actually accessing services.[2] High back-end cost sharing can impede access to care that improves health outcomes and reduces the likelihood of expensive complications.

Adults age 65 and older are much more likely to live with one or more chronic conditions and face a higher financial burden to obtain necessary care. The Medicaid and Medicare programs include cost sharing protections for low-income beneficiaries, but important gaps leave some low-income older adults exposed to sizeable, potentially even devastating, out-of-pocket costs. This brief explores and explains the cost sharing protections for low-income older adults, identifies some of the key gaps and gives recommendations to inform future advocacy.

Cost Sharing and Self-Rationing of Care

Basic supply and demand theory suggests that increasing cost sharing should reduce the use of services. However, simply reducing access to services does not necessarily lead to a more *efficient* healthcare system. The literature shows individuals respond to higher cost sharing by reducing "necessary" and "unnecessary" care in roughly equal proportions. A number of studies show that individuals with lower incomes reduce services more dramatically than relatively better-off individuals. Even relatively small increases in copays for low income individuals – on the order of one or two dollars – have been shown to present a significant barrier to care.[3]

Reducing the use of necessary and proven cost-effective care could actually decrease the efficiency of the system while simply shifting costs onto beneficiaries. Increasing cost sharing to reduce utilization

for one service may simultaneously increase the frequency or intensity of service utilization in other areas. For example, increasing copays for key preventive medications, like antihypertensives, correlates with poorer adherence to the prescription and often with increased hospitalization or emergency department rates.[4] Not only does this indicate worse health outcomes, but because hospitalization is far more costly than medication, even a small increase in hospital costs can substantially offset any savings generated by increased medication copays.

Cost Sharing Protections for Low-Income Older Adults

Because older adults generally have higher needs for health care, they are also among the most impacted by high cost sharing. Medicare provides the primary coverage for the vast majority of adults age 65 and older. While Medicare offers a generally solid benefit package covering inpatient (Part A) and outpatient (Part B) services, out-of-pocket expenses for beneficiaries are substantial.[5] Medicare offers some protections for low-income enrollees, particularly in the area of prescription medications (Part D). However, most beneficiaries seek some form of supplemental insurance to reduce the heavy Part A and B cost burden.

Medicaid, in contrast, offers excellent cost sharing protections, though Medicaid is generally only available to individuals with very low income and assets. Low-income older adults often qualify for *both* Medicare and Medicaid and are commonly referred to as "dual eligibles." This section reviews the considerable and complicated Medicare cost sharing obligations and the ways seniors reduce these costs through supplemental coverage, most notably through Medicaid for lower-income seniors.

Original Medicare (Parts A and B)

Medicare cost sharing and premiums can add up quickly. Beneficiaries with no supplemental coverage must pay steep deductibles for each hospital inpatient admission ($1,216), with additional copays for longer stays. In addition, Medicare includes a $147 annual deductible plus 20% coinsurance for most outpatient services, a monthly premium for Part B ($105/month in 2014), and additional out-of-pocket expenses for Part D prescription drug coverage.[6] Furthermore, unlike Medicaid or individual market private insurance, traditional Medicare lacks an aggregate out-of-pocket cap for inpatient and outpatient care and includes a coverage cap on lifetime inpatient hospital days.[7]

Adults older than 65 generally have lower incomes and spend a much higher proportion of that income on health expenses. In 2012, the median income for adults over 65 was $20,380, roughly 68% of the median income for individuals age 64 and under.[8]

In 2012, the median Medicare household spent 14% of annual income on health-related expenses, nearly three times the share spent by non-Medicare households (5%).[9] Lower-income beneficiaries

between 100-199% of Federal Poverty Level (FPL), whose income is often too high to qualify for Medicaid, expended the highest share of their incomes (15.7%) on health care.[10] By contrast, Medicare households under 100% FPL and covered by Medicaid used just 3.9% of their income on health care expenses.[11]

Medigap and Other Supplemental Medicare Coverage

The vast majority of Medicare beneficiaries receive or purchase supplemental coverage to ease the cost sharing burden, ensure financial stability and cover additional inpatient stays.[12] These options include Medicaid (discussed below), a private Medigap plan, or employer-sponsored supplemental coverage. Older adults with low incomes are less likely to have access to employer-sponsored coverage.[13] Moreover, the number of employers offering retiree coverage has declined steadily for three decades, so this discussion of supplemental insurance will focus on Medigap and Medicaid.[14]

A Cost Sharing Scenario: Traditional Medicare

Joe is a 68-year-old retired handyman with traditional Medicare insurance and Part D. He is otherwise healthy but takes medication for his hypertension. In February 2014, Joe falls off a ladder and is briefly hospitalized for a lower back injury. He later visits a physical therapist for lower back rehabilitation.

By virtue of his work history, Joe pays no premiums for Part A inpatient care, but here is a quick summary of his out-of-pocket expenses for the year:

Part B premium: **$105/month = $1260**
Part D premium: **$40/month = $480**
Generic antihypertensive: **$10/month after $310 deductible (deductible met after 3 mos.) = $400**
Deductible for hospital stay: **$1216**
20 physical therapy visits ($300/visit): **$147 deductible then 20% of remaining bill** = **$1317**

Total OOP = $4983

Given the high cost sharing in traditional Medicare, access to supplemental coverage through Medigap is a key option for many lower middle income older adults. The most popular Medigap plans (C, F and G) cover nearly all Medicare deductibles and coinsurance (apart from Part D prescription drugs).[15] Clearly, Medicare cost sharing represents such a significant burden for older adults that – despite their fixed incomes – they are willing to pay the monthly Medigap premium in addition to the required Medicare costs to eliminate their risk of unaffordable cost sharing in case of an illness.

Medigap premiums vary widely across plan types and states, but the most common amounts typically range from $150 to $200 per month.[16] Medigap is relatively more common among lower middle-income beneficiaries who can afford the premium and make too much to qualify for Medicaid, but may not have access to supplemental insurance from an employer. Nearly 80% of Medigap enrollees earn from $10,000 to $40,000.[17] Medigap supplemental insurance is also more common in rural areas.

In several northern plains states – Iowa, Nebraska, Kansas and the Dakotas – roughly half of all Medicare enrollees purchase Medigap supplemental coverage.[18] African Americans, Hispanics and Asian American are less likely to enroll in Medigap, but this may reflect the fact that they typically live in more urban areas.[19] Finally, individuals in relatively poorer health who anticipate needing more care may be more likely to purchase a Medigap plan to insulate themselves from high Medicare cost sharing.

Despite the fact that many lower middle-income beneficiaries rely on Medigap to mitigate their risk of high Medicare cost sharing, some policy-makers actively advocate for limiting Medigap coverage. For example, some proposals push to eliminate "first dollar" coverage, which would require all Medigap plans to include an annual deductible (such as $500 combined for Parts A and B).[20] Others are pushing to levy a tax on Medigap premiums.[21] The crux of the debate centers on whether and to what extent Medigap's reduced cost sharing induces higher overall health care spending. A number of studies have indicated higher spending for Medigap enrollees relative to other groups, with the implication that lower cost sharing encourages overutilization of services.[22] However, higher spending may be explained by "self-selection," where a relatively less healthy individual is more likely to choose to enroll in Medigap.[23]

Even studies that attempt to account for self-selection provide little or no evidence that higher spending for Medigap enrollees reflects excess spending on unneeded services.[24] For example, one commonly cited study of higher spending in Medigap found that Medigap policy holders received roughly twice as much preventive care as those without supplemental insurance.[25] Preventive care is generally considered a cost-efficient use of health care dollars. Moreover, no credible evidence indicates that the proposed policy changes, such as increasing premiums to depress Medigap enrollment and/or ending "first dollar coverage" by forcing Medigap enrollees to pay deductibles, would do anything to increase the cost-efficiency of Medicare health spending. Decades of research on across-the-board deductibles or standard coinsurance shows that these blunt approaches lead to roughly equal reductions in "necessary" and "unnecessary" care.[26] As discussed below, reducing necessary preventive care like medications for chronic conditions correlates with adverse health outcomes, including expensive hospitalizations that offset savings from the upfront reductions in service use.[27]

In short, the proposed Medigap policy changes would reduce Medicare spending primarily by shifting costs directly onto beneficiaries and, based on cumulative research findings, would encourage indiscriminate self-rationing and delayed care. Ironically, while proponents of increasing Medigap premiums or cost sharing assume that higher Medicare spending is an artifact of lower beneficiary cost sharing, Noel-Miller's analysis of Medicare out-of-pocket spending finds that Medigap beneficiaries already have by far the highest average out-of-pocket health spending of any Medicare

coverage group.[28] This suggests a population with higher health needs, not a group that is overusing the Medicare system.

Medicare Advantage

Medicare Advantage (MA), also known as Part C, is a capitated managed care option allowing Medicare beneficiaries to voluntarily receive their Medicare services from a managed care company instead of traditional Medicare. MA generally offers lower premiums and reduced cost sharing with integrated prescription drug coverage. The Centers for Medicare & Medicaid Services (CMS) estimates that over 84% of Medicare beneficiaries have access to an MA plan that offers prescription coverage and lower overall cost sharing without charging additional premiums (beyond the required Part B monthly premium.)[29] Affordability varies considerably across Medicare Advantage plans, but all are required to set an out-of-pocket maximum (at most $6,700 for Parts A & B in 2014) and must at least match the actuarial value of cost sharing in traditional Medicare. CMS also sets some limits for particular services and groups of services.[30] The lower premiums and cost sharing may attract beneficiaries who cannot qualify for Medicaid but are unable to afford a Medigap premium.

A growing share of Medicare beneficiaries, now exceeding 28%, has enrolled in MA plans.[31] Enrollment is even higher in urban areas (30%), where beneficiaries generally have greater choice between plans. Medicare Advantage has become the most prevalent form of Medicare coverage among beneficiaries with incomes between $10,000 and $20,000.[32] Interestingly, people of color who do not qualify for Medicaid are much more likely to select MA over Medigap, though this discrepancy may reflect location and other demographic differences.[33]

Although MA plans may address concerns regarding cost sharing and affordability, they can raise other concerns regarding access. Medicare Advantage plans achieve lower cost sharing partly by limiting enrollees' choice of providers and deploying strict utilization management techniques that can complicate access to care. Moreover, MA plans continue to be paid more than it would cost to cover comparable beneficiaries under traditional fee-for-service Medicare.[34] This paper does not focus on a cost/quality analysis of the Medicare Advantage program for low-income older adults – particularly older people of color – but the literature to date is decidedly mixed on how MA performs relative to traditional Medicare in terms of overall access to timely, good quality care.[35]

Medicaid

Generally, the lowest-income Medicare beneficiaries also qualify for full Medicaid coverage, also known as dual eligibility. Each state Medicaid program sets an income limit (generally in the range of 75% to 100% FPL) below which older adults with low assets can qualify for Medicaid.[36] Many states have taken up a Medicaid option to cover individuals with higher incomes (up to about 225% of the

federal poverty level) who require either institutional care or supports and services offered through various Medicaid Home- and Community-Based Services (HCBS) programs. Another pathway through which seniors may qualify for full Medicaid benefits is by "spending down," which allows individuals to reduce their effective income by deducting incurred health expenses.

Any individual who qualifies as a full dual eligible is entitled to Medicaid's robust cost sharing protections, including:

- Nominal copay limits (up to $4 for most services) for individuals below poverty;
- Generally no premiums for individuals below 150% FPL;
- No deductibles in excess of $4 for individuals under 100% FPL;
- Exemptions from cost sharing for various groups and specific services, including preventive services, hospice services and emergency services;
- No denial of a needed service due to inability to pay cost sharing for individuals below 100% FPL;
- A 5% aggregate household cap on out of pocket Medicaid expenses.[37]

These Medicaid protections are a critical feature that makes health care much more affordable for older adults who are dually eligible. However, states have considerable flexibility to vary Medicaid cost sharing within these general rules, and the U.S. Department of Health & Human Services has recently approved a number of Medicaid expansion demonstrations under § 1115 of the Social Security Act that further weaken beneficiary protections against excess out-of-pocket expenses, especially with respect to premiums.[38]

Notably, the Medicaid cost sharing protections do not apply to most prescription drugs for dual eligibles.[39] Dual eligibles get their prescription drug coverage through Part D and are subject to Part D rules and procedures.[40] In terms of benefits, Part D plans typically offer more limited coverage than Medicaid formularies. In terms of cost sharing, all dual eligibles automatically qualify for full Low Income Subsidies (LIS) from Part D.[41] This subsidy, also known as "extra help," eliminates Part D premiums and deductibles and sets nominal drug copays that are generally comparable or slightly better than Medicaid cost sharing limits.[42] However, because Medicaid protections do not extend to Part D, some key Medicaid protections, such as continuing benefits during an appeal, do not apply to Part D medications for dual eligibles.

Medicare Savings Programs (MSPs)

Low-income Medicare beneficiaries who do not otherwise qualify for Medicaid may qualify for one of the three Medicare Savings Programs (MSPs) that help pay for Medicare cost sharing, though they receive no Medicaid benefits. Such individuals are known as *partial* dual eligibles. (Most full dual

eligibles also qualify for help with their Medicare cost sharing through an MSP.)[43] Eligibility for the three different MSP programs depends on income and assets, with lower income and assets triggering more Medicare cost sharing reductions.[44] See Table 1.

Table 1. Medicare Savings Program Summary.

Program	Income limit	Asset limit	Cost sharing protections
Qualified Medicare Beneficiary (QMB)	≤ 100% FPL	Varies by state, but strictest limits are $8,660 individuals/ $13,750 couples*	Medicaid covers premiums, deductibles and coinsurance for Medicare Parts A & B. Part D full low income subsidy (LIS).
Specified Low Income Beneficiaries (SLMB)	100% - 120% FPL		Medicaid covers premiums for Part B. Part D full LIS.
Qualifying Individuals (QI-1)	120% - 135% FPL		Medicaid covers premiums for Parts B. Part D full LIS.

* This minimum asset limit includes a $1,500 per person burial allowance permitted by Medicare. States have flexibility to create additional income disregards and to increase, or even eliminate, asset limits. *See* 42 U.S.C. § 1396a(r)(2).

Medicare Service Programs, especially QMB, substantially enhance affordability for older adults in Medicare. The QMB "buy in" covers all Medicare Part A & B cost sharing for this group, including premiums, 20% Part B coinsurance for outpatient services, and Part A and B deductibles.[45] Quality Medicare Beneficiaries also automatically receive the full Part D low-income subsidy. In short, QMB mitigates nearly all Medicare cost sharing, though an individual with QMB would still have copays for medications and would have to find a way to pay for services that Medicare typically does not cover, like vision, dental and personal care. Also, while these protections are excellent by the letter of the law, enforcement has been uneven. Many QMB beneficiaries continue to be illegally balance billed by providers, to the point where CMS issued clarifying guidance on this issue in 2012.[46]

The SLMB and QI-1 programs offer more limited cost savings, but they do cover the Part B premium that allows these older adults to avoid penalties associated with not maintaining Part B coverage. The Part B premium alone amounts to $1,260/year for most beneficiaries. Furthermore, like QMB, SLMB and QI-1 enrollment *automatically* confer the full low income subsidy for Part D medications, albeit with slightly higher copayments.

Beyond the similarities in benefits, SLMB and QI-1 also differ in several respects. Funding for the QI-1 program is constantly imperiled. While SLMB is an entitlement program, meaning that any individual who meets the eligibility criteria qualifies (as is QMB), Congress funds QI-1 through block grants to the states. This means states get a fixed amount of funding for QI-1 coverage and may cap enrollment. Furthermore, the funding has historically been appropriated on a temporary basis, and Congress has

to issue new extensions periodically to keep QI-1 funded (which it has done repeatedly for well over a decade).[47] Funding, however, has not been steady. While appropriations nearly doubled to $1 billion in 2011 in the wake of a major recession, contentious budget negotiations led to a nearly 30% cut in 2012. By 2014, appropriations were still more than 20% less than 2011 levels.[48] Meanwhile, as America's population ages the number of seniors eligible for Medicare and for MSPs increases.

MSP Enrollment

Although the MSP program is beneficial to lower-income seniors, under-enrollment has been an ongoing problem. A comprehensive report from the Congressional Budget Office (CBO) in 2004 estimated that among individuals not otherwise eligible for Medicaid, only 33% of those potentially eligible for QMB and a scant 13% of potentially eligible SLMB beneficiaries were actually enrolled.[49] Notably, some recent evidence suggests an uptick in MSP participation. In 2012, the U.S. Government Accountability Office (GAO) conducted a review of MSP changes instituted by the Medicare Improvements for Patients and Providers Act (MIPPA) intended to increase outreach, align asset tests between MSP and the Part D Low Income Subsidy program and streamline the MSP eligibility process.[50] The GAO found modest enrollment increases – roughly 5% annually in the two years after the changes went into effect.[51] Furthermore, the Medicare-Medicaid Coordination Office (MMCO) reported that between 2006 and 2011, enrollment in MSP programs increased by 49% (39% for adults 65 and older), while overall Medicare enrollment increased by 12.5%.[52]

Numerous barriers reduce MSP participation, mostly stemming from a lack of coordination and alignment between the Social Security Administration, CMS and state Medicaid agencies that administer the MSPs. Some of these barriers include:

- Individuals must often submit multiple applications to different entities for different benefits: to the state Medicaid agency for MSP, to CMS for Medicare and to the SSA for social security benefits like SSI;
- Requirements to count and verify income and assets vary substantially across states and between programs. In particular, asset rules for LIS may not match with states asset rules for MSPs;
- The various agencies often cannot readily share data and information, instead putting the burden on beneficiaries; and
- Education and outreach about the availability of MSPs is insufficient.

The Medicare Payment Advisory Commission (MedPAC) has acknowledged the need to improve participation and even expand MSP eligibility. In its 2008 Report to Congress, MedPAC recommended covering Part B premiums for individuals with incomes up to 150% FPL. This aligns with Part D LIS eligibility thresholds.[53] Such a policy shift would also require expanding, or at least renewing funding for the QI-1 program, which is currently funded through March 31, 2015.[54]

Finally, states and CMS should consider how to facilitate the transition of individuals with Health Marketplace coverage or Medicaid to Medicare when they turn 65. This transition, sometimes called the "Medicare cliff," often exposes seniors to unexpected increases in cost sharing and premiums, provider discontinuity, and a different scope of benefits.[55] However, it also presents opportunities for coordination. Data on enrollee's Modified Adjusted Gross Income (MAGI) collected in the application for Medicaid or Advanced Premium Tax Credits could help target enrollees potentially eligible for MSPs or Part D Low Income Subsidies. Ultimately, no lower-income senior should go through a coverage transition without being screened for all Medicaid programs, including MSPs, which may make her Medicare coverage more affordable.

Medicare Part D Prescription Drug Coverage

One of the largest sources of out-of-pocket spending for adults over age 65 is prescription medications. Medicare Part D covers prescriptions for both Medicare-only and dual eligible individuals. In 2014, Part D premiums averaged roughly $32/month, but typical plans include substantial additional beneficiary cost sharing.[56] The Affordable Care Act gradually closes the infamous "doughnut hole" in Medicare prescription drug coverage, which describes a coverage gap where, prior to the ACA, individuals paid *all* their medication costs once the total cost of their medications exceeded an initial coverage limit and before catastrophic coverage kicked in.[57] But even after eliminating that coverage gap (in 2020), Part D coverage will continue to have significant cost sharing, including the actuarial equivalent of 25% coinsurance with a deductible.[58]

As noted above, all dual eligibles receive their drug coverage through Part D.[59] Drugs covered by Part D are not considered Medicaid benefits and thus are not subject to Medicaid beneficiary protections, including cost sharing protections.[60]

Fortunately, Part D offers reduced cost sharing for individuals with incomes below 150% FPL and limited assets. All full and partial dual eligibles, as well as individuals with income below 135% FPL and low assets, qualify for the full LIS that eliminates Part D premiums, deductibles and "doughnut hole" costs. Notably, copayments for medications are actually below the nominal limits permitted under Medicaid.

Medicare-only beneficiaries with incomes 135-150% FPL or with assets above the full LIS limits, qualify for partial LIS. Partial LIS also eliminates the doughnut hole, but requires 15% coinsurance instead of copays and includes sliding scale premiums. After an individual spends $4,550 out-of-pocket on medications, a limited copay replaces the coinsurance.

Ultimately, for older adults who are not eligible for full or partial LIS, Part D has relatively high cost sharing. This may decrease adherence to needed prescription regimens and negatively impact health

outcomes. Dual eligibles and other low-income individuals rely on LIS cost reductions, which are substantial.

Cost Sharing and the "Offset Effect"

Cost sharing represents a significant financial burden for older adults, especially those with no supplemental Medicare coverage. This financial burden results in vulnerable seniors being faced with terrible choices: choosing to pay rent instead of purchasing needed medications or taking the medications instead of buying food.

Such Sophie's choices would be easier to accept if the economic incentives created by cost sharing were not so flawed. At its base, most cost sharing does little to improve the efficiency of care because standard cost sharing does not effectively discriminate between cost-efficient and cost-inefficient services. Rather, it creates a financial incentive to avoid *all* care and leaves the consumer to determine which services to avoid. Unfortunately, some highly cost-efficient services, like preventive screenings or medications to manage chronic conditions, may also appear to be more "discretionary." No urgent symptoms compel an individual to pay for such treatments that reduce long-term costs by avoiding expensive complications and hospitalizations. This exemplifies some of the flawed logic of cost sharing. A similar example is the "offset effect," whereby the "savings" from cost sharing on one service are offset by increased use of other services. For example, reduced adherence to medications due to higher copays often results in more frequent hospitalizations that drive up the cost of care.[61]

> Chandra et al. ***found that increased copayments for clinician office visits and prescriptions induced significant declines in both office visits (17.5%) and in prescriptions filled, especially for drugs to treat chronic illness.[63] However, these decreases also correlated with a 6% increased risk of hospitalization.***

Measuring the impact of cost offsets can be challenging because the frequency of events like hospitalizations and ED visits is relatively low. Consequently, any incremental impact attributable to higher cost sharing is difficult to detect without a large sample size and a multiple year study.[62] However, because adverse events like hospitalizations are so serious and expensive, even a small increase attributable to these events can quickly wipe out perceived savings from reduced office visits or prescription drug use. Older adults with chronic conditions, who generally have higher risk of hospitalizations, are among the groups most affected by the offset effect. One of the most notable studies of the offset effect involved retired Medicare enrollees in the California Public Employees'

Retirement System. *Chandra et al.* found that increased copayments for clinician office visits and prescriptions induced significant declines in both office visits (17.5%) and in prescriptions filled, especially for drugs to treat chronic illness.[63] However, these decreases also correlated with a 6% increased risk of hospitalization. For the sickest beneficiaries, hospital spending increased by nearly $2 for every $1 saved. For all chronically ill individuals, 43% of savings realized by reduced medications and office visits were offset by increased hospital spending.[64]

Another study of roughly 900,000 Medicare enrollees from 2001 to 2006 found, overall, plans that increased copays had 19.8 fewer ambulatory visits per 100 enrollees as compared to controls that did not increase copays. However, the study population also experienced 2.2 more hospitalizations and 13.4 more annual inpatient hospital days per 100 enrollees. Based on the authors' reasonable estimates for service costs and copays, the Medicare health plans with higher copays would save a bit more than $7,100 per 100 enrollees in outpatient services, but at the cost of $24,000 per 100 enrollees for increased hospitalization costs.[65]

Similarly, an evaluation of Georgia's Medicaid program found that after the state instituted $2-$3 medication copays in 2002, enrollees with cancer reduced their prescription drug use by 16% compared to similar Medicaid populations in two control states.[66] This reduction corresponded to a slight but significant increase in ED visits and a $2,300-$3,500 relative increase in total treatment costs for enrollees with cancer.[67]

In fact, some studies show that *reducing* copays to increase medication adherence may actually save money. For example, *Stuart et al.* tracked diabetic Medicare recipients for three years finding that increased adherence to statins (for cholesterol) and RAAS-1 inhibitors (for high blood pressure) corresponded with reduced overall health expenditures. They estimated the savings from a 10% increase in adherence (e.g., through lower copays) would more than pay for the added cost of the medications.[68] *Hoadley et al.* similarly found that reducing or eliminating copays for generic statins is the single most important factor to increase adherence, encouraging the use of generics and generating overall savings for Medicare.[69]

These studies all reveal a substantial offset effect among the most vulnerable populations. Not all studies look for or find significant offsetting costs associated with higher cost sharing.[70] Notably, the RAND Health Insurance Experiment in the 1970s, which remains the gold standard for a randomized cost sharing experiment, generally found that participants with higher cost sharing for outpatient visits had fewer hospitalizations.[71] However, the HIE also found that health outcomes for low-income populations were worse in several areas.[72] Furthermore, it did not include the elderly.

The literature makes two clear conclusions about the impact of cost sharing on older adults. First,

adding cost sharing to a service *does* tend to reduce use of that service. Second, people tend to reduce such services even if they may really need them. Even trained health professionals often disagree about the relative value and medical necessity of services in different individual contexts. Blunt financial disincentives, such as high copays or deductibles, should not trump these highly personalized medical evaluations resulting from consultation between individuals and their healthcare provider. Not surprisingly, such economic disincentives hurt low-income older adults more than others. Taken together, the clinical research generally supports the hypothesis that sicker people with higher healthcare needs are more likely to ration care when their costs go up and also more likely to suffer the consequences. Systemically, the result is the worst of both worlds: seniors have worse health outcomes because they cannot afford to get necessary prescribed care, and, at least for the chronically ill, overall health care costs may even increase due to offsets.

Conclusion

The information presented above points to five clear recommendations to improve affordability, and thus access to care and health outcomes, for lower income seniors:

1. **Cost sharing in traditional Medicare represents a major financial barrier to care. Lower-income seniors should have access to more comprehensive cost sharing protections in traditional Medicare.** A number of recent proposals seek to redesign Medicare cost sharing in ways that would *increase* the financial burden on many beneficiaries, such as combining the Part A & B deductible. Especially for lower-income individuals, the current structure leads to rationing of both necessary and less-necessary care, and these proposed changes would only make that problem worse. Medicare should instead shift away from deductibles, which lead to indiscriminate reductions in care, and also reduce cost sharing on cost-efficient services that improve outcomes and decrease the likelihood of expensive complications. Medicare should also implement cost sharing protections for Parts A & B that reduce cost-sharing for all individuals below a specific income threshold, such as the 250% threshold used by the Marketplace. In all cases, Medicaid MSP programs must remain in place, to provide a safety net for the lowest-income individuals.

2. **Medicaid protections – when properly implemented – are a good starting point for rethinking traditional Medicare cost sharing.** Though Medicaid is not perfect, it offers a number of substantial protections that could serve as models for Medicare. For example, traditional Medicare should also implement two key affordability protections already used in Medicaid: (1) a sliding scale maximum out-of-pocket spending limit tied to an individual's income, and (2) maximum copayments for Part A & B services (as are already used for Part D LIS) that are set low enough to limit the potential adverse impacts on accessibility to needed care for low-income seniors.[73]

3. **Until and unless traditional Medicare cost sharing adds cost sharing protections, Medigap, Medicaid, Medicare Advantage and other supplemental coverage should remain accessible and their protections should not be undermined.** Proposals to require deductibles in Medigap would likely lead to indiscriminate reductions in services that worsen health outcomes and may not save Medicare money. Adding taxes to the premiums seniors pay would also likely lead more lower-income individuals to forgo supplemental insurance, thus exposing them to substantial financial risk. The systemic goal should be to make *Medicare* meet the needs of seniors so that Medigap and other supplemental coverage become obsolete.

4. **Barriers to MSP enrollment must be eliminated and the QI-1 program must have guaranteed funding.** These programs serve as a critical safety net and must be preserved and strengthened. As it stands, the gaps in consumer protection remain too large and should be reduced. Ideally, federal MSP eligibility limits should be simplified and at least matched to Part D LIS limits. But MSPs already give states the flexibility to expand eligibility to meet the needs of their growing population of older residents.[74]

5. **Any health insurance system, especially one covering older adults, should account for chronic conditions.** Vulnerable older adults with chronic conditions cannot not afford to pay for every single treatment they need over the course of a long treatment plan. For many of these conditions, increased cost sharing may have a profoundly negative impact that worsens health outcomes and actually reduces the efficiency of the system of care. Cost sharing for chronic conditions should be eliminated, or at the very least, redesigned to apply once to the entire treatment plan in a way that will not pose a constant disruption to on-going care.

6. **Researchers should focus on the cost sharing consequences on long term services and supports.** Though beyond the scope of this paper, an urgent need exists for a national conversation on how to establish, finance and maintain a care system for long-term supports and services (LTSS). Medicare covers only limited stays in skilled nursing facilities and generally does not cover personal care services, while the private LTSS coverage market is expensive and limited. Consequently, Medicaid is currently the nation's default LTSS payer. But individuals who require LTSS become eligible for Medicaid only if their incomes are low enough and after their assets have been sufficiently depleted. In the meantime, seniors face serious consequences – bankruptcy, unnecessary institutionalization and/or in unsafe conditions in their own home – because they cannot afford the care they need or must tap all their resources to attain it. The Affordable Care Act scratched the surface with the since-repealed CLASS Act, but recent efforts to address this critical issue have taken no more than baby steps to analyze the problem, which we intend to explore in a future paper.[28] Until a more coherent system is in place, seniors will bear the brunt of our social inaction, to devastating effect on their health, finances and quality of life.

ENDNOTES

[1] Special thanks to David Lipschutz at the Center for Medicare Advocacy for his comments and consultation on earlier drafts of this brief.
[2] A deductible is the cost paid by an enrollee before insurance coverage begins. Copays are fixed amount paid by the enrollee for a particular service. Coinsurance is a percentage of the total cost of a service paid by the enrollee.
[3] Leighton Ku et al., Ctr. on Budget & Policy Priorities, *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program* (2004), www.cbpp.org/files/11-2-04health.pdf; Marisa Elena Domino et al., *Increasing Time Costs and Copayments for Prescription Drugs: An Analysis of Policy Changes in a Complex Environment*, 46 HEALTH SERVICES RES. 900 (2011); Jeffrey Kullgren et al., *Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans*, 170 ARCHIVE INTERNAL MED. 1918 (2010).
[4] Michael T. Eaddy et al., *How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review*, 37 PHARMACY & THERAPEUTICS 45 (2012); Amal N. Trivedi et al., *Increased Ambulatory Care Copayments and Hospitalizations among the Elderly*, 362 NEW ENG. J. MED. 320 (2010); Dana P. Goldman et al., *Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health*, 298 JAMA 61, 64 (2007).
[5] Original Medicare does not cover dental, vision or personal care services. This adds additional out-of-pocket expenses for many seniors.
[6] For more detail, *see* Appendix A. *See also* Medicare.gov, *Your Medicare Costs* (last visited Sept. 24, 2014), http://medicare.gov/your-medicare-costs/index.html.
[7] Medicare's prescription drug program, Part D, does have a soft aggregate spending cap.
[8] Medicare Payment Advisory Comm'n ("MedPAC"), *Report to Congress: Medicare and the Health Care Delivery System*, 68 (June 2014), http://www.medpac.gov/documents/reports/jun14_entirereport.pdf?sfvrsn=0.
[9] This includes Medicare premium costs, cost sharing and expenses for services Medicare does not cover, such as dental care and long term care. Average annual spending amounted to $4722/household. Juliette Cubanski et al., The Henry J. Kaiser Fam. Found. ("KFF"), *Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households*, 1 (2014), http://kff.org/medicare/issue-brief/health-care-on-a-budget-the-financial-burden-of-health-spending-by-medicare-households/.
[10] *Id.* at 3; *See also* Claire Noel-Miller, AARP, *Medicare Beneficiaries' Out-of-Pocket Spending for Health Care*, 3 (2012), http://www.aarp.org/health/medicare-insurance/info-05-2012/medicare-beneficiaries-out-of-pocket-spending-for-health-care-AARP-ppi-health.html.
[11] Cubanski et al., *supra* note 9, at 3.
[12] Estimates for individuals with no supplemental coverage range from 8% to 14%. *See* Gretchen Jacobson et al., KFF, *Medigap Reform: Setting the Context for Understanding Recent Proposals*, 1 (Jan. 2014), http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8235-02-medigap-reform-setting-the-context-for-understanding-recent-proposals1.pdf; Claire Noel-Miller, *supra* note 10, at 5.
[13] Nearly 70% of Medicare beneficiaries with access to employer-sponsored supplemental coverage have incomes exceeding $20,000. Frank McArdle et al., KFF, *Retiree Health Benefits at the Crossroads*, 1, 3 (Apr. 2014), http://kff.org/medicare/report/retiree-health-benefits-at-the-crossroads/.
[14] In 2013, only 28% of large firms (over 200 employees) and 5% of small firms offered retiree benefits. Employer-sponsored supplemental coverage will likely continue to drop due to tax policy changes around retiree health plans and the existence of Marketplace coverage as a viable and affordable alternative. *Id.* at 1. Some employers set up special Health Reimbursement Accounts to help their retirees pay for Medigap premiums.
[15] Private insurance companies may offer any of ten standardized Medigap plans, distinguished by different letters (A-D, F, G, and K-N). Congress directed the National Association of Insurance Commissioners to develop these standard plans for Medicare. Four other standard plans (E, H, I, and J) are no longer sold after June 1, 2010. Minnesota, Massachusetts and Wisconsin offer different standardized Medigap plans. *See* Jennifer T. Huang et al., KFF, *Medigap: Spotlight on Enrollment, Premiums, and Recent Trends*, 4-6 (Apr. 2013), http://kff.org/medicare/report/medigap-enrollment-premiums-and-recent-trends/.
[16] This premium range is based on 2010 data, the most recent available. *Id.* at 9.
[17] Gretchen Jacobson et al., *supra* note 12, at 3.
[18] *Id*.
[19] Hispanics and African Americans are also more likely to forego supplemental coverage altogether. America's Health Insurance Plans ("AHIP") Ctr. for Policy Research, *Low-Income & Minority Beneficiaries in Medicare Advantage Plans, 2011*, 3 (Feb. 2013), http://www.ahip.org/Low-IncomeMinorityMA2011/.
[20] For a range of the proposed reforms, *see* Gretchen Jacobson et al. *supra* note 12, at 7. *See also* Amanda Cassidy, *Health Policy Brief: Putting Limits on "Medigap,"* HEALTH AFF. 1, 3-4 (2011), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=51.

[21] MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, 17-19 (June 2012), http://www.medpac.gov/documents/reports/jun12_entirereport.pdf?sfvrsn=0.
[22] *Id.* at 14-17; Christopher Hogan, MedPAC, *Exploring the Effects of Secondary Insurance on Medicare Spending for the Elderly* (2009), http://www.medpac.gov/documents/contractor-reports/Jun09_SecondaryInsurance_CONTRACTOR_RS_REVISED.pdf?sfvrsn=0; Marika Cabral & Neal Mahoney, National Bureau of Economic Research, *Externalities and Taxation of Supplemental Insurance: A Study of Medicare and Medigap*, (Jan. 2014), http://www.marikacabral.com/Cabral_MahoneyMedigap.pdf.
[23] In addition to self-selection, one critique of Medigap spending comparisons found other confounding factors, such as the failure to control for services received from the Veterans Administration and other military sources, which likely led to overestimated Medigap spending. *See* Jeff Lemieux et al., *Medigap Coverage and Medicare Spending: A Second Look*, 27 HEALTH AFF. 469 (2008).
[24] Marika Cabral & Neal Mahoney, *supra* note 22; *See also* Christopher Hogan, *supra* note 22.
[25] Christopher Hogan, *supra* note 22, at 41.
[26] Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRAC. MGMT. 317 (1992), http://www.rand.org/pubs/reprints/RP1114.html.
[27] Amitabh Chandra et al., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AM. ECON. REV. 193 (2010).
[28] Claire Noel-Miller, *supra* note 10, at 5.
[29] MedPAC, *Report to Congress: Medicare Payment Policy*, 330 (Mar. 2014), http://www.medpac.gov/documents/reports/mar14_entirereport.pdf?sfvrsn=0.
[30] For a list of these specific service and category limits, *see* U.S. Ctr. for Medicare & Medicaid Services ("CMS"), *Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, 88-93 (Apr. 7, 2014), http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf . The *Final Call Letter* also sets limits on tiering, coinsurance and copays for prescription drugs in Part D. *Id.* at 123-26.
[31] MedPAC, *supra* note 29, at 323.
[32] Roughly a third of beneficiaries in this income range are enrolled in MA. AHIP Ctr. for Policy Research, *supra* note 19, at 2. Medicaid coverage remains much more common than MA for beneficiaries with incomes below $10,000 (47% to 27%). *Id.*
[33] *Id.* at 5; *but see also* Edwin Park and Robert Greenstein, Ctr. on Budget & Policy Priorities, *Low-Income and Minority Beneficiaries Do Not Rely Disproportionately on Medicare Advantage Plans* (April 12, 2007), http://www.cbpp.org/cms/?fa=view&id=237.
[34] MedPAC, *supra* note 29 at 325.
[35] Marc N. Elliott et al., *How Do the Experiences of Medicare Beneficiary Subgroups Differ between Managed Care and Original Medicare?*, 46 HEALTH SERVICES RES. 1039 (2011); Amal N. Trivedi et al., *Trends in the Quality of Care and Racial Disparities in Medicare Managed Care*, 353 N. ENG. J. MED. 692 (2005).
[36] In most states, this category is tied to Supplemental Security Income (SSI) benefits, which cover Aged, Blind and Disabled (ABD) individuals with incomes up to $720/month (~74% FPL) and assets under $2000. Some states have slightly more restrictive eligibility thresholds, while others implemented a state option to expand ABD Medicaid eligibility up to the federal poverty limit.
[37] States may apply Medicaid's aggregate cost sharing limit on a monthly or quarterly basis. 42 U.S.C. § 13960-1(b)(2). Codified at 42 C.F.R. § 447.56(f)(1).
[38] While these Medicaid expansion demonstrations do not directly impact seniors, who are not eligible for Medicaid expansion, they set a precedent for allowing states to ignore critical Medicaid cost sharing protections. Moreover, CMS' approval of these cost sharing provisions is of questionable legality. For instance, it is unclear what novel hypothesis these demonstrations will test. *See Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011); *Wood v. Betlach*, 922 F. Supp. 2d 836 (D. Ariz. 2013); *see also Beno v. Shalala*, 30 F. 3d 1057 (9th Cir. 1994).
[39] 42 U.S.C. § 1396u-5(d)(1).
[40] States have the option to cover drugs that are not part of the Part D formulary as Medicaid services. These drugs would be subject to Medicaid beneficiary and cost sharing protections.
[41] 42 U.S.C. § 1395w-114(a)(3)(B)(v). *See also* Appendix A.
[42] Currently, the limits are $2.55 (generic)/$6.35 (brand name).
[43] The QMB and SLMB programs accept beneficiaries who are otherwise eligible for Medicaid benefits, but not QI-1. *See* 42 U.S.C. § 1396a(a)(10)(E)(iv).
[44] A fourth MSP, the Qualified Disabled & Working Individuals (QDWI) program, covers certain individuals aged 19-64 with disabilities who have exhausted their Part A premium exemption. Since it focuses on younger adults and enrolls only several hundred beneficiaries nationwide, this brief does not detail QDWI. *See also* CMS, *Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs* (June 2014), http://cms.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.

[45] QMB is particularly important for individuals with very low incomes who lack the necessary work credits to be eligible for social security benefits (and thus exempt from Part A premiums.) Such individuals likely cannot afford the Part A premiums ($426/month in 2014), but could enroll in Medicare through QMB because the program pays their Part A "buy-in."
[46] Ctrs. Medicaid & CHIP Servs. ("CMCS") & Medicare-Medicaid Coordination Office ("MMCO"), *Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs)* (Jan. 6, 2012), http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf; CMS, Medicare Learning Network Matters, *Prohibition on Balance Billing Qualified Medicare Beneficiaries (QMBs)* (updated Mar. 28, 2014), http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf.
[47] QI-1 funding is currently tied to periodic appropriations to postpone implementation of the Sustainable Growth Rate (SGR) formula, which would drastically cut Medicare provider reimbursement if not renewed every year. Recent proposed legislation would permanently resolve the SGR "doc fix," but would only fund QI an additional 5 years.
[48] 42 U.S.C. § 1396u-3(g).
[49] Cong. Budget Office ("CBO"), *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, 29 (2004), http://www.cbo.gov/publication/15841.
[50] U.S. Gov't. Accountability Office ("GAO"), *Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment*, (Sept. 2012), http://www.gao.gov/products/GAO-12-871.
[51] *Id.*at 1.
[52] MMCO, *Medicare-Medicaid Dual Enrollment from 2006 through 2011*, 1-2, 4 (Feb. 2013), http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf.
[53] MedPAC, *supra* note 8, at 61. MedPAC has since recommended changing the cost sharing structure for all of original Medicare, but its 2014 report acknowledges the continued importance of expanding QI-1 eligibility. *Id.* at 68.
[54] Protecting Access to Medicare Act of 2014, Pub. L. 113-93, § 201, *amending* 42 U.S.C. § 1396a(a)(10)(E)(iv).
[55] Leonardo Cuello, Nation'l Health Law Program, *Understanding the Medicare Coverage "Cliff"* (June 2014), http://www.healthlaw.org/publications/browse-all-publications/Health-Advocate-June-2014#.VCLckBY6zVQ.
[56] CMS, *Annual Release of Part D National Average Bid Amount and other Part C & D Bid Related Information*, 2 (July 30, 2013), http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/PartDandMAbenchmarks2014.pdf. Individuals with incomes over $85,000/year pay higher adjusted premiums. *Id.* at 3.
[57] Medicare.gov, *Costs in the Coverage Gap* (last visited Sept. 24, 2014), http://www.medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html. Catastrophic coverage starts when individual out-of-pocket Part D spending reaches $4550 and reduces cost sharing to the greater of 5% coinsurance or a limited copay ($2.55 generic/$6.35 brand name).
[58] 42 U.S.C. § 1395w-102(b)(1), (2).
[59] Some states cover additional medications not on the Part D formulary through Medicaid.
[60] 42 U.S.C. § 1396u-5(d).
[61] Amitabh Chandra et al., *supra* note 27, at 210.
[62] *Id*.
[63]*Id*. at 201.
[64] *Id.* at 210.
[65] Amal N. Trivedi et al., *supra* note 4.
[66] Sujha Subramanian, *Impact of Medicaid Copayments on Patients with Cancer*, 49 MED. CARE 842, 845 (2011).
[67] *Id*. at 846. Enrollees with comorbidities reduced prescriptions even more dramatically than patients with no comorbidities. *Id*.
[68] Bruce Stuart et al., *Does Medication Adherence Lower Medicare Spending among Beneficiaries with Diabetes?*, 46 HEALTH SERVICES RES. 1180 (2011).
[69]The authors also found smaller effects for requiring prior authorization, step therapy and higher cost sharing for brand name medications, but these policies would likely decrease adherence and possibly worsen health outcomes for some individuals, especially those patients for whom a brand name medication may be the best, or the only, clinical option. John F. Hoadley et al., *In Medicare Part D Plans, Low or Zero Copays and Other Features to Encourage the Use of Generic Statins Work, Could Save Billions*, 31 HEALTH AFF. 2266, 2271 (2012).
[70] David J. Magid et al., *Absence of Association Between Insurance Copayments and Delays in Seeking Emergency Care Among Patients with Myocardial Infarction*, 336 NEW ENG. J. MED. 1722 (1997).
[71] Emmett B. Keeler, *supra* note 26.
[72] Robert H. Brook et al., RAND Corp., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*, 3 (2006), http://www.rand.org/pubs/research_briefs/RB9174.html.
[73] Discrepancies exist between the maximum limits set by these two programs. In particular, medication copay limits set out in Medicare Part D for dual eligible individuals with incomes below poverty are less than *half* the "nominal" limits permitted by CMS

for Medicaid-*only* beneficiaries with similar incomes. The cost sharing literature finds that copays of even $1 or $2 can raise substantial barriers to care for beneficiaries with very low incomes, suggesting that the lower nominal copay limits may be more appropriate. *See, e.g.,* Leighton Ku et al., *supra* note 3.

[74] States already have the flexibility to raise effective eligibility by disregarding income or assets. 42 U.S.C. § 1396a(r)(2). As of 2010, eight states (AL, AZ, CT, DE, ME, MS, NY & VT) and the District of Columbia have eliminated asset tests for MSPs altogether. Medicare Rights Ctr., *Medicare Savings Program Financial Eligibility by State* (2014), http://www.medicareinteractive.org/uploadedDocuments/mi_extra/MSPFinancialEligibiltyGuidelines.pdf.

[75] U.S. Senate Comm'n on Long-Term Care, *Report to Congress* (Sept. 2013), http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf.

[76] Individuals making over $85,000/year pay higher premiums for Parts B and D based on their income, up to $335/month for Part B.

[77] CMS, *supra* note 30.

[78] 42 C.F.R. § 423.104(d)(5)(i).

[79] KFF, Medicare Advantage 2014 Spotlight: Plan Availability and Premiums (2014), http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/#PremiumsBenefits2014. CMS estimates that 84% of Medicare beneficiaries have access to a Medicare Advantage plan that charges only the Part B premium. Id." (in this draft the endnote is not labeled but sits between 77 and 79.)

Appendix A. – Summary of 2014 Cost sharing Limits and Protections for Medicare Beneficiaries (*continued on next page*)

Status	Part A: Inpatient	Part B: Outpatient	Part D: Medications
Original Medicare only	**Premiums** (most beneficiaries exempt): $426/month	**Premiums:** ~$105/month[76]	**Premiums:** Vary, but national average is $32/month.[76]
	Cost sharing: $1,216 deductible per benefit period 61-90 days: $304/day 90+ days: $608/day until lifetime reserve days are used up. Nursing facility: Days 1-20: $0 Days 21-100:$152/day Days 100+: no coverage	**Cost sharing:** **$147 deductible**/year + **20% coinsurance** for most services Home health services, certain preventive services and screenings, lab tests and an annual wellness visit are free of cost sharing. Physical therapy may include special limitations.	**Cost sharing:** **Deductible** no more than **$310**. **25% coinsurance** (or actuarially equivalent variation) Cost sharing varies considerably between plans, but CMS sets certain limits on copays, coinsurance and tiering.[77] Higher spending after reaching initial coverage limit ("Doughnut hole") now phasing out.
	Annual Cap: None	**Annual Cap: None**	**Annual Cap:** After $4550 in out-of-pocket costs, beneficiaries pay the greater of 5% coinsurance or a copay ($2.55 generic/ $6.35 brand name.)[78]
Medigap Insurance	~$60-$200 monthly premiums, depending on state and plan type. Covers most or all Medicare Part A & B cost sharing. Also adds 365 extra inpatient care coverage days.		N/A
Medicare Advantage	**Premiums:** Beneficiary must be exempt from Pt. A premiums.	**Premiums:** ~$105/month[76]	**Premiums:** Average MA premium in 2014 was $49/month (plus the Pt. B premium). Most plans include prescription drug coverage.[79]
	Cost sharing: Plans must at least match actuarial value of FFS Medicare, both overall and for specific categories and services.[77] MA plans often apply lower daily inpatient copays in lieu of the FFS deductible and cover hospital stays beyond the lifetime reserve.	**Cost sharing:** Must not exceed FFS cost sharing. Additional limits on specific services also apply.[77] Typically lower, especially when the MA premium is higher.	**Cost sharing:** See above regarding Medicare-only Part D plans. Cost sharing varies considerably between plans, but CMS sets certain limits on copays, coinsurance and tiering.[77]
	Annual cap: At most $6,700 (includes Pts. A and B).	**Annual cap:** At most $6,700 (includes Pts. A and B).	**Annual cap:** After $4,550 in out-of-pocket costs, beneficiaries pay the greater of 5% coinsurance or a small copay.

Appendix A. – Summary of 2014 Cost sharing Limits and Protections for Medicare Beneficiaries

Status	Part A: Inpatient	Part B: Outpatient	Part D: Medications
Full Dual Eligibles			
Institutionalized or receiving HCBS	Medicaid cost sharing and share-of-cost requirements.	Medicaid cost sharing and share-of-cost requirements.	No cost sharing or premiums.
Non-institutionalized, Income <100% FPL	Medicaid cost sharing and benefits apply.	Medicaid cost sharing and benefits apply.	No premium or deductible, $1.20 generics/$3.60 brand name.
Non-institutionalized Income > 100% FPL	Medicaid cost sharing and benefits apply.	Medicaid cost sharing and benefits apply.	No premium or deductible, $2.55 generics/$6.35 brand name.
Partial Dual Eligibles			
QMB (≤ 100% FPL) **Assets:** Varies by state. No less than $8,660 single/$13,750 married.	No Premiums, deductibles or coinsurance. Medicaid cost sharing rules apply (except for Part D).	No premiums, deductibles or coinsurance. Medicaid cost sharing rules apply (Except for Part D).	**Full LIS subsidy:** No premium or deductible, Copays $2.55 generics/$6.35 brand name.
SLMB (100-120% FPL) **Assets:** Varies by state. No less than $8,660 single/$13,750 married.	Same as original Medicare.	No premiums, but deductibles and coinsurance apply.	**Full LIS subsidy:** No premium or deductible, Copays $2.55 generics/$6.35 brand name.
QI-1 (120-135% FPL) **Assets:** Varies by state. No less than $8,660 single/$13,750 married.	Same as original Medicare.	No premiums, but deductibles and coinsurance apply.	**Full LIS subsidy:** No premium or deductible, Copays $2.55 generics/$6.35 brand name.
Non-Dual Eligibles			
Income < 135% FPL **Assets:** ≤ $8,660 single ≤ $13,750 married	Same as original Medicare.	Same as original Medicare.	**Full LIS subsidy:** No premium or deductible, Copays $2.55 generics/$6.35 brand name.
Income < 135% FPL **Assets:** $8,661-$13,440 single $13,751-$26,860 married	Same as original Medicare.	Same as original Medicare.	**Partial LIS subsidy:** No premium, $63 deductible, coinsurance ≤15%, $2.55/$6.35 copays after $4,550 OOP limit.
Income 135-150% FPL **Assets:** ≤ $13,440 single ≤ $26,860 married	Same as original Medicare.	Same as original Medicare.	**Partial LIS subsidy:** Sliding scale premium, $63 deductible, coinsurance 15%, $2.55/$6.35 copays after $4,550 OOP limit.