Medicare Cost Cap Act

Lowering Out-of-Pocket Costs for People with Medicare

Led by Senators Blunt Rochester, Wyden, Schumer, Merkley, Lujan, Markey, Warren, Reed, Duckworth, Welch, Booker, Gillibrand, Padilla, Van Hollen, and Murray, the ***Medicare Cost Cap Act*** will:

- Lower out-of-pocket costs, shielding **more than half of all people with Traditional Medicare** from catastrophic costs over the next decade, while lowering skyrocketing Medigap premiums.
- Guarantee **all people with Medicare are protected**, no matter what coverage option they choose, leveling the playing field between Traditional Medicare and private plans.
- Shield seniors who rely almost exclusively on their Social Security benefits from rising premiums and cost-sharing. Medicare Part B premiums eclipsed $200 for the first time this year, straining the finances of retirees.

These policies complement Democratic priorities to strengthen Traditional Medicare in other ways, such as by improving behavioral health care, adding dental, vision, and hearing benefits, and containing costs system-wide, such as by expanding Medicare drug price negotiations.

Background: Currently, Traditional Medicare has no limit on beneficiaries' out-of-pocket spending, putting them at risk of confronting unlimited health care costs if they face serious illness or hospitalization. Medicare Advantage, employer-sponsored insurance, and insurance bought on the Marketplace all have annual caps on out-of-pocket spending. **Americans who choose Traditional Medicare deserve the same protection.** According to AARP, "Adding an out-of-pocket spending limit to traditional Medicare, similar to the one that exists for people enrolled in MA. This change would not only help protect individuals from the risk of incurring high out-of-pocket costs but would also reduce the policy imbalances between traditional Medicare and MA[1]."

Additionally, the inconsistent and complex patchwork of programs to assist low-income seniors and people with disabilities has created longstanding barriers that keep eligible people from receiving assistance with premiums, cost sharing, and prescription drug costs through Medicare Savings Programs (MSPs) and the Medicare Part D Low-Income Subsidy (LIS).

Complicated requirements, including asset tests, varying eligibility thresholds across programs, and inconsistent enrollment rules, create administrative burdens for both beneficiaries and state agencies, discourage enrollment, and often exclude low-income seniors who struggle to afford

[1] https://www.aarp.org/pri/topics/health/coverage-access/medicare-costs-premiums-outlook/

health care. Over half a million beneficiaries who qualify for MSPs are not enrolled, leading to missed benefits and higher out-of-pocket costs[2].

Solution: The ***Medicare Cost Cap Act*** establishes an annual $5,000 financial liability out-of-pocket cap in Traditional Medicare and protects seniors and people with disabilities living paycheck to paycheck from rising costs. **The bill would:**

Cap Seniors' Costs at No More than $5,000

Section II of the Act creates a $5,000 financial liability cap for hospital and provider benefits (Medicare Parts A and B). Direct out-of-pocket cost sharing and payments made by wraparound health coverage or Medigap plans on behalf of the beneficiary to cover cost sharing would count toward the cap.

- A $5,000 cap guarantees all people with Medicare are protected from catastrophic costs, creating parity with private Medicare plans and ensuring seniors can choose coverage based on their preferences - not financial risk.
    - Recent reporting confirms that despite inflated payments to private insurance companies, MA plans are increasingly exiting select markets, leaving seniors with virtually no affordable options.
- In 2028, according to an analysis from Brown University's Center for Advancing Health Policy through Research, **3.2 million** beneficiaries are projected to directly benefit from a $5,000 cap through reduced cost sharing[3].
    - Over the next ten years, more than **52% of beneficiaries** are expected to exceed the $5,000 cap at least once.
    - Additionally, a $5,000 cap is projected to **reduce average beneficiary spending by $1,255 per year**[4].

[2]https://www.cms.gov/newsroom/press-releases/hhs-takes-most-significant-action-decade-make-care-older-adults-people-disabilities-more-affordable
[3] https://repository.library.brown.edu/studio/item/bdr:8b7r54vp/
[4] https://repository.library.brown.edu/studio/item/bdr:8b7r54vp/

Lower Premiums and Cost-Sharing for Seniors Living on Fixed Incomes

Section III of the Act enhances programs that protect low-income Medicare beneficiaries by:

Eliminating Asset Tests

- The bill would eliminate asset limits to allow financially vulnerable beneficiaries to access essential health care and prescription drugs without being penalized for having modest savings.
    - Already, 12 blue and red states have eliminated asset tests for MSPs[5].
- This policy also minimizes administrative burden for states now further stressed by Republicans' largest Medicaid cuts in history, including onerous paperwork requirements.

Increasing and Aligning Income Thresholds

- The bill would align eligibility criteria across Medicare cost-sharing programs and increase the income threshold to 200% FPL (an annual income of $31,300 for an individual in 2026).
- This alignment will simplify the confusing patchwork of MSPs, ensure seniors living on fixed incomes can afford their premiums and cost-sharing, and make Traditional Medicare a more affordable, competitive option.

No Wrong Door Automatic Enrollment

- The bill establishes bidirectional eligibility deeming between MSPs and LIS, increasing MSP enrollment by ensuring that eligible beneficiaries enrolling in LIS also have an easy path to enrollment in MSPs.
- Facilitated enrollment should flow both ways, reduce administrative barriers to receiving benefits for both beneficiaries and states, and ensure seniors receive the full range of assistance for which they qualify.

[5] Alabama, Arizona, Connecticut, Delaware, District of Columbia, Louisiana, Maine, Massachusetts, Mississippi, New Mexico, New York, Oregon, Vermont, and Washington