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EXAMINING TRADITIONAL MEDICARE'S BENEFIT DESIGN

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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CONTENTS

	Page
Advisory of February 16, 2013, announcing the hearing	2

WITNESSES

Glen M. Hackbarth, Chairman, Medicare Payment Advisory Commission	6
A. Mark Fendrick, M.D., Director, University of Michigan Center for Value-Based Insurance Design	31
Tricia Neuman, Senior Vice President and Director, Kaiser Program on Medicare Policy, Kaiser Family Foundation	39

SUBMISSIONS FOR THE RECORD

AARP, letter	81
AFL–CIO, statement	84
AFSCME, statement	89
Alliance for Retired Americans, statement	93
American Academy of Actuaries, statement	97
California Health Advocates, statement	107
Center for Fiscal Equity, statement	117
Council for Affordable Health Insurance, statement	121
Leadership Council of Aging Organizations, letter	126
National Alliance on Mental Illness, statement	128
National Association for Home Care and Hospice, statement	133
National Committee to Preserve Social Security and Medicare, statement	143
UAW, statement	145
USW, statement	148

EXAMINING TRADITIONAL MEDICARE'S BENEFIT DESIGN

TUESDAY, FEBRUARY 26, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 10:26 a.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Brady Announces Hearing on Examining Traditional Medicare's Benefit Design

Washington, Feb. 2013

House Ways and Means Health Subcommittee Chairman Kevin Brady (R–TX) today announced that the Subcommittee on Health will hold a hearing to review the current benefit design of the Medicare Fee-For-Service program and consider ideas to update and improve the benefit structure to better meet the needs of current and future beneficiaries. **The hearing will take place on Tuesday, February 26, 2013 in 1100 Longworth House Office Building, beginning at 10:30 a.m.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of witnesses will follow.

BACKGROUND:

Created in 1965, the Medicare benefit was originally modeled on the Blue Cross Blue Shield plans that were prevalent throughout the nation at that time. However, the last half-century has seen significant changes in how health care benefits are designed and delivered. Yet Medicare retains the original bifurcated system of hospital and physician services, and has an array of confusing deductibles and coinsurance levels that neither creates incentives for beneficiaries to make better decisions about their health care needs nor protects beneficiaries from unexpected health costs. Not surprisingly, many beneficiaries purchase additional coverage to bring more certainty and clarity to their out-of-pocket costs.

To address these and other concerns, the Medicare Payment Advisory Commission (MedPAC) made recommendations in its June 2012 Report to Congress to redesign the traditional Medicare benefit package. In this report, MedPAC suggested improving and updating Medicare's current cost sharing structure, by maintaining on aggregate the same level of cost sharing as the traditional benefit, but redistributing cost sharing through the use of tiered copayment, coinsurance and a new combined deductible for Medicare Parts A and B. MedPAC also recommended providing an out-of-pocket maximum for beneficiaries in traditional Medicare, protection that is currently required of Medicare Advantage plans or obtained by beneficiaries through the purchase of supplemental insurance. A number of other bipartisan commissions have recommended similar changes to traditional Medicare's benefit design.

In announcing the hearing, Chairman Brady stated, **"There is bipartisan recognition that the current structure of the Medicare benefit is outdated, confusing, and in need of reform, and taking steps to improve the current array of confusing deductibles, copayments and coinsurance is long overdue. This hearing will enable the Subcommittee to investigate the limitations, inefficiencies and inadequacies of traditional Medicare's cost sharing structure and identify ways to bring the Medicare program into the 21st Century."**

FOCUS OF THE HEARING:

The hearing will review the current Medicare benefit design and examine ways to improve it.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, March 12, 2013**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman BRADY. The subcommittee will come to order. Welcome to the first hearing of the Health Subcommittee for the 113th Congress. Today we will review the outdated and confusing benefit design of the traditional Medicare program, the structure of which is essentially unchanged from its inception in 1965 it maintain separate programs and benefits for hospital and physician services, and doesn't coordinate care between the two.

Because of the outdated structure of the Medicare benefit, today's beneficiaries are inundated with an array of confusing deductibles, coinsurance and copayments with no protection from high healthcare costs unless they enroll in a private plan. As a result, over 90 percent of seniors must obtain some type of supplemental coverage, whether a purchase on their own, through an employer or from Medicaid.

Despite vast improvements and innovations in the healthcare sector that have transformed how care is delivered, Medicare has lumbered through the past half century on the same trajectory. Can you imagine a world where someone has to buy hospital and nursing home coverage from one insurance company, physician office coverage from another insurance company, prescription drug coverage from yet another company, and likely supplemental coverage from a fourth insurance company? Yet this is exactly how the current Medicare benefit is designed. No private insurance company in its right mind would design and offer a benefit that looks like this. And given a choice, most seniors wouldn't accept it.

The need to reform the outdated Medicare benefit is long overdue. I appreciate the work of the nonpartisan Medicare Payment Advisory Commission and bipartisan groups like the Bowles-Simpson Commission and Bipartisan Policy Center to further this issue. Their effort to dig into this complicated topic and advance long-overdue reform has been critical.

Updating the Medicare benefit design will bring the program into the 21st century and meet the needs of current and future seniors. It will bring the traditional Medicare benefit in line with the types of benefits and cost sharing that one in four beneficiaries currently enjoy from Medicare Advantage plans. These plans are able to offer predictable copayments versus coinsurance, protection against high out-of-pocket costs, and are often able to incentivize beneficiaries to receive care in high-quality and efficient settings.

However, as we will hear today, because of changes included in Obamacare and regulations developed by the Centers for Medicare and Medicaid Services, Medicare Advantage plans have fewer opportunities to design the benefit packages that beneficiaries want. Instead of promoting this model, the President's new healthcare law is pulling these plans and the 13 million beneficiaries enrolled in them back into the 1960s.

For the sake of our seniors, we need to break down barriers and give these plans greater flexibility to continue to innovate and offer affordable coverage while improving patient outcomes. This is something traditional Medicare has not been able to do. Moving from Medicare's half-century old design to one that provides beneficiaries with rational cost sharing and protection from high healthcare costs will be challenging, but it is necessary. Simply maintaining the current outdated, confusing and inefficient structure while the program remains on a quiet path to insolvency, is not the answer. Instead we have to move forward to improve this critical program, providing greater protections for seniors and placing the program on sound financial footing.

It is my hope that this hearing will be the start of efforts to work in a bipartisan fashion to modernize the Medicare program for all seniors and people with disabilities.

Before I recognize Ranking Member McDermott for the purposes of an opening statement, I ask unanimous consent that all Members' written statements be included in the record. Without objection, so ordered.

Chairman BRADY. I now recognize Ranking Member McDermott for his opening statement.

Mr. McDERMOTT. Thank you, Mr. Chairman. I look forward to this process. And I was just sitting up here thinking that Mr. Johnson and I were the only two people who sit on this committee who remember the last time this committee tried to reform the benefit package. That was 1988. It was a catastrophic—it was called the Medicare Catastrophic Coverage Act. It had an outpatient prescription drug benefit and a cap on beneficiaries' out-of-pocket costs. And my first vote in the Congress in 1989 in this committee was to vote against the repeal of that change. So I think that as we move forward into this area, we really ought to keep in mind what happened then.

Republicans often assert that Medicare is outdated and needs reform, and I agree. No social program could ever be designed that anticipates what is going to happen 50 years later, or 60 or 70 years later, but they ignore that substantial progress has already been made to strengthen the essential program.

The ACA reduces Medicare spending, extends its solvency, and brings growth to per-patient costs to record lows. Preventive services are now free of charge to beneficiaries, and we finally have laid the groundwork to reward treatment value over volume.

Yet further improvements are needed, but much of the current Republican proposal does more harm than good, in my view. Benefit restructuring specifically to generate savings, whether in the name of deficit reduction, paying for other initiatives, or simply masquerading as reform, is bad policy and bad politics; 1989. It may be tempting when running the numbers and calculating the averages, but it is all too easy to lose sight of the very real people whose lives and well-being hang in the balance.

For example, we long sought to add catastrophic coverage to Medicare, and I have talked about that. If it is combined with a unified deductible to offset the change, it inevitably will mean raising the costs to roughly four out of five beneficiaries. Moving to a combined deductible of $500 or more will triple the current Part B deductible. A surprising number of beneficiaries have costs below $500 and so would pay monthly premiums for benefits they never use. Meanwhile, the catastrophic cap almost certainly will be set at such a high level that it will benefit only a few, probably 5 percent or so, of the beneficiaries.

These challenges become even more complicated if cost sharing is reconfigured by creating new copays or increasing coinsurance for current services like hospital visits and home health care. And given the average beneficiary makes only about $22,500 and already spends disproportionately more on health care than a younger person, additional premium cost is done at some risk.

At a minimum, benefit redesign would require a substantial expansion of the Medicare Savings Program to ensure affordability for low-income Medicare patients. And with all but 12 percent of Medicare participants receiving supplemental coverage that insulates them from potential changes, the question is, why do it? The answer is because some want to prohibit or discourage first-dollar coverage in supplemental plans.

Then the tradeoffs get even more tricky. Do you want to dictate terms of private insurance? Do you instead penalize beneficiaries for choices they made in the free-enterprise system? Do you tell

employers what retiree benefits they can or cannot offer? What do you say to people who have already traded lower wages for better retiree coverage?

Now, we are all searching for the ever-elusive health policy holy grail that promotes value over volume and quality over quantity, but there isn't a simple answer. Our ability to reliably measure quality and value is in its infancy, and there is much work to be done. Even with good information, purchasing health care is different from making other expenditures. Few patients can shop around for bargains when their health is on the line, nor should we expect it of them.

On a final note, I want to express my optimism that bipartisanship will enable the committee to move forward on the SGR reform. We are all tired of doing the SGR patch. The recent Republican outline leaves plenty of room for agreement if people want to find it. If done smartly, this issue could reshape our entire health economy for the better, but costs can't just be hoisted onto the backs of the beneficiaries. There are better options with stronger policy justifications to pay for the needed SGR policy changes.

With that, I look forward to discussing the many tradeoffs inherent in reconfiguring Medicare's benefit package with today's expert witnesses.

Thank you, Mr. Chairman.

Chairman BRADY. Great. Thank you, sir.

Chairman BRADY. Today we will hear from three witnesses: Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission; Dr. Mark Fendrick, director of the Center for Value-Based Insurance Design at the University of Michigan; and Tricia Neuman, senior vice president of the Kaiser Family Foundation and Director of the Foundation's Program on Medicare Policy.

Thank you all for being here today. I look forward to your testimony. You will be recognized for 5 minutes for the purposes of an opening statement.

Mr. Hackbarth, we will begin with you.

STATEMENT OF GLENN M. HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. HACKBARTH. Thank you, Chairman Brady, Ranking Member McDermott, and members of this Health Subcommittee. It is a pleasure to be here to talk to you about the Medicare benefit design.

Mr. McDermott, I am also one who has very sharp memories of catastrophic insurance. In 1988, I was the Deputy Administrator of the Health Care Financing Administration, so I join you and Mr. Johnson in those recollections.

The current Medicare benefit package is both inadequate and confusing. It is inadequate because it lacks catastrophic coverage, one of the most important features of any insurance program, and it is confusing for all of the reasons that Mr. Brady mentioned in his opening statement; Part A and B, and various deductibles, and use of coinsurance instead of copayments. Given that, it is not surprising that many Medicare beneficiaries, in fact the vast majority, want to have supplemental coverage to augment Medicare.

MedPAC has recommended redesign of the Medicare benefit package using five principles as guideposts. First of all, there should be no increase in average liability for Medicare beneficiaries. We believe the existing Medicare benefit package is not too rich. If anything, given the population served, it may be too lean, and so we recommend no reduction in the actuarial value of the benefit package.

Second, we recommend that an out-of-pocket limit be added to the program, catastrophic coverage.

Third, we recommend that design of the benefit be simplified so it is more readily understood and more predictable for Medicare beneficiaries.

Fourth, we recommend that the Secretary of HHS be given broad authority to modify cost sharing, both reduce and increase cost sharing, based on the value of the services provided, and that assessment, of course, should be based on scientific evidence.

And finally, we recommend a charge on supplemental insurance. When a beneficiary buys supplemental insurance, that increases the cost of care incurred by the Medicare program. The premium paid by the beneficiary only covers a fraction of that added cost. We think it is appropriate for there to be a charge on that supplemental insurance to reflect, in effect, the implicit subsidy from the taxpayer for supplemental coverage.

I want to emphasize that we do not recommend prohibiting various types of supplemental coverage. If a beneficiary wishes to buy first-dollar coverage, he or she should be able to do that, but they ought to face more of the added cost to the Medicare program resulting from that private choice.

Whenever you talk about patient cost sharing, two types of concerns are raised. In fact, during MedPAC's discussion of this issue, we spent a lot of time on each of these questions. The first concern is that cost sharing reduces the use of both appropriate and inappropriate services. The evidence is pretty clear on that. So if our supplemental charge were to cause Medicare beneficiaries to stop having first-dollar coverage and face more cost sharing, there would be the risk that some appropriate services would be stopped as well as inappropriate services.

The fear, of course, is that when that happens, two bad things can occur. One is the total cost of care could increase. If patients don't get needed care, they could end up with hospitalizations that cost more. In addition, they could end up with a worse outcome, which none of us want. This is why it is so important to give the Secretary of HHS authority to modify copayments based on the value of the services provided. If a service is shown to be a very high value for patients, we ought to seek to lower the cost sharing. If the value is low, we ought to seek to increase the cost sharing.

The second concern that is often raised when patient cost sharing is discussed is the effect on low-income beneficiaries, and that would be true, of course, also with our charge on supplemental insurance. If the concern is protection of low-income beneficiaries, as well it might be, we think a targeted approach is preferable.

For example, expansion of the Medicare Savings Program, the program for qualified Medicare beneficiaries that pays cost sharing for low-income beneficiaries. That sort of a targeted approach is

preferable to this implicit subsidy that is offered for supplemental coverage that is available to beneficiaries of both low and high incomes. So target our response to these problems.

With that, Chairman Brady, I look forward to your questions.

Chairman BRADY. All right. Thank you, Mr. Hackbarth.

[The prepared statement of Mr. Hackbarth follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

TESTIMONY IS EMBARGOED UNTIL 10:30 AM ON TUESDAY, FEBRUARY 26, 2013

Reforming Medicare's benefit design

February 26, 2013

Statement of

Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Chairman Camp, Ranking Member Levin, Subcommittee Chairman Brady, Subcommittee Ranking Member McDermott, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's recommendation to reform Medicare's benefit design.

The Medicare Payment Advisory Commission is a Congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.

Introduction

Over the last several years, the Commission has made a range of recommendations to the Congress regarding traditional fee-for-service (FFS), Medicare Advantage (Part C), and the prescription drug benefit (Part D) designed to improve the coordination and quality of care, to improve the equity of payment, to improve program integrity, and to reduce spending. Most of those efforts have been aimed at providers of care. It was the Commission's judgment that policy changes focused on the provider were the most effective first step to improving the Medicare program. However, there is another actor in the delivery of care—the beneficiary. Here the Commission has also considered policy changes—for example, generating and disseminating quality information, examining shared decision-making protocols, and redesigning the traditional Medicare benefit structure. The Commission has also recommended that Medicare Advantage (MA) and the accountable care organization (ACO) initiative be designed to reward beneficiaries for making cost-conscious choices. In order for Medicare to produce both quality care and lower spending growth, the incentives of providers and beneficiaries need to be aligned to achieve these goals.

The Commission has been considering ways to reform the traditional benefit package with two main objectives: to give beneficiaries better protection against high out-of-pocket (OOP) spending and to create incentives for them to make better decisions about their use of discretionary care. In this testimony, we focus on the Commission's recommended redesign of the FFS benefit package

from our June 2012 report and summarize the Commission's views on key design issues related to restructuring cost sharing under the FFS benefit.

The cost-sharing structure of the traditional FFS benefit has remained basically unchanged since 1965. The current FFS benefit has considerable cost-sharing requirements. For Part A services, it includes a relatively high deductible for inpatient hospital care ($1,184 in 2013) and daily copayments for long stays at hospitals and skilled nursing facilities. Patients with more than one hospital admission in a year can be liable for more than one hospital deductible for the year. For Part B services, the FFS benefit has a relatively low deductible ($147 in 2013) but requires beneficiaries to pay 20 percent of allowable charges for most services, except for home health, clinical laboratory, and certain preventive services. Annual changes in the deductibles and copayments under Part A and Part B are linked to average annual increases in Medicare spending for those services.

Under this design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. As a result, a small percentage of Medicare beneficiaries incur very high levels of cost-sharing liability each year (Table 1). For example, among FFS beneficiaries who were enrolled in Part A and Part B for 12 months in 2009, 6 percent had a cost-sharing liability of $5,000 or more. Without additional coverage, they would be subject to significant financial risk from very high levels of OOP spending.

Table 1. Distribution of Medicare beneficiaries' cost-sharing liability in 2009

Range of cost-sharing liability per beneficiary	Percent of FFS beneficiaries	Average amount of cost sharing liability per beneficiary
$0	6%	$0
$1 to $135 (2009 Part B deductible)	3%	$85
$136 to $499	34%	$289
$500 to $999	19%	$713
$1000 to $1,999	16%	$1,456
$2,000 to $4,999	16%	$3,048
$5,000 to $9,999	4%	$6,869
$10,000 or more	2%	$15,536

Note: FFS (fee-for-service). Amounts reflect cost sharing under FFS Medicare—not what beneficiaries paid out of pocket. Most beneficiaries have secondary insurance that covers some or all of their Medicare cost sharing. Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year and not enrolled in private Medicare plans.

Source: MedPAC analysis based on data from CMS.

But for most Medicare beneficiaries, what they paid out of pocket is much less than their cost-sharing liability. In part due to the lack of comprehensiveness of the FFS benefit design, almost 90 percent of FFS beneficiaries have supplemental coverage through medigap, employer-sponsored retiree plans, or Medicaid. While this additional coverage addresses beneficiaries' concerns about the uncertainty of OOP spending under the FFS benefit, it also eliminates beneficiary incentives at the point of service and limits Medicare's ability to use cost sharing as a policy tool. As currently structured, many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, regardless of whether there is evidence that the service is effective or ineffective. Moreover, most of the costs of increased utilization are borne by the Medicare program, meaning both the taxpayers and other Medicare beneficiaries pay the premiums.

As mentioned, beneficiaries can have supplemental coverage through medigap, employer-sponsored retiree plans, or Medicaid. For most beneficiaries who purchase Medigap policies, the amount they pay in premiums is often well above the amount they would have incurred in cost sharing in the absence of the supplemental coverage. Yet, beneficiaries continue to buy such

coverage because it has value to them in providing peace of mind. However, even though medigap policies are standardized, it is not easy for beneficiaries to determine the true value of the product they are buying. Medigap policies can have widely varying premiums for the exact same coverage. In learning about policies, most beneficiaries rely on insurance agents, who may not have incentives to help beneficiaries make the optimal choice in deciding whether or not to buy a medigap policy in the first place and, if so, which policy to buy. In addition, outside of the medigap open enrollment period (the 6-month period after turning 65 and enrolling in Part B), switching to a different medigap policy usually would require medical underwriting and higher premiums.

To address the above shortcomings of the current benefit design, the Commission recommended a redesign based on several key principles:

- protect beneficiaries against high OOP spending, thus enhancing the insurance value of the FFS benefit and mitigating the need for beneficiaries to purchase supplemental insurance;
- create clearer incentives for beneficiaries to make better decisions about their use of care;
- hold aggregate beneficiary cost-sharing liability the same as under current law;
- allow for ongoing adjustments and refinements in cost sharing as evidence of the value of services accumulates and evolves; and
- recoup at least some of the additional costs resulting from the higher service use that supplemental insurance imposes on the Medicare program while still allowing risk-averse beneficiaries the choice to buy supplemental coverage if they wish to do so.

In contrast to many recently proposed changes to Medicare benefits that would require beneficiaries to pay more, the Commission's recommendation to hold beneficiary liability neutral reflects our judgment that traditional Medicare's benefit structure is not too rich, especially for the population covered. We believe that the actuarial value of the benefit package should not be reduced while protecting beneficiaries against high OOP spending. At the same time, in recommending an additional charge on supplemental insurance, we maintain that it is reasonable to ask beneficiaries to pay more when their decision to get supplemental coverage imposes additional costs on the program that are not fully reflected in their supplemental

premiums. Those costs are currently paid for by all Medicare beneficiaries through higher Part B premiums and by the taxpayer.

The Commission's June 2012 recommendation to reform benefit design

The Congress should direct the Secretary to develop and implement a fee-for-service benefit design that would replace the current design and would include:

- an out-of-pocket maximum;
- deductible(s) for Part A and Part B services;
- replacing coinsurance with copayments that may vary by type of service and provider;
- secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum;
- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on supplemental insurance.

The Commission's views on the redesign of the Medicare benefit

The recommendation encapsulates the Commission's views on key design issues broadly related to beneficiary cost sharing. The overall structure of cost sharing is defined by: the OOP maximum, above which the beneficiary pays no (or minimal) costs; the deductible, under which the beneficiary pays all costs; and in between, where the beneficiary pays for some portion according to a specified set of rules.

OOP maximum to protect beneficiaries from the financial risk of very high Medicare costs

The Commission maintains that protecting beneficiaries against the economic impact of catastrophic illness is very important. Because the current FFS benefit does not have a limit on the amount of beneficiaries' cost sharing, a small percentage of Medicare beneficiaries incur very high levels of cost sharing each year. Adding an OOP maximum to the FFS benefit would reduce the financial risk for beneficiaries with very high spending and could mitigate the need to purchase supplemental insurance, a significant expense for many beneficiaries.

An OOP maximum is a fundamental feature of an insurance program; it provides financial protection against an unlikely but highly costly event. In general, an OOP maximum is valuable to beneficiaries in two ways. First, those who actually incur catastrophic levels of Medicare costs in a given year would be able to limit their liability at the specified OOP maximum. Therefore, their cost sharing would be lower with the OOP maximum than without it. Moreover, as one considers insurance coverage over a period of several years, a larger percentage of beneficiaries would reach the OOP maximum at some point. For example, the percentage of beneficiaries with annual cost-sharing liability of $5,000 or more at least once over a four-year period is about double the number for a single year—13 percent compared with 6 percent.

Second, even if beneficiaries did not reach the OOP maximum in a given year, they still were subject to less risk of paying for very high OOP spending. Risk-averse beneficiaries want to be protected from uncertainty and variability in medical spending. Therefore, an OOP maximum that makes very high OOP spending less uncertain and variable has real value, regardless of whether the actual OOP spending for a given beneficiary is high enough to benefit from it. Although beneficiaries may vary in the level of protection they desire and may even have difficulty quantifying how much the value of insurance protection is worth to them, the value of an OOP maximum would be the peace of mind some beneficiaries get from having such protection if they need it.

Deductible(s) for Part A and Part B services that may be combined or separate

A deductible is a fixed dollar amount that a beneficiary pays in a given year before Medicare starts paying for covered services. Its use in benefit design is more pragmatic than intrinsic. If the goal of an OOP maximum is to provide insurance protection against very high medical costs and the goal of cost sharing—copayments and coinsurance—is to provide incentives at the point of service, the role of a deductible is mainly to reduce the cost of other aspects of the benefit package, such as premiums, copayments, and coinsurance. (However, compared with copayments and coinsurance, a deductible can have a different effect on incentives at the point of service.) While beneficiaries might consider a deductible to be financially burdensome, their overall cost might be lower due to a lower premium and cost sharing with a deductible than without it.

The current FFS benefit has separate deductibles for Part A and Part B services: $1,184 for Part A services and $147 for Part B services in 2013. This structure of having two distinct parts is mainly historical, reflecting the structure of private insurance as it existed in the 1960s. Since then, the norms in private insurance have changed and a single deductible for all medical services is typical. (Most plans still have a separate deductible for drug benefits.) From a perspective of using cost sharing to create appropriate incentives for beneficiaries, the current structure of deductibles is not ideal: a relatively high deductible for inpatient care, which is usually not discretionary and is less likely to be influenced by cost sharing, coupled with a low deductible for physician and outpatient care, which are more discretionary and more likely to be influenced by cost sharing. A single combined deductible for both types of services might lessen the effects of the current structure on beneficiary incentives somewhat. In addition, it would be easier for beneficiaries to understand and track all Medicare services together, rather than to track them in separate categories.

However, a combined deductible would affect individual beneficiaries' cost sharing differently, depending on their use of services. In general, beneficiaries who use only Part B services—the majority of beneficiaries in a given year—would see an increase in their deductible amount compared with their currently low Part B deductible. In contrast, under a combined deductible (depending on its level), beneficiaries who received inpatient services—roughly 20 percent in a given year—could see a decrease in their deductible amount compared with their currently high Part A deductible. Given these dynamics, beneficiaries' desire for a low combined deductible based on their individual circumstances is certainly understandable. However, their circumstances can change suddenly and unpredictably, and their calculations may turn out very wrong. For example, if individuals who have few health problems get sick unexpectedly, they may be better off under a benefit package with a higher deductible coupled with lower copayments and a lower OOP maximum.

The Commission did not express a definitive position on combined or separate deductibles. However, combining Part A and Part B deductibles presents important challenges for implementation. Under current law, Part A benefits are automatic for individuals who receive benefits from Social Security on the basis of age or disability, whereas Part B enrollment is voluntary. As a result, a small percentage of beneficiaries do not participate in both parts of the

program. About 93 percent of beneficiaries enrolled in Part A also enroll in Part B. For the 7 percent of beneficiaries who participate in Part A or Part B only, issues related to how a combined deductible and OOP maximum would apply need to be resolved.

Copayments, rather than coinsurance, that may vary by type of service and provider

Copayment is a form of cost sharing that specifies a fixed dollar amount paid by the beneficiary at the point of service, whereas coinsurance specifies a fixed percentage of medical expense paid by the beneficiary. The current FFS benefit uses both forms of cost sharing: daily copayments for long stays at hospitals and skilled nursing facilities and 20 percent coinsurance of allowable charges for most Part B services, except for home health, clinical laboratory, and certain preventive services. The Commission prefers the set dollar amounts of copayments because they are more clearly understood by beneficiaries and reduce uncertainty. Especially if the amounts are set to create incentives for beneficiaries to make better decisions about their use of care, copayments are easy to understand, compare, and respond to. Their simplicity makes copayments more effective in influencing people's use of services. Participants in our focus groups echoed these positive qualities of copayments. In contrast, the idea of paying 20 percent of an unknown total bill worried many participants, who considered coinsurance an open-ended liability for which they could not budget in advance. Not having to deal with the hassle of complicated and unpredictable bills was another reason for buying supplemental insurance offering first-dollar coverage.

Compared with the current FFS benefit, any changes in cost sharing—in the form of a deductible or copayments—will bring about changes in beneficiaries' use of services. Ideally, beneficiaries would respond to changes in cost sharing selectively—decreasing the use of nonessential services that are unlikely to improve their health but not changing their use of essential services that are necessary for maintaining good health despite the increase in cost sharing. As discussed in our previous reports, extensive literature about the effects of cost sharing on the use of health care services shows that people generally reduce their use of health care when they have to pay more out of pocket, and vice versa. Their responses tend to vary by type of service—larger responses for discretionary care and smaller responses for urgent care—but not necessarily based on whether the service is appropriate or essential. For example, a Commission-sponsored study

showed that total Medicare spending was 33 percent higher for beneficiaries with medigap than for those with no supplemental coverage, and 17 percent higher for beneficiaries with employer-sponsored coverage.[1] Having secondary insurance was not associated with higher spending for emergency hospitalizations, but it was associated with higher Part B spending that ranged from 30 percent to over 50 percent more. Overall, beneficiaries with private supplemental insurance spent more on elective hospital admissions; preventive care; office-based physician care; medical specialists; and services such as minor procedures, imaging, and endoscopy.

Reduction in the use of both effective and ineffective care raises the question of whether any potential negative effects from reducing essential care could lead to higher rates of hospitalization and ultimately to higher total spending. This issue of "offset effects" may be particularly important if low-income people in poorer health were more likely to forgo needed care, along with nonessential care, as cost sharing increased. (Two recent studies raise concern about such offset effects among Medicare beneficiaries, although the evidence suggests that the size of this offset is unlikely to be large enough to overcome the savings of cost-sharing changes.[2]) The RAND Health Insurance Experiment (HIE) did not show adverse health effects due to reductions in the use of health care for the average person in the study, but those findings are unlikely to hold true for everyone.[3] (The HIE excluded the elderly population from the study.) In fact, although the results were not statistically significant, the HIE found that low-income people with chronic conditions were at greater risk of adverse health outcomes. Because the elderly are more likely to be both low income and have chronic conditions, changes in cost sharing could have an impact on health outcomes among the Medicare population.

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1 Hogan, C. 2009. *Exploring the effects of secondary insurance on Medicare spending for the elderly.* A study conducted by staff from Direct Research, LLC, for MedPAC. Washington, DC: MedPAC.

2 Chandra, A., J. Gruber, and R. McKnight. 2010. Patient cost-sharing and hospitalization offsets in the elderly. *American Economic Review* 100, no. 1 (March 1): 193-213. Trivedi, A. N., H. Moloo, and V. Mor. 2010. Increased ambulatory care copayment and hospitalizations among the elderly. *New England Journal of Medicine* 362, no. 4 (January 28): 320-328.

3 Newhouse, J. P. 1993. *Free for all? Lessons from the RAND Health Insurance Experiment.* Cambridge, MA: Harvard University Press.

The Commission recognizes that cost sharing may be too blunt a tool because beneficiaries respond to changes in cost sharing indiscriminately. Ideally, cost sharing would work in conjunction with other management tools for encouraging efficient and appropriate use of health care. However, in the Medicare FFS environment with open-ended service use and provider participation, cost sharing may be one of the few policy tools available.

Secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services

Over the long term, the Medicare program needs to move toward a benefit design that gives individuals incentives to use higher value care and discourage using lower value care. Policymakers have become more aware that not all health care services have the same value—or the same value for everyone—but identifying which services are of higher or lower value for a given individual is difficult.[4] These determinations must be evidence based, and several years ago, the Commission recommended that policymakers establish an independent public–private entity that would produce information to compare the clinical effectiveness of a health service with its alternatives. The Congress created the Patient-Centered Outcomes Research Institute to identify national priorities for and sponsor comparative clinical-effectiveness research.

The Commission maintains that the ultimate implementation of changes to the FFS benefit design must not only specify a set of cost-sharing requirements and define services to which those requirements would apply but also allow for flexibility to alter or eliminate cost sharing based on the value of services. To encourage the use of high-value services and discourage the use of low-value services, the Congress should consider giving the Secretary authority to reduce cost sharing on services if evidence indicates that doing so would reduce Medicare spending or lead to better health outcomes without increasing costs, or to raise cost sharing on low-value services. This authority would be exercised through the usual notice and comment rulemaking process. For example, under current law, there are no cost-sharing requirements for many preventive services, and the Secretary has administrative authority to modify or eliminate coverage of preventive

4 The term "value based" is used in two ways. Value-based purchasing refers to strategies for paying providers, and value-based insurance design refers to cost-sharing options designed to encourage beneficiaries to use high-value health care services or providers and discourage use of low-value services or providers. Testing these approaches would help policymakers decide which of them could steer beneficiaries more effectively toward the use of high-value services or away from low-value services.

services based on evidence. This flexibility to adjust and refine cost sharing is especially important as evidence evolves. This provision does not diminish congressional authority. If the Congress disagreed with the Secretary's proposed actions, it could act to stop the changes.

No change in beneficiaries' aggregate cost-sharing liability

There are many different ways to combine the three design elements discussed earlier. Within the general structure of cost sharing defined by a deductible, a set of copayments by type of service, and an OOP maximum, there are—in theory—many possibilities consisting of different levels of cost-sharing amounts and definitions of services to which they are applied. In practice, however, a set of feasible design combinations would be constrained by the overall cost of those choices.

The Commission considers it important to allow for different possible combinations of design elements and subsequent adjustments and refinements by the Secretary. However, the Commission does not wish to shift the cost of improving the benefit package to provide better protection against high OOP spending to the beneficiary in the aggregate. Therefore, the Commission has recommended holding the average cost-sharing liability of the beneficiary the same as under current law. In effect, this approach allows the Congress to set the overall value of the Secretary's benefit package and the Secretary is then given discretion within that limit.

An additional charge on supplemental insurance to recoup at least some of the added costs imposed on Medicare

For most Medicare beneficiaries, their actual OOP spending is much smaller than their cost-sharing liability under FFS Medicare because they have additional coverage. In fact, the lack of comprehensive coverage in the FFS benefit design leads many beneficiaries to take up supplemental coverage that fills in some or all of Medicare's cost sharing and protects them from catastrophic financial liability.

At the same time, supplemental coverage can lead to more use of services and spending. In general, there are two possible reasons for the higher spending. First, many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, regardless of whether there is evidence that a given service is effective or ineffective. Under such minimal exposure to cost sharing, beneficiaries have incentives to receive more care without experiencing additional OOP

costs, and providers have no incentives to manage utilization. Therefore, some portion of the higher spending observed among beneficiaries with supplemental coverage is arguably due to an insurance effect (also called moral hazard). Second, beneficiaries who are sicker and likely to use more services are more likely to buy supplemental coverage. Conversely, beneficiaries who are healthy and do not expect to use many services are more likely to risk potentially high cost sharing without supplemental coverage. It is likely that this selection effect is also partly responsible for the higher spending observed among those with supplemental coverage.

Since the FFS benefit provides indemnity insurance, cost sharing is one of the few means by which the Medicare program can provide incentives affecting beneficiaries' use of medical services. But almost 90 percent of FFS beneficiaries have supplemental coverage that fills in some or all of Medicare's cost sharing, effectively nullifying the program's tool for influencing beneficiary incentives. By effectively eliminating FFS Medicare's price signals at the point of service, supplemental coverage generally masks the financial consequences of beneficiaries' choices about whether to seek care and which types of providers and therapies to use. Therefore, unless supplemental policies were restructured to retain some cost sharing, any changes in cost sharing in the FFS benefit package would have a limited effect on beneficiaries with supplemental coverage.

There are two philosophically different approaches to address the insurance effect of supplemental coverage. One approach is to regulate how supplemental policies can fill in FFS cost-sharing requirements (for example, redefine medigap policies so that they no longer completely fill in FFS cost-sharing requirements). Another approach is to impose an additional charge on supplemental policies. Rather than prohibiting supplemental insurance from filling in all of Medicare's cost sharing, this approach would not change the use of Medicare services among beneficiaries who choose to keep their supplemental coverage. However, it would change the effective price of their coverage. If the regulatory approach can be described as not allowing beneficiaries to add costs to Medicare through supplemental coverage, the additional charge approach can be described as allowing beneficiaries to add costs to Medicare but requiring them to pay for at least some of those additional costs.

In considering policies related to supplemental coverage, the Commission prefers the additional charge approach over the regulatory approach. The additional charge would apply to most sources of supplemental coverage, including medigap and employer-sponsored retiree plans. (However, implementing consistent changes with respect to medigap and employer-sponsored retiree plans would require different legislative changes. The additional charge would not apply to MA plans because they are at risk for benefit designs that increase costs relative to their capitation payments and are able to employ other tools for managing their enrollees' use of services.) The Commission considers it important that risk-averse beneficiaries who wish to buy first-dollar coverage or reduce the uncertainty in their OOP spending through supplemental insurance should be allowed to do so but effectively at a higher price. Regulating supplemental benefits, in contrast, would prevent even those beneficiaries who very much value extra insurance from buying such policies at any price.

Illustrative benefit package

Table 2 presents an illustrative benefit package consistent with the Commission's views on FFS benefit design reform. The package is modeled after the MA-style benefits that include the following copayments: $20 for each primary care physician visit, $40 for each specialist physician visit, $100 for each hospital outpatient visit, $750 for each inpatient hospital admission, and $80 for each skilled nursing facility day. We also included a $150 copayment per episode for home health care. The Commission's recommendation would require a range of copayments for durable medical equipment and Part B drugs. However, for simplicity, we included 20 percent coinsurance for durable medical equipment and Part B drugs. The annual OOP maximum is $5,000. To keep cost sharing relatively reasonable, the package includes a $500 combined deductible. We kept the overall beneficiary cost-sharing liability of this package roughly equal to that of the current FFS benefit. We want to emphasize that this package is for illustration only, to analyze the trade-offs between design elements. It does not represent the Commission's recommended benefit package.

Table 2. Illustrative benefit package

FFS benefit package	Illustrative package keeping beneficiary liability neutral
OOP maximum	$5,000 per year
A & B deductible	$500 per year
Hospital	$750 per admission
Physician	$20 PCP/$40 specialist visit $100 advanced imaging
Part B drugs	20% coinsurance*
Outpatient	$100 per visit
SNF	$80 per day
DME	20% coinsurance*
Hospice	0% coinsurance
Home health	$150 per episode**

Note: FFS (fee-for-service), OOP (out-of-pocket), PCP (primary care physician), SNF (skilled nursing facility), DME (durable medical equipment).
*For simplicity, we modeled 20 percent coinsurance for durable medical equipment and Part B drugs; copayments in these categories would require a range of copayments.
**We modeled the $150 copayment per episode considered by the Commission in 2011 as a 5 percent coinsurance on home health services.

In general, the set of copayments in the illustrative benefit package is within the range of typical copayments we see in MA plans. However, MA plans tend to use medical management to complement their use of cost sharing and to mitigate the potentially negative effects from reducing essential care or increasing less essential care. While copayments can make beneficiaries aware of the price of care at the point of service, thus creating incentives to make better decisions about their use of discretionary care, medical management can mitigate the effects of reducing care indiscriminately.

The following analysis of spending and distributional impacts is based on the above illustrative benefit package combined with a 20 percent additional charge on medigap and employer-sponsored retiree plans. (An additional charge would need to be significantly greater than 20 percent to recoup the entire cost of higher service use imposed on the Medicare program by beneficiaries with supplemental coverage.) The scope of the analysis excludes dual-eligible beneficiaries because we assumed current law where Medicaid would fill in any changes under the alternative benefit package and would keep the cost sharing the same for those beneficiaries.

Spending impacts

We modeled the effects of the above illustrative benefit package using Medicare claims data from 2009. (Our June 2012 report includes a detailed discussion of the assumptions underlying our

analysis.) Table 3 shows the relative change in annual Medicare program spending under the illustrative benefit package, combined with a 20 percent additional charge on supplemental insurance. It presents only a one-year snapshot of relative changes. Most importantly, it does not represent a budgetary score, which would take additional factors into account.

Table 3. Budgetary effects of the illustrative benefit package, 2009

Percent keeping supplemental coverage	Percent change in Medicare program spending in 2009	Revenue offset generated by 20% additional charge	Net percent change in Medicare program spending
All	+1.0%	-1.5%	-0.5%
75%	0.0%	-1.0%	-1.0%
50%	-1.5%	-0.5%	-2.0%
None	-4.0%	0.0%	-4.0%

Note: Numbers are rounded to the nearest 0.5 percent. Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We estimated a one-year snapshot of relative changes in Medicare program spending, compared with the actual spending in 2009, if the illustrative benefit package had been in place. Additional charge on supplemental insurance represents revenue to the program and is shown as a decrease in program spending. These estimates do not represent a budgetary score, which would take additional factors into account.

Source: MedPAC analysis based on data from CMS.

Under the illustrative benefit package, which holds average beneficiary cost-sharing liability roughly equal to current law, program spending would increase by about 1 percent if all beneficiaries kept their current levels of supplemental coverage. Given the OOP maximum—which made the illustrative benefit package more generous compared with current law—the same level of cost-sharing liability would correspond to higher total spending under the illustrative benefit package. As a result, program spending would also be higher. However, the 20 percent charge on supplemental insurance would generate about 1.5 percent in revenue offsets. The net budgetary effect would be about 0.5 percent in savings. In contrast, if all beneficiaries dropped their current supplemental coverage, program spending would decrease by about 4 percent because of reduced utilization, and no revenues would be collected from the additional charge on supplemental insurance, with a net budgetary effect of about 4 percent in savings.

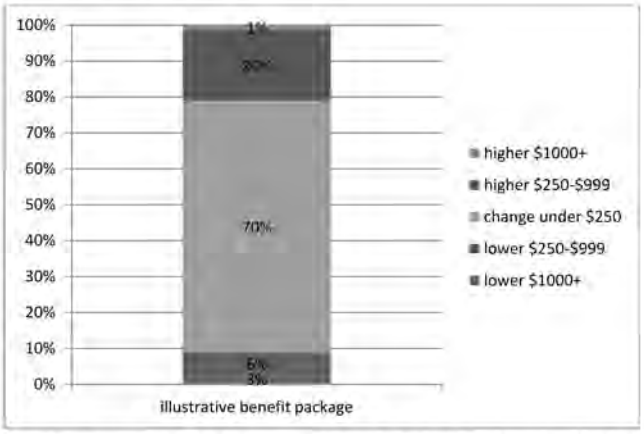
Distributional impacts

Overall, the average beneficiary cost-sharing liability under the illustrative benefit package would be roughly equal to current law by design. However, it would be much less variable because of the

OOP maximum. For example, assuming no change in current supplemental coverage, the standard deviation of cost-sharing liability in 2009 among beneficiaries included in our analysis decreased from $2,370 under current law to $1,250 under the illustrative benefit package, around the mean liability of $1,380.

The effects of the illustrative benefit package (without the 20 percent additional charge) on beneficiaries would vary by their use of services. First, those beneficiaries with cost-sharing liability above the $5,000 OOP maximum and no supplemental coverage would see their OOP spending go down. In Figure 1, this group would be included in the 9 percent of beneficiaries whose OOP spending decreased by $250 or more. (Results in Figure 1 assume no change in supplemental coverage among beneficiaries who currently have supplemental coverage.) By contrast, those beneficiaries with no hospitalization and low use of Part B services would see their cost sharing go up, since the revised benefit design would effectively lower the Part A deductible and raise the Part B deductible compared with current law. In Figure 1, this group would be included in the 21 percent of beneficiaries whose OOP spending increased by $250 or more. In general, beneficiaries with at least one hospital admission would see their cost sharing go down under the illustrative benefit package compared with the current benefit package. For the majority of beneficiaries (70 percent), their OOP spending would not change much because for many of them, their supplemental insurance would dampen the changes in their cost-sharing liability.

Figure 1. Changes in Medicare out-of-pocket spending under the illustrative benefit package, 2009



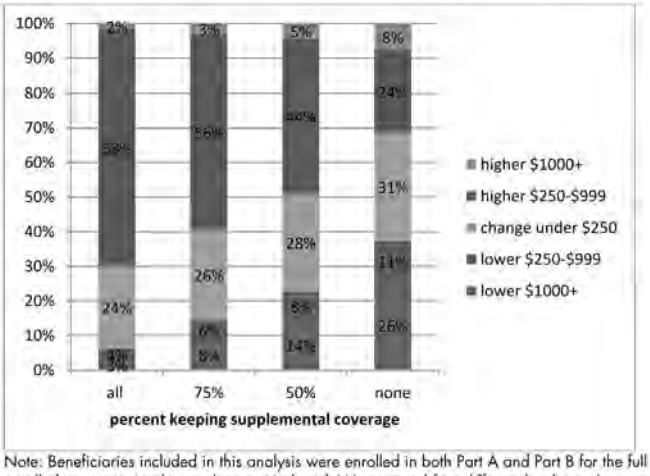
Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We assumed no change in supplemental coverage among beneficiaries who currently have supplemental coverage. Out-of-pocket spending excludes Part B premium.

Source: MedPAC analysis based on data from CMS.

Some beneficiaries who currently have supplemental insurance would drop or reduce their coverage in response to the additional charge and new Medicare benefits. In theory, changes in the FFS benefit and the additional charge on supplemental insurance could alter the individual cost-benefit analysis of having supplemental coverage. First, for some individuals, the benefit of extra protection provided by supplemental insurance would be lower if the FFS benefit were to have an OOP maximum. Without a larger decrease in supplemental premiums to offset the lower value, those beneficiaries would choose to drop supplemental policies. Second, holding the FFS benefit constant, the additional charge on supplemental insurance would increase the effective premiums on those plans and provide an incentive for beneficiaries to switch to medigap policies that required paying more of Medicare's cost sharing or to drop supplemental coverage altogether. If beneficiaries were to drop supplemental insurance, they could choose to stay in traditional FFS or switch to MA.

Figure 2 shows the estimated distributional impact of changes in total OOP costs—the sum of OOP spending and supplemental premiums—under four scenarios: Among beneficiaries who currently have medigap and employer-sponsored retiree insurance, we assumed that all, three-quarters, half, or none of them keep their current supplemental insurance. Compared with Figure 1, the distributional impacts in Figure 2 are noticeably different. For beneficiaries who keep their supplemental coverage, total OOP costs would be higher because of the 20 percent additional charge on supplemental insurance: At 2009 premium levels, the 20 percent additional charge would translate into a $420 increase per year ($35 per month) on medigap plans and a $200 increase per year on employer-sponsored retiree plans. In contrast, for beneficiaries who drop their supplemental coverage, total OOP costs would be the net effect of higher cost sharing paid OOP and savings on their supplemental premiums ($2,100 per year on medigap plans and $500 per year on employer-sponsored retiree plans, assuming a 50 percent employer subsidy rate).

Figure 2. Changes in Medicare out-of-pocket spending and supplemental premium under a 20 percent additional charge on supplemental insurance, 2009



Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We assumed four different levels in take-up rates among beneficiaries who currently have medigap insurance: 100%, 75%, 50%, and 0%. Out-of-pocket spending excludes Part B premium. The change in supplemental premium includes the 20% additional charge on supplemental insurance. Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis based on data from CMS.

If all beneficiaries kept their current supplemental coverage, the 20 percent additional charge on supplemental insurance would increase the total OOP cost significantly. Whereas 70 percent of beneficiaries would have little change in OOP costs under the illustrative benefit package in Figure 1, 70 percent of beneficiaries would have an annual increase of $250 or more under the illustrative benefit package in Figure 2 because of the 20 percent additional charge on supplemental insurance. The distribution shifts as fewer beneficiaries keep their current supplemental coverage, since the savings from dropping their medigap or employer-sponsored retiree plans decrease their total OOP costs. If all beneficiaries dropped their current supplemental coverage, 32 percent would experience an increase of $250 or more. Additionally, 31 percent would have little change in their OOP costs 36 percent would see a decrease of $250 or more.

Improving the Medicare benefit for beneficiaries

Distributional impacts discussed earlier highlight that a small percentage of beneficiaries incur very high cost sharing in a given year and thus would benefit from the OOP maximum under the illustrative benefit package. But a larger percentage of beneficiaries would reach the OOP maximum at some point over a longer period of time. Table 4 compares beneficiaries' hospitalization and spending over one year versus four years. For example, in 2009, 19 percent of full-year FFS beneficiaries had at least one hospitalization, whereas 46 percent did from 2006 to 2009. Similarly, 6 percent of full-year FFS beneficiaries had $5,000 or more in cost-sharing liability in 2009, whereas 13 percent had at least one year of $5,000 or more in cost-sharing liability over four years.

Table 4. More beneficiaries would be better off with an out-of-pocket maximum over time

Full-year fee-for-service beneficiaries who had:	2009	2006-2009
1 or more hospitalizations	19%	46%
2 or more hospitalizations	7%	19%
$5,000 or more in annual cost-sharing liability	6%	13%
$10,000 or more in annual cost-sharing liability	2%	4%

Note: Includes beneficiaries who were enrolled in fee-for-service Medicare for four full years, from 2006 to 2009. Excludes those who had any months of private Medicare plan enrollment.

Source: MedPAC analysis based on data from CMS.

The overall spending patterns of Medicare beneficiaries show that in a given year, Medicare spending is highly concentrated, with a small number of beneficiaries accounting for a large proportion of the program's annual expenditures. This pattern is characteristic of insurance programs in general. However, only about half of beneficiaries with high spending one year continue to incur high spending the next year. Although the presence of serious chronic illness can predict high spending, much of very high spending is largely random, due to health costs that are unpredictable. This spending pattern implies that the probability of catastrophic spending over time is higher than the probability in one year would indicate. Even beneficiaries with low spending in a particular year would benefit from the financial protection of insurance as they face greater odds of having a high-spending year over time. Therefore, additional insurance protection that mitigates the risk under Medicare would be valuable to beneficiaries.

One key purpose of insurance is to reduce the financial risk posed by catastrophic medical expenses. Risk-averse individuals want protection from the risk of very high and unpredictable medical expenses. To avoid such risks, they should be willing to pay a premium higher than the average cost of care they might face. The more risk-averse they are, the more willing they are to pay for the insurance. And the more variable potential outcomes are, the more valuable the insurance protection will be. For example, under the illustrative benefit package, the average cost-sharing liability is about the same as under current law, at about $1,380. However, the distribution of cost-sharing liability is much less variable because of the OOP maximum, as

summarized by the standard deviation of $1,250 compared with $2,370 under current law (see Table 5). Although the average cost-sharing liability is about the same, the illustrative benefit package offers much lower financial risk and provides greater insurance protection to beneficiaries.

Table 5. Out-of-pocket maximum reduces the risk of high medical expenses, 2009

	Average cost-sharing liability, 2009	Standard deviation of cost-sharing liability, 2009
Current law	$1,380	$2,370
Illustrative benefit package	$1,380	$1,250

Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We estimated the cost-sharing liability in 2009 if the illustrative benefit package had been in place, compared with the actual cost-sharing liability in 2009.

Source: MedPAC analysis based on data from CMS.

Although most people are risk averse and are willing to pay to reduce risk, an optimal benefit design does not mean no risk at all. The Commission's recommendation on the redesign of the FFS benefit package attempts to balance this fundamental trade-off between two opposing forces—risks and incentives—in the context of an unrestricted FFS system where very few policy tools are available for encouraging efficient and appropriate use of health care.

Chairman BRADY. Dr. Fendrick.

STATEMENT OF A. MARK FENDRICK, M.D., DIRECTOR, UNIVERSITY OF MICHIGAN CENTER FOR VALUE-BASED INSURANCE DESIGN

Dr. FENDRICK. Good morning, and thank you, Chairman Brady, Ranking Member McDermott and Members of the Subcommittee. I am Mark Fendrick, a professor at the University of Michigan. I address you today as a primary care physician, medical educator, and a public health professional.

Mr. Chairman, I completely agree with your statement that the current structure of the Medicare benefit is outdated, confusing, and in need of reform. Moving from a volume-driven to a value-based system requires both a change in how we pay for care, and how we engage consumers to seek care.

With some notable exceptions, most U.S. health plans including Medicare implement cost sharing in a "one size fits all" way, in that beneficiaries are charged the same amount for every doctor visit, every diagnostic test and every prescription drug. As Mr. Hackbarth just mentioned, asking Americans to pay more for all services results in decreases in both non-essential and essential care. While this blunt approach may reduce short-term expenditures, noncompliance with high-value services often leads to adverse health outcomes and higher overall costs. This is penny wise and pound foolish. Conversely, asking Americans to pay less for all services can lead to the overuse of harmful services and those that provide little value. The concept that medical services differ in the health benefits they produce is referred to as clinical nuance, and clinical nuance should be utilized in the reallocation of medical spending.

Mr. Chairman, does it make sense to you that my Medicare patients pay the same copayment for a life-saving cancer drug as a drug that will make their toenail fungus go away? Due to the lack of appropriate incentives, Medicare beneficiaries use too little high-value care, and too much low-value care. It is common sense; when barriers to high-value treatments are reduced and access to low-value treatments is discouraged, we obtain more health for every dollar spent.

Medicare is a key component to our Nation's commitment to our elderly and disabled, and it must be sustained. Even with the recent advantage regarding preventive services, as Mr. McDermott mentioned, traditional Medicare allows little flexibility to implement clinically driven benefits. Specifically program administrators cannot lower cost-sharing levels for services recommended in clinical guidelines, and they are also limited in the amount they can increase coinsurance rates for a harmful procedure.

Since changes to traditional Medicare are difficult, an interim step could be to legislate changes to Medicare Advantage. Today the tools available to MA are also blunt instruments. Legislative and regulatory restrictions prevent clinical nuance in MA, including the lack of flexibility to steer patients to high-performing providers in a very rigid benefit design.

To this I recommend the following recommendations: First, MA plans should have the flexibility to vary cost-sharing for a par-

ticular service according to where the service is provided and by whom. The Commonwealth Fund recently estimated that nearly $200 billion in savings would accrue to Medicare over the next decade if we were to "develop a value-based design that encourages Medicare beneficiaries to obtain care from high-performing systems". Currently MA plans use provider networks, but they are limited in how they may vary cost-sharing within that network. This restriction forces MA plans to either exclude low-performing providers completely or permit complete access to them. There is no intermediate step.

Second, MA plans should have the flexibility to impose differential cost sharing based on evidence. There are evidence-based services that I beg my patients to do, such as critical treatments for asthma, diabetes, and depression. There are also other services that are harmful or unnecessary, and according to the literature, these services account to nearly 20 percent of Medicare expenditures.

Last, MA plans should have the flexibility to set enrollee cost sharing based on clinical information, such as diagnosis. MA plans are currently constrained by non-discrimination rules that prohibit different benefits for targeted subgroups of beneficiaries. Even though the clinical appropriateness of a specific service may vary widely among MA enrollees, cost sharing for any service must be the same for everyone. The flexibility to enroll cost sharing based on scientific evidence and clinical information is a crucial element to the safe and efficient allocation of Medicare expenditures.

So as you consider changes to Medicare benefits, it is my hope that you will take the commonsense step to allow MA plans to vary cost sharing on the amounts of health produced. Despite the urgency to bend the cost curve, Congress should avoid blunt changes that reduce quality of care. Using benefit design to encourage utilization of high-value services and deter access to low-value services can improve health, enhance personal responsibility, and reduce costs.

I look forward to your questions.

Chairman BRADY. Thank you, Doctor, very much.

[The prepared statement of Dr. Fendrick follows:]

TESTIMONY IS EMBARGOED UNTIL 10:30 AM ON TUESDAY, FEBRUARY 26, 2013

UNITED STATES HOUSE OF REPRESENTATIVES WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

TESTIMONY:

THE ESSENTIAL ROLE OF CLINICAL NUANCE IN MEDICARE'S BENEFIT DESIGN

February 26, 2013

Statement of:

A. Mark Fendrick, MD

Professor of Internal Medicine and Health Management & Policy

Director, Center for Value-Based Insurance Design

University of Michigan

University of Michigan V-BID
North Campus Research Complex
2800 Plymouth Road
Ann Arbor, MI 48109-2800
734.615.9635
734.763.5455
vbidcenter@umich.edu
www.vbidcenter.org

Good morning and thank you, Chairman Brady, Ranking Member McDermott, and Members of the Subcommittee. I am Mark Fendrick, Professor of Internal Medicine and Health Management & Policy at the University of Michigan. I am addressing you today, not as a representative of the University, but as a practicing primary care physician, a medical educator, and a public health professional. I have devoted much of the past two decades to studying the United States health care delivery system and founded the University's Center for Value-Based Insurance Design [www.vbidcenter.org] in 2005 to develop, implement and evaluate innovative payment initiatives and health insurance designs intended to ensure efficient expenditure of health care dollars and maximize benefits of care.

Mr. Chairman, I applaud you for holding this hearing on "Examining Traditional Medicare's Benefit Design," because quality improvement and health care cost containment are among the most pressing issues for our national well-being and economic security. We are well aware that the U.S. spends far more per capita on health care than any other country, yet lags behind other nations that spend substantially less on key health quality and population health measures. However, research shows that if we reallocated our health care dollars to services for which there is clear evidence for improving clinical outcomes, we could simultaneously enhance quality and reduce the amount we spend. There is consistent agreement among stakeholders that there is already enough money being spent on health care. Thus, instead of the unwavering focus on *how much* we spend – I suggest we shift our attention to *how well* we spend our increasingly scarce health care dollars in order to maximize the amount of health produced for each dollar spent.

FROM A VOLUME-DRIVEN TO VALUE-BASED SYSTEM

Moving from a volume-driven to value-based delivery system requires a change in both how we pay for care (supply side initiatives) and how we engage consumers to seek care (demand side initiatives). Other testimonies today and at earlier Committee hearings have focused on the critical importance of reforming care delivery and payment policies. These are important and worthy conversations. Prior to this hearing, little attention has been directed to how we can alter consumer behavior as a policy lever to bring about a more effective and efficient delivery system. While you have heard about the potential of Accountable Care Organizations, Patient-Centered Medical Homes, bundled payment models, and other initiatives to influence providers, today I propose that **value-driven consumer incentives - through benefit designs that promote smart decisions and enhanced personal responsibility - must be aligned with payment reform initiatives for us to really "bend the cost curve" for health care**. As noted in Mr. Hackbarth's testimony, MedPAC's 2012 Report to Congress recognized the importance of beneficiary decision-making, and I commend the Subcommittee for exploring this matter today.

DANGERS OF A BLUNT APPROACH TO BENEFICIARY COST-SHARING – THE IMPORTANCE OF "CLINICAL NUANCE"

Over the past few decades, public and private payers have implemented multiple managerial tools to constrain health care cost growth with varying levels of success. The most common approach to directly impact consumer behavior is cost shifting: requiring beneficiaries to pay more in the form of increased premiums and increased cost-sharing for clinician visits, diagnostic tests and prescription drugs. With some notable exceptions, most US health plans—including Medicare—implement cost-sharing in a "one size fits all" way, in that beneficiaries are charged the same amount for every doctor visit, diagnostic test, and prescription drug [within a specified formulary tier]. As Americans are required to pay more to visit their clinicians and fill their prescriptions, a growing body of evidence demonstrates that increases in patient cost-sharing lead to decreases in the use of both non-essential and essential care. Peer-reviewed studies reveal that when patients are asked to pay more for high-value cancer screenings, clinician visits and potentially life-saving drugs, they buy significantly less.

A noteworthy example is a *New England Journal of Medicine* study that examined the effects of increases in copayments for doctor visits in Medicare Advantage plans [Trivedi A. *N Engl J Med*. 2010;362(4):320-8]. As expected, individuals who were charged more to see their physician went less often; however, these patients were hospitalized more frequently, and their total medical costs increased. While this blunt approach may reduce expenditures in the short-term, higher rates of noncompliance may lead to inferior health outcomes and higher overall costs in certain clinical circumstances. This seemingly counterintuitive effect simply demonstrates that the age-old aphorism, "penny wise and pound foolish," applies to health care.

Conversely, decreases in cost-sharing applied to all services regardless of clinical benefit - which may be the case in certain Medicare supplemental insurance products - can lead to overuse or misuse of services that are potentially

harmful or provide little clinical value. **To efficiently reallocate medical spending and optimize population health, the basic tenets of clinical nuance must be considered. These tenets recognize that: 1) medical services differ in the benefit provided; and 2) the clinical benefit derived from a specific service depends on the patient using it.**

Does it make sense to you, Mr. Chairman, that my Medicare patients pay the same copayment to see a cardiologist after a heart attack as a dermatologist for mild acne, or that the patient copayment is the same for a drug that could save a life from cancer as it is to make toenail fungus go away? On the $4 generic drug tier available to most Americans, there are drugs so valuable I have often reached into my own pocket to help patients fill these prescriptions; while for the same price, there are also drugs of such dubious safety and efficacy, I honestly would not give them to my dog. Our current "one size fits all" system lacks clinical nuance, and frankly, to me, makes no sense. Chairman Brady, in your announcement for this hearing, you stated, "There is bipartisan recognition that the current structure of the Medicare benefit is outdated, confusing, and in need of reform, and taking steps to improve the current array of confusing deductibles, copayments and coinsurance is long overdue." I could not agree more. Only after we acknowledge the limitations, inefficiencies and inadequacies of Medicare's cost-sharing structure, can we identify ways to improve it. Medicare beneficiaries avail themselves of too little high-value care and too much low-value care. We need benefit designs that support consumers in obtaining evidence-based services such as diabetic retinal exams and life-saving drugs through lower cost-sharing (when clinically indicated), and discourage individuals through higher cost-sharing from using dangerous or low-value services such as those identified by professional medical societies in the Choosing Wisely initiative. Payers, purchasers, beneficiaries and taxpayers can attain more health for every dollar spent by incorporating greater clinical nuance into benefit design.

VALUE-BASED INSURANCE DESIGN [V-BID]

More than a decade ago, the private sector began to implement a concept our team developed known as Value-Based Insurance Design, or V-BID, in response to the lack of clinical nuance in available public and commercial health plans. **The basic V-BID premise calls for reducing financial barriers to evidence-based services and high-performing providers and imposing disincentives to discourage use of low value care.** A V-BID approach to benefit design recognizes that different health services have different levels of value. It's common sense—when barriers to high-value treatments are reduced and access to low-value treatments is discouraged, these plans result in better health at any level of care expenditure.

Let me be clear, Mr. Chairman, I am not asserting that using clinical nuance in benefit design is the single solution to all of Medicare's problems. But, if we are serious about "bending the health care cost curve" and improving health outcomes, we must change the incentives for consumers as well as those for providers. **Cost containment through blunt changes to Medicare benefit design must not produce avoidable reductions in quality of care,** and therefore should include clinically driven, not exclusively price driven, strategies.

Your Subcommittee is currently examining many exciting, some unproven, supply-side payment reform initiatives such as bundled payments, pay for performance, Patient-Centered Medical Homes, and ACOs. If these initiatives provide incentives to clinicians to recommend the right care, it is of equal importance that incentives for the patients are aligned with these goals as well. As a physician practicing in a medical home, **it is incomprehensible to realize that my patients' insurance coverage does not offer easy access for those exact services for which I am benchmarked.** Does it make sense that I am offered a financial bonus to get my patient's diabetes under control when the benefit design makes it prohibitively expensive to fill their insulin prescription or provide the copayment for their eye examination?

I'm pleased to tell you that the intuitiveness of a clinically nuanced design is driving momentum at a rapid pace in the private sector, and we are truly at a "tipping point" in its adoption. Hundreds of private self-insured employers, public organizations, non-profits, and insurance plans have designed and tested value-based programs. Just a few recent examples include the Connecticut State Employees' Health Enhancement Program, UnitedHealth Group's Diabetes Health Plan, Aetna, and Blue Shield of California's "Blue Groove" Plan, each of which provide incentives for individuals with chronic diseases to seek the right care at the right time from the right provider.

TRADITIONAL MEDICARE: LIMITS TO IMPLEMENTING CLINICAL NUANCE IN BENEFIT DESIGN

Medicare is a key component of our nation's commitment to take care of the elderly and disabled among us, and we all agree that the program must be sustained for future generations. Although there are some noteworthy advances implementing clinical nuance, such as the requirement that Medicare, the Federal Employee Health Benefits Programs, and private plans provide selected primary preventive services with no patient cost-sharing [Section 1001 of the Patient Protection and Affordable Care Act [PPACA] and section 2713 of the Public Health Service Act], **traditional Medicare is constrained by a set of rules and laws that allow little flexibility to implement clinically-driven, value enhancing strategies.**

Two specific features of Traditional Medicare can be viewed as potential barriers to innovation. First, Traditional Medicare beneficiaries have complete freedom regarding provider choice. Second, current benefit design generally does not allow for clinically nuanced cost-sharing. Specifically, program administrators cannot lower cost-sharing levels for a guideline recommended service such as a diabetic retinal eye exam, and they are limited in how much they can adjust coinsurance rates upward for a wasteful imaging test or harmful procedure. This lack of flexibility is highly problematic, and it fails to recognize the well-accepted notion that health care services differ in the clinical benefit achieved.

Although the "one size fits all" approach to Medicare copayments dates back to its inception in the 1960s, expert groups such as the Medicare Payment Advisory Commission (MedPAC) have repeatedly advocated for the use of V-BID as a strategy for improving quality and lowering the rate of cost growth. For example, in its 2012 Report to Congress, MedPAC references the potential benefit of implementing V-BID concepts to encourage the use of high-value services for improved health outcomes. Additionally, in 2009, Senators Hutchison and Stabenow introduced a bipartisan bill, S.1040 "Seniors' Medication Copayment Reduction Act of 2009," to allow a demonstration of V-BID within Medicare Advantage plans.

INFUSING 'CLINICAL NUANCE' INTO MEDICARE ADVANTAGE

As sweeping changes to the Traditional Medicare program are difficult to enact, an interim step could be to legislate moderate changes to the Medicare Advantage program. In contrast to the Traditional Medicare program, Medicare Advantage incorporates a system of competing private health plans. In theory, Medicare Advantage can implement innovative programs designed to improve value by applying techniques successfully implemented in the commercial health insurance market. In reality, the tools available to Medicare Advantage are limited, and include network formation, provider facing-interventions (like performance bonuses), and utilization management programs. The use of these blunt instruments often does not align economic incentives with clinical value and hinders plan ability to design benefits to promote quality and efficiency. **Additional flexibility in benefit design would allow Medicare Advantage to achieve greater efficiency and encourage personal responsibility among consumers.**

There are two major restrictions within the Medicare Advantage program that prevent clinical nuance and the promotion of high-value services and providers: (1) a lack of flexibility to steer patients to high value providers; and (2 a rigid, outdated benefit design. The standards for provider networks and non-discriminatory benefit designs were established in an effort to protect consumers from unfavorable practices such as predatory risk steering. While some of these provisions successfully improve consumer protection, they also severely limit innovation within the Medicare Advantage program and perpetuate a "one size fits all" approach to care delivery. Since these consumer protection standards prevent seniors from receiving the highest possible clinical benefits of care, they may be construed as undermining their original intent.

I. FLEXIBILITY IN IMPOSING DIFFERENTIAL COST-SHARING FOR USE OF DIFFERENT PROVIDERS OR SETTINGS

Since the value of a clinical service may depend on the specific provider or the site of care delivery, **Medicare Advantage plans should have the flexibility to vary cost-sharing for a particular outpatient service in accordance with who provides the service and /or where the service is delivered.** A recent report from The Commonwealth Fund Commission on a High Performance Health System estimated that $189 billion in savings to Medicare would accrue over 10 years if we were to "develop a value-based design that encourages beneficiaries to obtain care from high-performing care systems." This flexibility is increasingly feasible, as quality metrics and risk-adjustment tools become better able to identify high-performing health care providers and/or care settings that consistently deliver superior quality. For example, a Medicare Advantage plan might wish to impose a $50 copayment for an out of

network office visit, a $25 copayment for an in-network office visit, and a $0 copayment for an in-network office visit that takes place at a recognized patient-centered medical home (PCMH), that has demonstrated better performance on key quality measures. Existing rules prohibit this level of variance in beneficiary cost-sharing.

Currently, Medicare Advantage plans are allowed to create a provider network, but are limited in how they vary copays *within* that network. This restriction forces Medicare Advantage plans to either exclude low-performing providers completely, or permit access to them – no intermediate processes are allowed. Strict standardization in the cost sharing structures within a network severely hinders the ability of Medicare Advantage plans to promote high quality care and take steps to reduce waste and inefficiency.

The provider network requirements also create challenges for care coordination among providers. The inability to use incentives to encourage beneficiaries to access care across a specified provider group hinders the ability for practitioners to track progress, encourage proper follow-up, and prevent the need for costly services due to lack of medical adherence. This is particularly important as we seek a return from a multi-billion dollar investment in health information technology. While the long-term intent of electronic medical records is to seamlessly share data across all providers, currently the most common use is among providers in a designated group.

Improving provider choice is an essential tool that will allow plans to incorporate clinical nuance, enhance consumer engagement, and drive higher quality of care in Medicare Advantage products. **Network adequacy standards must allow issuers to create multi-tier cost sharing structures by encouraging and requiring different tiers of co-pays for services and providers that have proven high- and low-value outcomes.** Many stakeholders recognize the merit of permitting plans greater flexibility to incentivize beneficiaries to select high performing providers; the Medicare Payment Advisory Committee submitted these policy recommendations in the 2011 and 2012 Reports to Congress.

II. Flexibility in Imposing Differential Cost-Sharing for Use of Different Services

To date, most clinically nuanced designs have focused on lowering patient out-of-pocket costs (carrots) for high-value services. These are the services I beg my patients to do - for which there is no question of their clinical value - such as immunizations, preventive screenings, and critical medications and treatments for individuals with chronic disease such as asthma, diabetes and mental illness (e.g. as recommended by National Committee for Quality Assurance, National Quality Forum, professional society guidelines). Despite unequivocal evidence of clinical benefit, there is substantial underutilization of these high-value services across the spectrum of clinical care. Multiple peer-reviewed studies show that when patient barriers are reduced, compliance goes up, and, depending on the intervention or service, total costs go down.

Yet, from the payer's perspective, the cost of incentive-only "carrot" based V-BID programs depends on whether the added spending on high-value services is offset by a decrease in adverse events, such as hospitalizations and visits to the emergency department. While these high-value services are cost-effective and improve quality, many are not cost-saving – particularly in the short term. However, research suggests that non-medical economic effects—such as the improvement in productivity associated with better health—can substantially impact the financial results of V-BID programs.

While significant cost-savings are unlikely with incentive-only "carrot" programs in the short term, **a V-BID program that combines reductions in cost-sharing for high-value services and increases in cost-sharing for low-value services can both improve quality and achieve net cost savings.** Removing harmful / unnecessary care from the system is essential to reduce costs and improve quality and patient safety. Evidence suggests significant opportunities exist to save money without sacrificing high-quality care. For example, in 2011, the lowest available estimates of waste in the US health care system exceeded 20% of total health care expenditures. Though less common, some V-BID programs are designed to discourage use of low-value services and poorly performing providers. Low-value services result in either harm or no net benefit, such as services labeled with a D rating by the U.S. Preventive Services Task Force. **Many services that are identified as high quality in certain clinical scenarios are considered low-value when used in other patient populations, clinical diagnoses or delivery settings.** For example, cardiac catheterization, imaging for back pain, and colonoscopy can each be classified as a high- or low-value service depending on the clinical characteristics of the person, when in the course of the disease it is provided, and where it is delivered.

Fortunately, there is a growing movement to both identify and discourage the use of low-value services. The ABIM Foundation, in association with Consumers Union, has launched Choosing Wisely, an initiative where medical specialty societies identify commonly used tests or procedures whose necessity should be questioned and discussed. Thus far, twenty-six medical specialties have identified at least five low-value services within their respective fields while twelve additional societies are also preparing low-value services lists. Substantial cost savings are available from efforts such as Choosing Wisely. Savings of more than $5 billion were estimated if the recommendations of a recent top five overused clinical services list across three primary care specialties were implemented in practice. Thus, **programs that include both carrots and sticks may be particularly desirable in the setting of budget shortfalls.**

III. Flexibility in Imposing Differential Cost-Sharing for Certain Services For Specific Enrollees

Since a critical aspect of clinical nuance is that the value of a medical service depends on the person receiving it, we recommend that Medicare Advantage plans be granted the flexibility to impose differential cost-sharing for specific groups of enrollees. **The flexibility to target enrollee cost-sharing based on clinical information (e.g., diagnosis, clinical risk factors, etc.) is a crucial element to the safe and efficient allocation of Medicare expenditures.** Under such a scenario, a plan may choose to exempt certain enrollees from cost-sharing for a specific service on the basis of a specific clinical indicator, while imposing cost-sharing on other enrollees for which the same service is not clinically indicated. Under such a clinically nuanced approach, plans can recognize that many outpatient services are of particularly high-value for beneficiaries with conditions such as diabetes, hypertension, asthma, and mental illness, while of low-value to others. (For example, annual retinal eye examinations are recommended in evidence-based guidelines for enrollees with diabetes, but not recommended for those without the diagnosis.) Without easy access to high-value secondary preventive services, previously diagnosed individuals may be at greater risk for poor health outcomes and avoidable, expensive, acute-care utilization. Conversely, keeping cost-sharing low for these services for all enrollees, regardless of clinical indicators, can result in overuse or misuse of services leading to wasteful spending and potential for harm.

Currently, Medicare Advantage plans are constrained by non-discrimination rules that prohibit plans from tailoring benefits to particular subgroups of patients who may receive particularly high value from a given service. If Medicare Advantage plans were to encourage use of a certain service by lowering copays, they must lower copays for everyone in the plan, even though clinical appropriateness may vary. In order to allow plans to incorporate the principles of clinical nuance in their Medicare Advantage products, the standards placed on these plans regarding targeting intervention by clinical circumstance should be updated.

Permitting "clinically nuanced" variation in copayments and coinsurance would give Medicare Advantage plans a necessary tool to incentivize beneficiaries to receive high-value services. This addition would eliminate many of the challenges and limitations of the "one size fits all" model. Medicare Advantage plans would then be able to target clinically appropriate populations for reduced cost-sharing for evidence-based high-value services and increased cost sharing for harmful services or those with unproven medical benefit.

CONCLUSION

It is my hope that as you consider changes to the Medicare benefit design, you will take the common-sense step of allowing co-payments to vary based on whether an intervention is high-value or low-value. As a practicing clinician, I believe that the goal of our health care system is to produce health, not to save money. That said, I strongly concur that health care cost containment is absolutely critical for our nation's fiscal health. Although there is urgency to bend the health care cost curve, cost containment efforts must not produce avoidable reductions in quality of care. **Applying clinical nuance in benefit design presents an enormous opportunity for the Medicare program.** If such principles encourage the utilization of high-value providers and services while discouraging only low-value services, Medicare Advantage plans can improve health, enhance consumer engagement, reduce costs, and mitigate legitimate concerns around "one size fits all" cost-sharing. Key stakeholders—including a large and growing number of medical professional clinical societies—agree that discouraging consumers from using specific low-value services and providers must be part of the strategy. As evidence-driven approaches to identify high- and low-value services and providers are coupled with carefully designed strategies for consumer education and communication, Medicare can produce more health at any level of health expenditure.

Thank you.

Chairman BRADY. Ms. Neuman.

STATEMENT OF TRICIA NEUMAN, SENIOR VICE PRESIDENT AND DIRECTOR, KAISER PROGRAM ON MEDICARE POLICY, KAISER FAMILY FOUNDATION

Ms. NEUMAN. Thank you, Chairman Brady, Ranking Member McDermott, and distinguished Members of the Subcommittee. I appreciate the opportunity to testify at a hearing examining the traditional Medicare benefit design.

Since the 1970s, the idea of simplifying benefits under traditional Medicare has been under discussion, but proposed solutions have typically involved very difficult tradeoffs. A change in the benefit design could streamline and simplify benefits, could provide greater financial protections to people with significant expenses, and minimize the need for supplemental insurance, but as structured to produce Medicare savings, such a change could also be expected to increase costs for the majority of beneficiaries.

Medicare provides highly valued health insurance for 50 million people, Americans, many of whom have significant medical needs and modest incomes. Four in ten have at least three chronic conditions; one in four has a mental or cognitive impairment; half live on an income of less than $23,000.

As noted in your announcement for today's hearing, Medicare has a complicated benefit structure. It also has high cost-sharing requirements and no limit on out-of-pocket spending for services covered under Parts A and B.

As a result people on Medicare tend to have relatively high out-of-pocket costs, including cost-sharing requirements for Medicare, but also premiums for Medicare, premiums for supplemental coverage and for uncovered services. Health expenses now account for nearly 15 percent of Medicare household budgets. On average that is three times the share for non-Medicare households.

Proposals to change the traditional Medicare benefits design can have different goals which have direct implications for beneficiaries and for program spending. Proposals to change the benefit design could simplify benefits, encourage the use of highly valued services as you have just heard, improve benefits, or trim them back. Achieving Medicare savings could be a high priority or not.

Several recent proposals would simplify benefits, set a limit on cost-sharing obligations, and also reduce Federal spending. The Kaiser Family Foundation, with Actuarial Research Corporation researchers, examined an option to simplify the benefit design and achieve Medicare savings based on an approach specified by the Congressional Budget Office in their budget options report in 2011. That option includes a $550 unified deductible for Parts A and B, a uniform 20 percent coinsurance, and a new $5,500 limit on cost sharing. This approach would be expected to reduce spending for a very small share of the Medicare population, but generally people who are very sick with high costs.

Five percent of beneficiaries in traditional Medicare are expected to have lower out-of-pocket costs than they would under current law, and they would receive substantial savings on average. This would affect, for example, people with multiple inpatient stays, or a lot of postacute care, so it would be helped by the limit on out-

of-pocket spending. But most, and the analysis estimated 71 percent, would be expected to face higher costs. So seniors in relatively good health who may go to the doctor or see a couple of specialists in a year would see their deductibles triple from current levels to $550. And that illustrates the tradeoff.

This particular benefit redesign could be modified in a number of ways. Lowering the cost-sharing limit would help more people, but could also lead to higher Medicare spending. Raising the limit would help even fewer people and generate additional savings.

Another modification also described by the Congressional Budget Office would include restrictions in supplemental coverage along with a benefit design. It would prohibit Medigap from covering the unified deductible by limiting Medigap coverage beyond that point to a certain extent. This approach would increase the Medicare savings, mainly because people who have Medigap would be expected to use fewer services when confronted with higher cost sharing. Under this option nearly a quarter of people on Medicare would see costs decline, mainly due to lower Medigap premiums, but half would be expected to pay more; again, a difficult tradeoff.

Another modification would incorporate stronger protections for low-income beneficiaries in conjunction with a benefit design. Such an approach would simplify the program for all beneficiaries, protect those with limited means, but could diminish Federal savings, if not result in higher Federal spending.

Mr. Chairman, Medicare today enjoys strong support among seniors. Finding an approach that will streamline benefits, encourage beneficiaries to use highly valued services, and provide greater protections to those with high out-of-pocket expenses, all without shifting undue costs onto beneficiaries, remains a challenge, particularly in a deficit-reduction environment.

And I thank you, and I look forward to working with you and answering your questions.

Chairman BRADY. Great. Thank you.

[The prepared statement of Ms. Neuman follows:]

TESTIMONY IS EMBARGOED UNTIL 10:30 AM ON TUESDAY, FEBRUARY 26, 2013

CHANGING MEDICARE'S BENEFIT DESIGN: IMPLICATIONS FOR BENEFICIARIES

Patricia Neuman, Sc.D.
Director, Program on Medicare Policy and
Senior Vice President, The Henry J. Kaiser Family Foundation

Prepared for the Committee on Ways and Means
Subcommittee on Health

"Examining Traditional Medicare's Benefit Design"

February 26, 2013

Chairman Brady, Ranking Member McDermott, and distinguished members of the Subcommittee on Health, I am Tricia Neuman, a Senior Vice President at the Kaiser Family Foundation and Director of the Foundation's Program on Medicare Policy. The Kaiser Family Foundation is an independent, non-profit private operating foundation that is focused on health policy analysis, communications and journalism.

Thank you for the opportunity to testify on the topic of Medicare's benefit design, and the implications of possible changes for beneficiaries, other stakeholders, and program spending. Since the 1970s, the idea of simplifying Medicare's benefit design, while improving protections for those with truly catastrophic expenses, has been under discussion, but developing consensus around an alternative continues to be a challenge. A streamlined benefit design would be easier for beneficiaries to navigate, move Medicare toward the design of typical large employer plans, and provide substantial relief to a small number of beneficiaries with large medical expenses and peace of mind to others. Yet, if designed to be budget neutral or achieve federal savings, a restructured benefit package would be expected to increase costs for the majority of beneficiaries, many of whom have modest incomes, posing a clear policy dilemma.

Background

Medicare provides health insurance coverage for nearly one in six Americans, including 41 million seniors and 9 million younger adults with permanent disabilities. Health insurance coverage is important to people of all ages, but is especially important to people on Medicare. While some are fortunate to enjoy good health, many Medicare beneficiaries have significant medical needs and modest incomes (Exhibit 1). Four in ten beneficiaries live with three or more chronic conditions. About one in four beneficiaries is in fair or poor health and about the same share has a cognitive or mental impairment, such as Alzheimer's disease. More than half live on incomes of $22,500 or less.

Medicare, at 15 percent of the federal budget, has been and continues to be a part of discussions to reduce the federal deficit and debt. However, over the next decade, Medicare spending is projected to grow at a substantially lower rate than it did in the past

decade, at about the same rate as the economy, and at a slower rate than private insurance on a per person basis (Exhibit 2). While growth in per beneficiary spending has been substantially slowed, total Medicare spending is expected to rise as a share of the economy primarily due to a significant increase in the beneficiary population and rising health care costs (that will affect all payers). A wide range of proposals have been put forward to further slow the growth in Medicare spending that could potentially affect providers, plans, and beneficiaries, including options to simplify and restructure Medicare's current benefit design.[1]

Benefits, Supplemental Coverage, and Out-of-Pocket Spending

Medicare was designed to provide coverage of basic health benefits, and over time, has been expanded to include additional benefits, such as prescription drugs and full coverage of preventive services, which are important to the health and well-being of beneficiaries. Yet Medicare has relatively high deductibles and cost-sharing requirements, and a coverage gap for Part D enrollees that will be phased out by 2020. Unlike typical large employer plans, Medicare has no limit on out-of-pocket spending for inpatient and outpatient services. In fact, Medicare remains less generous than the typical large employer preferred provider organization (PPO) plan and the Blue Cross/Blue Shield Standard Option offered through the Federal Employees Health Benefits Program (also a PPO plan).[2]

Most beneficiaries in traditional Medicare have supplemental coverage to help cover some or all of Medicare cost-sharing requirements (Exhibit 3). Employer-sponsored plans (mainly for retirees) remain the primary source of supplemental coverage, providing additional coverage to 41 percent of beneficiaries in traditional Medicare in 2009. Another 21 percent of beneficiaries in traditional Medicare are covered by supplemental insurance policies, known as Medigap. Medicaid plays a key role in providing wrap around coverage for low-income beneficiaries – also 21 percent of beneficiaries in traditional Medicare.

Another 17 percent of all beneficiaries in the traditional Medicare program (12 percent of the total Medicare population) have no source of supplemental coverage. This includes a disproportionate share of beneficiaries with modest incomes, in fair or poor health, and

younger beneficiaries with permanent disabilities.[3] These beneficiaries would be fully exposed to higher deductibles and coinsurance requirements under many of the leading benefit redesign proposals.

A growing number of Medicare beneficiaries, now 27 percent, are covered by Medicare Advantage plans, rather than traditional Medicare. Medicare Advantage plans provide at least the same set of benefits as traditional Medicare, but do not typically have deductibles for services covered Parts A and B, and now include limits on enrollees' out-of-pocket spending (not to exceed $6,700 in 2013).[4] Cost-sharing requirements for various Medicare-covered services tend to vary across Medicare Advantage plans.

Even with Medicare, and supplemental insurance, beneficiaries' tend to have relatively high out-of-pocket health costs. In 2009, half of all Medicare beneficiaries spent 15 percent or more of their income on health-related expenses, including premiums, cost sharing for Medicare-covered services, and services not covered by Medicare; more than one-third of all beneficiaries (39%) spent at least 20 percent of their income on medical expenses that year.[5] Health expenses accounted for nearly 15 percent of Medicare household budgets in 2010, on average – three times the percent of health spending among non-Medicare households (Exhibit 4).

The Current Benefit Design and Recent Proposals

Medicare's benefit design has evolved over time, but from the outset was divided into two parts: Part A (primarily for inpatient hospital and post-acute care) and Part B (for physician and other outpatient services). As of 2006, Medicare also includes the Part D prescription drug benefit that is provided under private stand-alone plans (PDPs) or Medicare Advantage Drug Plans (MA-PDs), but not integrated with other covered benefits under traditional Medicare. This current benefit structure – with separate deductibles for Parts A, B and D, and cost-sharing requirements that vary by type of service – is more complex than a typical large employer-sponsored plan.

Over the years, a number of policymakers and other experts have proposed to simplify the Medicare benefit design. Benefit redesign proposals can be structured to strengthen or weaken the coverage provided by Medicare, and increase or decrease federal spending, depending on the benefit parameters, such as the level of the unified deductible, the limit on out-of-pocket spending, and the extent to which it incorporates financial protections for beneficiaries with low incomes.

In recent years, the idea of simplifying the benefit design has been considered in the context of broader efforts to reduce Medicare spending and to lower the federal deficit and debt. For example, in its 2011 report that examined spending and revenue options to reduce the deficit, the Congressional Budget Office (CBO) evaluated a benefit design that includes a combined Part A/B deductible of $550 (rather than $1,184 per benefit period for Part A and $147 for Part B in 2013), a uniform coinsurance of 20 percent for all benefits covered under Parts A and B, and a limit on out-of-pocket spending set at $5,500, along the lines of the benefit design recommended in 2010 by the National Commission on Fiscal Responsibility and Reform (also known as Simpson-Bowles).[6,7] Additionally, in 2012, the Medicare Payment Advisory Commission (MedPAC) recommended changes to the benefit design that would maintain aggregate cost-sharing requirements for beneficiaries, but would add an out-of-pocket spending limit, replace current coinsurance rates with copayments that may vary by service and provider, and grant the Secretary of Health and Human Services the authority to make value-based changes to Medicare's benefit design.[8] None of the proposals would integrate Part D in the benefit design.

On the one hand, these proposals would simplify the program, position traditional Medicare to look more like private insurance looks today, and provide financial protection to the small share of beneficiaries with truly catastrophic medical expenses whose costs would not otherwise be covered by supplemental insurance. In addition, the limit on out-of-pocket spending could also minimize the need for supplemental coverage and provide peace of mind for all beneficiaries concerned about catastrophic medical bills. But on the other hand, if designed to reduce Medicare spending, or even be budget neutral, such proposals would also likely increase out-of-pocket costs for the majority of beneficiaries, and for some, the increase would be substantial.

What are the Implications of a Restructured Benefit Design for Beneficiaries?

In November 2011, the Kaiser Family Foundation released a report that analyzed the distributional and cost implications of replacing Medicare's current benefit design with a unified deductible for Parts A and B of $550; a 20 percent coinsurance for most Medicare-covered services; and a $5,500 annual limit on out-of-pocket spending.[9] This benefit design is generally consistent with the proposal recommended by Simpson-Bowles-Bowles in 2010 and the option included in the CBO's Budget Options report released in 2011.[10] The following summarizes the results of the analysis, which assumes that the proposal was fully implemented in 2013. Our analysis, conducted with researchers at the Actuarial Research Corporation, focuses on the cost implications for beneficiaries, and illustrates the tradeoffs involved with benefit redesign.

The Effects of Creating a Unified $550 Part A/B Deductible with a 20 Percent Uniform Coinsurance for Most Services, and a $5,500 Annual Limit on Cost Sharing for Part A/B Services.

Restructuring Medicare's cost-sharing requirements in such a fashion would be expected to raise costs for the majority of Medicare beneficiaries while reducing spending for some of the sickest. The effects for any given individual would depend on the particular mix of Medicare-covered services they need and their supplemental coverage.

- **Five percent of beneficiaries in the traditional program (about 2 million) would be expected to see savings as a result of the changes, averaging $1,570 in 2013** (Exhibit 5).[11]
    - Beneficiaries using inpatient hospital and post-acute care, for example, would be more likely to be helped by the alternative benefit design because they are more likely to incur costs that exceed the limit on out-of-pocket spending (Exhibit 6). In any given year, this group would represent a small share of the total Medicare population, although, as noted by MedPAC, a larger share of the Medicare population would be helped by the out-of-pocket spending limit in general if observed over several years.[12]

- However, not all beneficiaries with intensive service use would see a reduction in spending. Beneficiaries with expenses that do not exceed the out-of-pocket limit could end up paying substantially more for their Medicare-covered services due to the new 20 percent coinsurance for home health services and on relatively short inpatient hospital and skilled nursing facility stays (even with a lower Part A deductible).

- **Overall, 71 percent of beneficiaries in the traditional program (about 29 million beneficiaries) are projected to see at least some increase in their out-of-pocket costs, including modest increases in Part B and supplemental insurance premiums, under the revamped system.**
  - For example, beneficiaries in relatively good health, who tend to have a few physician visits in a year but no inpatient care would be expected to have higher out-of-pocket costs, principally because they would face a unified deductible ($550) that is more than three times more than their current law deductible ($147 for Part B in 2013).
  - Five million beneficiaries would be expected to face an increase of $250 or more in their out-of-pocket costs, averaging $660 in 2013; more than one third of these beneficiaries have incomes between 100 and 200 percent of the federal poverty level, a group that is not generally eligible for cost-sharing assistance under Medicaid.

These changes to the benefit design would reduce Medicare spending by an estimated $4.2 billion in 2013, according to our analysis, but aggregate spending among Medicare beneficiaries would rise by $2.3 billion. The proposal would also be expected to result in higher costs for employers ($0.6 billion), TRICARE ($0.2 billion) and other payers ($0.4 billion). Medicaid spending (federal and state combined) would decrease modestly by $0.1 billion in 2013, mainly due to the limit on out-of-pocket spending. Taken together, the changes would result in a net reduction in total health care spending of less than $1 billion in 2013.

The Effects of Raising/Lowering the Out-of-Pocket Limit

Proposals vary in the level at which the out-of-pocket limit for traditional Medicare is set. A lower limit would help more beneficiaries, but erode Medicare savings. Conversely, a higher limit would help fewer beneficiaries, but increase Medicare savings (Exhibit 7).[13]

Assuming a $550 combined A/B deductible and 20 percent coinsurance on most Medicare covered services:

- With a $5,500 out-of-pocket spending limit, five percent of beneficiaries in traditional Medicare would be expected to see a reduction in out-of-pocket spending.
- With a $7,500 out-of-pocket spending limit, three percent of beneficiaries in traditional Medicare would be expected to see a reduction in out-of-pocket spending. With this higher limit, 39 percent of beneficiaries in traditional Medicare would be expected to see costs *increase* by at least $250, compared to 12 percent under the $5,500 limit. The higher limit would increase the federal savings associated with this proposal from $4.1 billion (associated with the $5,500 limit) to $13.2 billion in 2013.
- With a lower $4,000 out-of-pocket spending limit, 30 percent of beneficiaries in traditional Medicare would be expected to see a reduction in spending. The lower limit would result in a $5.1 billion *increase* in federal spending.

The Effects of Combining the Benefit Redesign with Restrictions on First Dollar Medigap Coverage

In addition to restructuring Medicare's benefit design, several recent proposals would prohibit or discourage beneficiaries from purchasing supplemental coverage generally or "first-dollar" coverage more specifically (i.e., insurance that pays upfront cost-sharing requirements for beneficiaries, such as the Part A or Part B deductible). For example, Simpson-Bowles would prohibit Medigap policies from covering the full deductible and would limit Medigap coverage above the deductible – in conjunction with aforementioned changes to the basic benefit design for traditional Medicare.[14] MedPAC also recommended

a premium charge on supplemental coverage (including both Medigap and employer-sponsored plans) in conjunction with changes to the benefit design for traditional Medicare.[15] In his FY2013 Budget, President Obama also proposed to increase Part B premiums for new enrollees who purchase "near first-dollar" Medigap coverage beginning in 2017, although he did not propose to fundamentally restructure the Medicare benefit design.[16]

Prohibiting first-dollar Medigap coverage in conjunction with a restructured benefit package would also create winners and losers, according to Kaiser Family Foundation analysis, under a policy where Medigap policies are prohibited from covering the first $550 in cost sharing and restricted from covering more than 50 percent of cost sharing above the deductible and up to the new spending limit, assuming full implementation in 2013.[17,18] Furthermore, Medigap provides peace of mind to millions of seniors by offering predictable monthly premiums that protect them against unexpected medical expenses and by simplifying the paperwork associated with paying their medical bills.

- **Half of all beneficiaries in traditional Medicare would be expected to see cost increases with Medigap restrictions and the benefit redesign (less than the 71% with expected cost increases under the benefit redesign alone) and nearly a quarter (24%) would be expected to see costs decline (versus 5% with the benefit design alone).** This is a more favorable distribution than the benefit redesign alone because the Medigap restrictions are expected to reduce Medigap premiums (as plans would cover fewer expenses) and reduce Part B premiums because beneficiaries would be expected to use fewer Part B services when faced with higher cost-sharing requirements.
- **The combined benefit redesign and Medigap restrictions would nonetheless increase costs for an estimated six million Medicare beneficiaries by more than $250, with an average increase of $780 in 2013.** More than half of the beneficiaries in this group have incomes below 200 percent of the federal poverty level. Restricting Medigap coverage would require enrollees to pay a greater share of their medical expenses on their own, which would be especially burdensome for enrollees with large medical expenses. For many enrollees with one or more hospitalizations, for example, the increase in cost-sharing requirements would more than offset any reductions in Part B and supplemental premiums.

The primary justification for these proposals is the view that supplemental coverage, especially first-dollar coverage, drives up Medicare spending by insulating enrollees from the cost of the services they use.[19] Numerous studies have demonstrated that increases in cost-sharing result in decreases in utilization. However, the literature also confirms that people forego both necessary and unnecessary care, the former of which could lead to health complications and additional costs in the long run. Research also suggests that, while cost sharing may affect the decision of whether to seek care, it has a smaller impact on the intensity of care provided, and it may have a smaller impact on the use of certain services.[20] For these and other reasons, Medicare is moving forward with demonstrations to test various delivery system and payment reforms that aim to change the incentives of providers, rather than relying primarily on increasing beneficiaries' financial obligations.[21]

Considerations for Low-Income Beneficiaries

This analysis does not consider the effects of strengthening protections for low-income beneficiaries, in conjunction with a benefit redesign. Today, many Medicare beneficiaries with modest incomes do not qualify for Medicaid's assistance with premium, cost-sharing, and other benefits because they do not meet the eligibility criteria. These beneficiaries would be especially hard hit by higher cost-sharing obligations, with or without the additional Medigap changes.

Some have advocated an approach that would shield those with relatively low incomes from an increase in Medicare deductibles and cost-sharing requirements. One approach for mitigating the effect on low-income beneficiaries would be to federalize premium and cost-sharing assistance and to raise income and asset eligibility levels, using the Part D low-income subsidy model as an example. Eligibility levels for Part D low-income subsidies are generally less restrictive than eligibility levels for assistance with Medicare premiums and cost-sharing under Medicaid and the Medicare Savings Programs.

Such an approach would provide stronger protections for low-income beneficiaries and alleviate some of the fiscal pressure on states by reducing spending by state Medicaid programs that currently cover Medicare premiums and cost sharing for eligible low-income Medicare beneficiaries. However, doing so would also erode expected federal savings or even lead to an increase federal spending.

Conclusion

Medicare today enjoys broad support among the public, and a large majority of seniors say the program is working well (Exhibit 8). Nonetheless, it is unlikely that Medicare's current benefit design is the one that would be drafted if the program were being created anew today. Further, with high cost-sharing requirements and no limit on out-of-pocket spending, the majority of beneficiaries have supplemental coverage.

Several recent benefit redesign proposals would provide real help to a small share of the Medicare population, but raise costs for the majority of beneficiaries – many of whom have modest incomes and devote a relatively large share of their incomes and household budgets towards health-related expenses. Finding an approach that will streamline benefits, coax beneficiaries toward high-value providers and services, provide greater protections to those with relatively high cost-sharing expenses, all without shifting excessive costs onto seniors, remains a challenge, particularly in a deficit reduction context.

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[1] Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future*, January 2013, available at: http://www.kff.org/medicare/8402.cfm.

[2] Kaiser Family Foundation, *How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?: A 2012 Update*, April 2012, available at: http://www.kff.org/medicare/7768.cfm.

[3] Kaiser Family Foundation, *Examining Sources of Supplemental Insurance and Prescription Drug Coverage Among Medicare Beneficiaries: Findings from the Medicare Current Beneficiary Survey, 2007*, August 2009, available at: http://www.kff.org/medicare/7801.cfm.

[4] Half of all Medicare Advantage enrollees were in a plan with a limit at or below $3,400 in 2012. Kaiser Family Foundation, *Medicare Advantage 2012 Spotlight: Enrollment Market Update*, June 2012, available at: http://www.kff.org/medicare/8323.cfm.

[5] Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2009 Cost and Use file.

[6] Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options*, March 2011, available at: http://www.cbo.gov/publication/22043.

[7] Simpson-Bowles also recommended a combined $550 deductible and a uniform 20 percent coinsurance rate. However, while the CBO option included an out-of-pocket spending limit of $5,500, Simpson-Bowles recommended an out-of-pocket spending limit of $7,500, with a five percent coinsurance rate for expenses between $5,500 and the spending limit. The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, available at: http://www.fiscalcommission.gov/news/moment-truth-report-national-commission-fiscal-responsibility-and-reform.

[8] MedPAC also recommended placing a surcharge on supplemental plans, including Medigap and employer-sponsored retiree plans. While MedPAC recommended these broad features of a new benefit design, they did not suggest specific parameters (such as specific copayment amounts). Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

[9] Kaiser Family Foundation, *Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending*, November 2011, available at: http://www.kff.org/medicare/8256.cfm.

[10] Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options*, March 2011, available at: http://www.cbo.gov/publication/22043. The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, available at: http://www.fiscalcommission.gov/news/moment-truth-report-national-commission-fiscal-responsibility-and-reform.

[11] Our analysis only defines beneficiaries with increases or decreases in out-of-pocket spending as those with changes in spending of $25 or more.

[12] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

[13] Kaiser Family Foundation, *Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending*, November 2011, available at: http://www.kff.org/medicare/8256.cfm.

[14] The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, available at: http://www.fiscalcommission.gov/news/moment-truth-report-national-commission-fiscal-responsibility-and-reform.

[15] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

[16] Office of Management and Budge, *Fiscal Year 2013 Budget of the U.S. Government*, February 2012, available at: http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf.

[17] Kaiser Family Foundation, *Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending*, November 2011, available at: http://www.kff.org/medicare/8256.cfm.

[18] The Kaiser Family Foundation also analyzed the impact of Medigap restrictions independent of benefit redesign: Kaiser Family Foundation, *Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs*, July 2011, available at: http://www.kff.org/medicare/8208.cfm.

[19] As an example of research exploring the impact of supplemental coverage on Medicare spending, see: Christopher Hogan, Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly, June 2009, available at: http://www.medpac.gov/documents/Jun09_SecondaryInsurance_CONTRACTOR_RS_REVISED.pdf. MedPAC also provides a summary of other research on this subject: Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

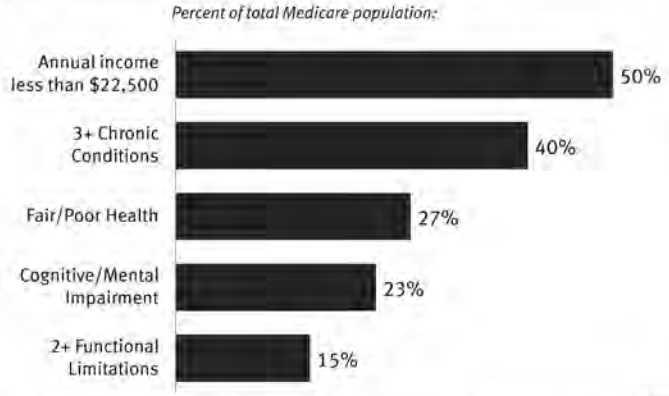
[20] Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcomes*, December 2010, available at: http://www.rwjf.org/content/rwjf/en/research-publications/find-rwjf-research/2011/12/cost-sharing--effects-on-spending-and-outcomes.html and Mathematica Policy Research, Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature, March 2006, available at http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf.

[21] After reviewing whether Medigap Plans C and F should be modified to include nominal cost sharing (rather than cover both the A and B deductibles), the National Association of Insurance Commissioners (NAIC) recommended that "no changes should be made to Plans C and F at this time," and that they did not agree "with the assertion being made by some parties that Medigap is the driver of unnecessary medical care by Medicare beneficiaries." National Association of Insurance Commissioners, *Letter to Health and Human Services Secretary Kathen Sebelius*, December 2012, available at: http://www.naic.org.

Exhibits

Exhibit 1

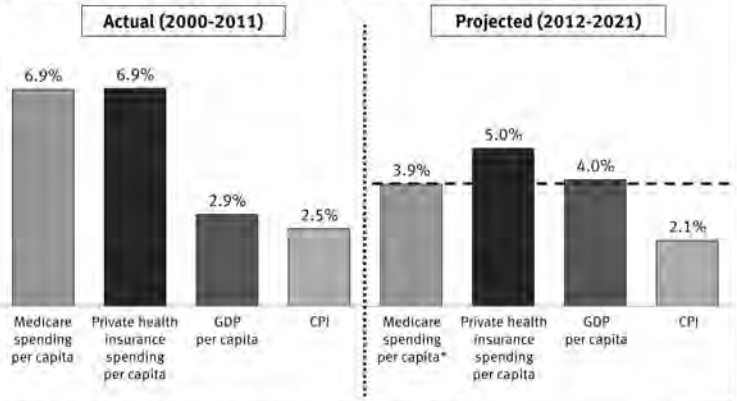
Many Medicare beneficiaries have significant health needs and low incomes



SOURCE: Urban Institute and Kaiser Family Foundation analysis, 2012; Kaiser Family Foundation analysis of the Medicare Current Beneficiary 2009 Cost and Use file.

Exhibit 2

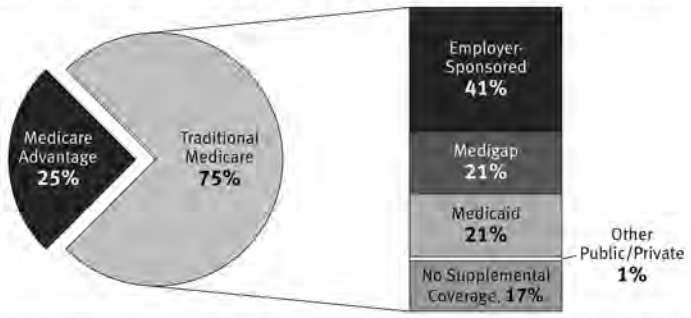
Medicare is projected to grow slower than the economy or private insurance on a per capita basis



NOTE: *Assumes no reduction in physician fees under Medicare between 2012 and 2021.
SOURCES: Kaiser Family Foundation analysis of data from Boards of Trustees, Bureau of Economic Analysis, Congressional Budget Office, Centers for Medicare & Medicaid Services, U.S. Census Bureau.

Exhibit 3

Most beneficiaries in traditional Medicare have some form of supplemental coverage; others are in Medicare Advantage



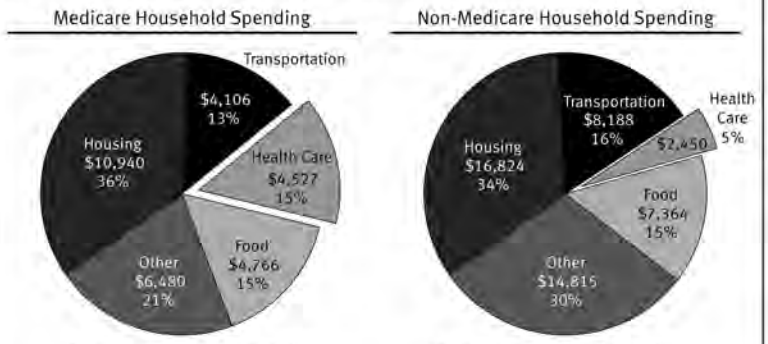
Total Number of Beneficiaries, 2009: **47.2 Million**

Beneficiaries with Traditional Medicare, 2009: **35.4 Million**

NOTE: Numbers do not sum due to rounding. Some Medicare beneficiaries have more than once source of coverage during the year; for example, 2% of all Medicare beneficiaries had both Medicare Advantage and Medigap in 2009. Supplemental Coverage was assigned in the following order: 1) Medicare Advantage, 2) Medicaid, 3) Employer, 4) Medigap, 5) Other public/private coverage, 6) No supplemental coverage; individuals with more than one source of coverage were assigned to the category that appears highest in the ordering.
SOURCE: Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary 2009 Cost and Use file.

Exhibit 4

Health expenses account for a relatively large share of Medicare beneficiaries' household budgets



Average Household Spending = $30,818

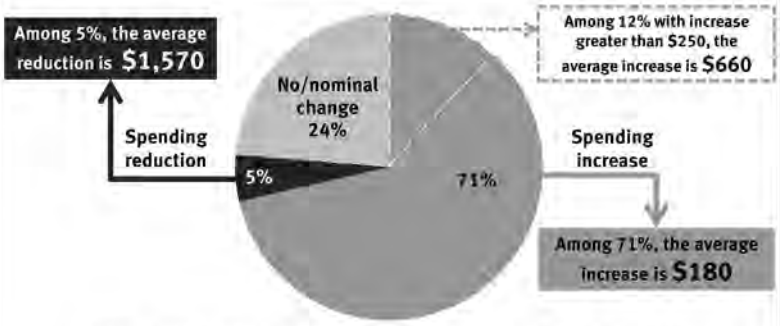
Average Household Spending = $49,641

SOURCE: Kaiser Family Foundation analysis of the Bureau of Labor Statistics Consumer Expenditure Survey Interview and Expense Files, 2010.

Exhibit 5

A small share of Medicare beneficiaries pay less with a restructured benefit design; most would face higher costs

Assumes $550 deductible, 20% coinsurance for all services, $5,500 cost-sharing limit



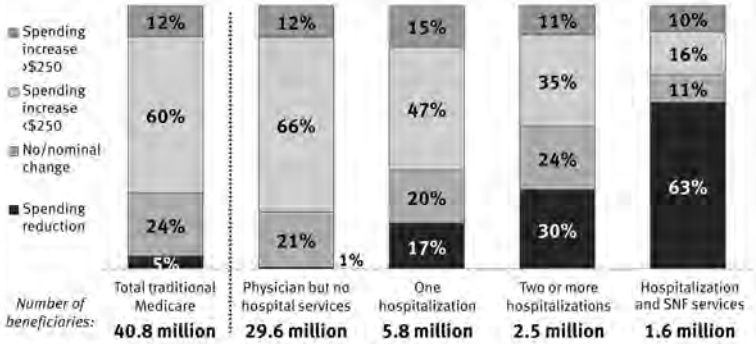
Total beneficiaries in traditional Medicare, 2013 = 40.8 million

SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: Out-of-pocket costs includes premiums and cost-sharing requirements. No/nominal change group includes beneficiaries with changes in spending no more than ±$25.

Exhibit 6

Most beneficiaries using inpatient and SNF care would have lower costs; they account for a small share of the Medicare population

Assumes $550 deductible, 20% coinsurance for all services, $5,500 cost-sharing limit

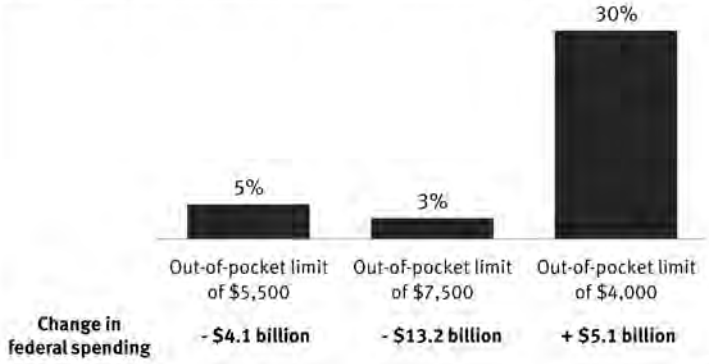


SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: FFS is fee-for-service. SNF is skilled nursing facility. Out-of-pocket spending includes premiums and cost-sharing requirements. No/nominal change group includes beneficiaries with changes in spending no more than ±$25. Users of hospitalization and SNF services are a subset of the 8.2 million beneficiaries with one or more hospitalization. Amounts may not total 100% due to rounding.

Exhibit 7

Share of beneficiaries expected to see a decrease in out-of-pocket spending varies by the level of the out-of-pocket limit

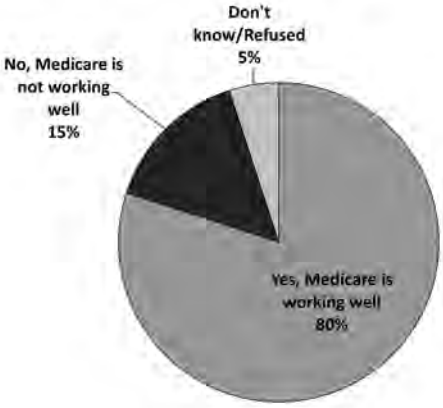
Alternative benefit design, 2013 = $550 deductible, 20% coinsurance for all services, plus out-of-pocket limit



SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.

Exhibit 8

The vast majority of seniors say Medicare is working well



SOURCE: Kaiser Family Foundation/Robert Wood Johnson Foundation/Harvard School of Public Health, The Public's Health Care Agenda for the 113th Congress (conducted January 3-9, 2013)

Chairman BRADY. All three witnesses are very helpful.

Mr. Hackbarth, for seniors listening today, besides just simplifying it and making it less confusing to handle all of the deductibles, copays, everything that goes with that, are the two biggest benefits to modernizing the design that, one, a cap on that out-of-pocket cost so that you sort of have that peace of mind that if you are one of those who hits the high-cost health care, and many seniors do, you know you are limited to what damage that might do? And secondly, looking at copays, which is a fixed dollar amount, versus coinsurance, again on that very expensive health care again, that too many seniors fear, for seniors are those the two biggest benefits of redesigning the system, and how many seniors will be impacted by that over their lifetime?

Mr. HACKBARTH. Yes. Chairman Brady, those are, I think, the two big benefits.

With regard to how many people benefit from catastrophic coverage, it is important to look at that over time. So in any given year, we estimate the number of beneficiaries that exceed $5,000 in out-of-pocket costs is about 6 percent. But if you look at a 4-year time horizon, that number doubles. And obviously, over the duration in Medicare of the typical Medicare beneficiary, the percentage grows and grows over time. So it is important to look at that value not 1 year at a time, but over the course of participation in Medicare.

Chairman BRADY. Yeah. And this is what I want to ask Ms. Neuman. One, I appreciated reading your analysis and testimony. Did you look at—is your analysis done over the lifetime of a Medicare senior or someone on disabilities, again, who is likely to face higher costs over a lifetime?

Ms. NEUMAN. No. We looked at a—we did a 1-year analysis of what the effects would be, and I don't disagree with Mr. Hackbarth. I think for a catastrophic benefit, there would certainly be more people who would benefit from a spending limit over time. Whether they perceive their lifetime risk is a different question, but we did not look at that. We looked at a single year.

Chairman BRADY. Can you do that? And here is why. One, the analysis was very interesting to read, and helpful, but, looking at 1 year of Medicare is like looking at the cost of 1 year of auto insurance, the year you didn't have an accident. Yeah, the price looks pretty high, but spread over time, and the difference here being everyone is likely to get sick. Many are likely to be seriously ill. Most are going to drive up some pretty healthy costs. So while on the front end there may be higher monthly premiums, deductibles, copays, over time that could be a significant savings for a senior. And Kaiser Health Foundation has a great reputation. Would you consider redoing that analysis and looking at it so we could look at a senior's healthcare costs over a longer period?

Ms. NEUMAN. We would certainly be happy to take a look at that.

Chairman BRADY. That would be very helpful. Thank you.

And, Dr. Fendrick, I read your testimony, but it was in four-point type, and so for us old geezers, you might consider making that a little bigger in the future, for those of us who are struggling to read these days.

The design that both encourages the use of value-based—I mean, the services you really need to make sure a senior wouldn't skip health care that they really need, how would you design—as we simplify it and unify it, how would you design it to make sure that we are encouraging seniors into those essential value services? What would be the key ingredient?

Dr. FENDRICK. First off, I would make sure——

Chairman BRADY. Can you hit that microphone?

Dr. FENDRICK. First thing I would recommend, no copayment for you to see your eye doctor so you could read my testimony.

I think the nice thing about the three witnesses, we all agree that the discussion should go beyond how much we spend on Medicare, but instead how well. In this concept of clinical nuances, you mentioned some good services which are highly recommended by professional societies, other organizations, are those that we would immediately identify and have already done in hundreds of organizations in the private sector to say these services are so important that patients should not pay a substantial out-of-pocket for them. As Mr. McDermott mentioned, that is currently the case for preventive services in most public and private plans, and we are, in fact, trying to extend these services for common chronic diseases for doctor visits, diagnostic tests, and drugs that have been identified by professional societies as the things that should be performed. And that would be the basic premise for us to move forward on the carrot side, or the high-value side, of value-based insurance design.

Chairman BRADY. On a scale of 1 to 10, how difficult is it now that—what we know today versus half a century ago?

Dr. FENDRICK. Given that almost all of your expenditures in Medicare are in chronic diseases, and most of those chronic diseases can be lumped into about 14 of them, and the fact that there are guidelines that are evidence based in most of those conditions, I would say that that is fairly straightforward.

Chairman BRADY. All right.

Well, thank you all very, very much. This was helpful.

Dr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman. I don't think—there is general agreement across this dais, I am sure, on the need for catastrophic limit. I don't think that is the question. The question really is, how do you pay for it? Now, we tried once in 1989, and maybe we will do better this time, but that is really the issue here. And, Mr. Hackbarth, I—or Dr. Hackbarth, I guess.

Mr. HACKBARTH. Mr.

Mr. McDERMOTT. Mr., did MedPAC in their looking at this, at the redesign, expect any savings to come out of the redesign of the way the payment was made?

Mr. HACKBARTH. From the redesign of the benefit package, no. As I said in my comments, we think the existing benefit package is not too rich, and so we were looking at a restructuring of the benefit package while holding average beneficiary liability at the current level.

Mr. McDERMOTT. If you shift the cost to beneficiaries, how does that get paid for?

Mr. HACKBARTH. So the other major feature of our proposal was the charge on supplemental insurance. And if you have a charge on supplemental insurance set at about 20 percent, then you generate additional revenues that can be used to either reduce federal spending or to cover additional benefits.

Mr. McDERMOTT. What did you assume was too high a supplemental coverage when you put that 20 percent surcharge on?

Mr. HACKBARTH. Well, we don't say that you can't have a particular type of supplemental coverage.

Mr. McDERMOTT. You could have it——

Mr. HACKBARTH. You could have it——

Mr. McDERMOTT [continuing]. But if you have a certain income, you are going to pay a surcharge? Is that the way it works out?

Mr. HACKBARTH. Yeah. What we modeled was everybody pays a surcharge under supplemental insurance. Then there is the question if you want to provide adequate protection to low income beneficiaries, how do you do that? Rather than having no surcharge, we think the way to do the low income protection is through something like the Qualified Medicare Beneficiary Program.

Mr. McDERMOTT. I remember in the Simpson-Bowles proposal, there was a lot of talk about this whole issue, and they said broad-based entitlement reform should include protections for vulnerable population. So I think it is generally accepted by everyone that whatever manipulation you do, you have to take care of the people at the bottom. Is that fair to say?

Mr. HACKBARTH. Yes.

Mr. McDERMOTT. And it is true that any proposal needs to be packaged with additional financial insurance—assurance for those in need, including not just people at 135 percent of poverty, but up to 200. Would you say?

Mr. HACKBARTH. Well, we have not made any recommendations on exactly where to set that level. Under the Qualified Medicare Beneficiary Program, the level is set at 100 percent of poverty level.

Mr. McDERMOTT. Is that high enough?

Mr. HACKBARTH. Again, if your goal is to protect low income beneficiaries, that number ought to be increased. Now, we do have some additional Medicare savings programs that go a little bit higher, but they are focused on paying the Part B premium as opposed to cost sharing at the point of service.

Mr. McDERMOTT. Ms. Neuman, you are probably aware of the National Association of Insurance Commissioners that reviewed the literature and produced a letter that says that they were unable to find evidence that cost sharing encouraged appropriate use of health care service. Are you aware of that?

Ms. NEUMAN. Yes, I am.

Mr. McDERMOTT. I ask unanimous consent to have that letter put into the record, Mr. Chairman.

Chairman BRADY. Without objection.

[The letter follows:]

NAIC National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

December 19, 2012

Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Ave.
Washington D.C. 20201

Dear Secretary Sebelius,

Pursuant to section 3210 of the Patient Protection and Affordable Care Act (ACA) you have requested the National Association of Insurance Commissioners (NAIC) to review and revise the NAIC Medicare supplement insurance (Medigap) model regulation to include nominal cost sharing in Medigap Plans C and F to encourage the use of appropriate physicians' services under Medicare Part B. Section 3210 directs the NAIC to base these revisions on evidence published in peer-reviewed journals or current examples used by integrated delivery systems.

Consistent with the process established by the Social Security Act for changes to Medigap standards, the NAIC appointed the Medigap PPACA (B) Subgroup (Subgroup) comprised of state insurance regulators, representatives from the Centers for Medicare and Medicaid Services (CMS), insurers and trade associations, consumer advocates, and other experts in the areas of Medicare and Medigap.

The NAIC has performed its requested review of the standards for Plans C and F under Section 3210 of the ACA. We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost sharing designed to encourage the use of appropriate physicians' services. Therefore, our recommendation is that no nominal cost sharing be introduced to Plans C and F. We hope that you will agree with this determination.

Medigap is a product that has served our country's Medicare eligible consumers well for many years, offering them security and financial predictability with regard to their Medicare costs. Medigap's protections are now inappropriately being held responsible for encouraging the overuse of covered services and increasing costs in the Medicare program.

We do not agree with the assertion being made by some parties that Medigap is the driver of unnecessary medical care by Medicare beneficiaries. As you are aware, Medigap plans pay benefits only after Medicare has determined that the services are medically necessary and has paid benefits. Medigap cannot alter Medicare's coverage determination and the assertion that Medigap coverage causes overuse of Medicare services fails to recognize that Medigap coverage is secondary and that only Medicare determines the necessity and appropriateness of medical care utilization and services.

The statute requires the NAIC to base nominal cost sharing revisions on "peer-reviewed journals or current examples of integrated delivery systems". However, the Subgroup discovered that there is a limited amount of relevant peer-reviewed material on this topic. None of the studies provided a basis for the design of nominal cost sharing that would encourage the use of appropriate physicians' services. Many of the studies caution that added cost sharing would result in delayed treatments that could increase Medicare program costs later (e.g., increased expenditures for emergency room visits and hospitalizations) and result in adverse health outcomes for vulnerable

EXECUTIVE OFFICE • 444 North Capitol Street, NW, Suite 701 • Washington, DC 20001-1509 p | 202 471 3990 f | 816 460 7493
CENTRAL OFFICE • 1100 Walnut Street, Suite 1500 • Kansas City, MO 64106-2197 p | 816 842 3600 f | 816 783 8175
CAPITAL MARKETS & INVESTMENT ANALYSIS OFFICE • 48 Wall Street, 6th floor • New York, NY 10005-2906 p | 212 398 9600 f | 212 382 4707
www.naic.org

populations (i.e., elderly, chronically ill and low-income). Most of the studies do not consider the same population of health insurance beneficiaries as those that purchase Medigap products.

The Subgroup also gathered information from integrated delivery systems (Medicare Advantage plans) but concluded that, because these managed care plans make medical necessity determinations for Medicare, any such practices were not directly relevant for Medigap.

Also, as you know, significant new changes to Medigap plan offerings were implemented recently in 2010 which introduced new plans with increased beneficiary cost sharing. Plan M, which requires 50% beneficiary cost sharing on the Medicare Part A deductible, and Plan N, which requires a $20 copay for physician office visits and a $50 copay on emergency room visits, were introduced. We are still learning the impact of these new offerings on both the Medigap market and to the Medicare program.

Therefore, we hope you will agree with our recommendation that no changes should be made to Plans C and F at this time. However, we recognize that you may find that the addition of nominal cost sharing is necessary to implement Section 3210. If that is your decision, please know that the Medigap PPACA (B) Subgroup conducted extensive work in this area and voted on possible areas for revision that should serve as the basis for any further work on the issue, pending your determination on the need for additional action. The findings and work products of the Subgroup, which have not been adopted through the full NAIC process, are publicly available on their web page.

As always, the NAIC stands ready to continue it regulatory role in developing Medicare supplement standards and to assist you in any way possible.

Respectfully submitted,

Kevin M. McCarty
NAIC President
Florida Insurance Commissioner

James J. Donelon
NAIC President-Elect
Louisiana Insurance Commissioner

Adam Hamm
NAIC Vice President
North Dakota Insurance Commissioner

Monica J. Lindeen
NAIC Secretary-Treasurer
Montana Commissioner of Securities & Insurance

Sandy Praeger
Commissioner, Kansas Department of Insurance
Chair, NAIC Health Insurance and Managed Care Committee

Mr. McDERMOTT. What does that mean in terms of using copays as a way of getting people to make decisions about their—I mean, if you are in an automobile accident and the ambulance comes and picks you up, do you shop at that point for which emergency room to go to?

Ms. NEUMAN. Cost sharing can be a blunt instrument. In some cases, for example, in the Part B drug benefit, it is a little bit more straightforward with generics versus brand name drugs. And even at the pharmacy, there is some——

Mr. McDERMOTT. I will give you drug benefit. Now, tell me some——

Ms. NEUMAN. But beyond that——

Mr. McDERMOTT. Give me some other area where people shop——

Ms. NEUMAN. Beyond that point, this is where I was heading, it gets——

Mr. McDERMOTT. Do people shop for artificial knees?

Ms. NEUMAN. I don't think so.

Mr. McDERMOTT. Well, I mean, one of my colleagues just had his knee replaced. Do they go around and ask the doctor, how much do you charge and how much do you charge? And I am going to take the cheaper one?

Ms. NEUMAN. It is generally very difficult for patients to do that, and often patients are motivated to do what their doctors tell them to do. That is why a lot of the work that has been done has been focused more on the providers side to give providers information to drive people to more value-based services, because in theory, the doctors have more information to sift together in order to advise their—advise consumers, so they don't use services that are not needed.

Mr. McDERMOTT. My point is, Mr. Chairman, patients don't shop, they follow what doctors tell them to do.

Chairman BRADY. Hence the problem. Mr. Johnson, you are recognized.

Mr. JOHNSON. Thank you, Mr. Chairman. I would like to follow up on his question, because you didn't answer it. If you break a leg or something and an ambulance comes, you don't have a choice of where to go or what doctor to see, generally speaking. They take you to the emergency room of some close hospital, or the county hospital if it happens to be close by. So how do you explain fixing that charge in Medicare? Any of you. Hackbarth, you have addressed that before.

Mr. HACKBARTH. Yeah. So I agree that when a person is in an automobile accident and they need to go to the emergency room, there is zero opportunity for shop, and nobody is thinking about which emergency room to go to and what the cost is. But there are decisions that beneficiaries make where they do make a decision about whether cost matters or not. For example, a decision about how many times to see a physician, or decisions about some tests. You hear from physicians all the time about patients saying, well, you know, I want the extra test, I want to be really sure. If there is some cost sharing on those decisions, patient decisions change, and so it is at that end of the spectrum, not the catastrophic illness

end. We all agree that we need complete coverage for really sick patients.

Mr. JOHNSON. Well, you know, I just experienced one with a hospital right here in Washington. They ordered some x-rays, and for crying out loud, you go in the x-ray room and they don't x-ray what the doc tells them to x-ray. They x-rayed about 10 or 15 other things, and they are going to charge you for it.

Dr. FENDRICK. If I could——

Mr. JOHNSON. And you are a doctor. Tell me how you avoid that?

Dr. FENDRICK. No. If I may, I think the very important point that is emerging, as Ms. Neuman said, that most of the initiatives that have come out both in the private and public sectors have been how to change how we pay and manage care on the supply side.

I think the important discussion, as we talk about reforming Medicare's benefit design, is to absolutely make sure that the patient and the doctors are aligned and, in fact, there is no conflict. The example, Mr. Johnson, I will give you is as I practice in a medical home, I am given a financial bonus to get my patients' diabetes under control and get their eyes examined. At the same time, cost sharing to get their insulin and to get their eyes examined have gone up. So the important alignment of provider and consumer incentives is critical.

And as a physician I will tell you, the emergency example is one reason why there is no recommendation in value-based insurance design to lower or raise cost sharing, because it is not a patient-sensitive issue, but the decision to get your fourth endoscopy or to see your seventh specialist, I think there are many situations where we could use soft paternalism and cost sharing to get patients to make better informed decisions, to A, get the high value care they need and, maybe more importantly, to cut the 20 percent waste that is driven by reasons that are not really understood.

Mr. JOHNSON. You know, it is kind of hard to get all the docs on the same page all across this country, too, because of the differences in where they live and how they operate. That is a real problem.

You know, Mr. Hackbarth, I appreciate your work to figure out which approach can improve the coordination of care in our fragmented system, but I reject the notion that the bureaucrats in Washington can tell providers how to care for patients, and I am interested in how you think that using payment policies to—reward good outcomes, and how do you approach that system with the docs and hospitals?

Mr. HACKBARTH. Yeah. So our thinking about payment reform, Mr. Johnson, is that we want to put more decision-making authority in the hands of clinicians as opposed to in the hands of bureaucrats. So one payment reform that moves those decisions out, but when you do that, there needs to be accountability for results both on total cost and quality. If we don't have that sort of payment reform, what I fear is increasing intrusion, defining the rules about what qualifies for fee-for-service payment and the like. So I think we are in accord on what the objective should be.

Mr. JOHNSON. Thank you, sir. Thank you, Mr. Chairman.

Chairman BRADY. Great. Thank you, sir. Mr. Thompson is recognized.

Mr. THOMPSON. Thank you, Mr. Chairman. Thank you for holding this very important hearing.

Ms. Neuman, is Medicare really as popular as those of us who go back to our district every weekend hear from our constituents? Do you have data or polling information?

Ms. NEUMAN. Yeah. I mean, our polling shows that Medicare is not only popular with the general—with seniors, but also very popular with the general public. Seniors like the way it works and say it is working well for them.

Mr. THOMPSON. So as complicated as it is, what is it about Medicare that makes it so popular with the general populace as opposed to a big corporate plan?

Ms. NEUMAN. Medicare gives people peace of mind when they get—have a disability or when they get older that they will have most of their health expenses covered.

Now, Medicare, as we have been talking about, has high cost-sharing requirements, but a lot of people have supplemental coverage. A lot of people who are retirees have gotten retiree health benefits from their former employers, others have MediGap, the very low income have Medicaid, so a lot of people have a pretty full package of benefits. That is not to say they don't pay for the services they receive in many instances, but they do have supplemental coverage.

Mr. THOMPSON. Thank you. As we deal with the whole issue of benefit redesign, it seems to me that that is going to—whenever you reform something, you are disrupting the current system, so you are going to have some beneficiaries who end up paying more and some who end up paying less. And I guess my question to all of you is how is that going to be perceived in the beneficiary community? Is it going to disrupt the popularity of Medicare? Will beneficiaries think it is a fair redistribution of the benefit? And we could start with you, Mr. Hackbarth.

Mr. HACKBARTH. Yeah. I think, Mr. Thompson, the commune——

Mr. THOMPSON. I can't hear you.

Mr. HACKBARTH. I am sorry. I think that communication is really important. The nature of insurance is a lot of people pay a little so that a smaller number of people are protected, and so the fact that a redesign might mean that a lot of people pay a little bit more to provide catastrophic coverage for the most seriously ill, that is just basic principles of insurance.

What people don't often take into account is the issue we discussed earlier. Don't think of this on a 1-year basis; think of this on the basis of your full time in Medicare as a beneficiary. The likelihood that you are going to benefit from that back-end protection grows dramatically over the course of your time as a Medicare beneficiary. That is not well understood, and it needs to be communicated.

Dr. FENDRICK. Mr. Thompson, I will just say two things: First, the movement toward free or low cost preventive care, both in public and private programs is universally accepted and one of the most important and well received aspects of healthcare reform.

As we have done focus groups in both commercial populations and in seniors, the idea of explaining to them about this one-size-fits-all system and giving them the comparison as opposed to paying the same for a drug that will save your life as one that is so dangerous, you wouldn't give to your dog, and instead set up a system that will encourage you to get the services that are recommended by their own doctors and their professional societies, and make it a little bit harder to get those services that are recommended by those same societies in an initiative called Choosing Wisely is almost universally accepted.

It is the communication piece that Mr. Hackbarth mentions that is so important in explaining to them the system that does not delineate your benefit design at all on what makes you healthier and what makes you harmful. And you can imagine with the right communications techniques, this is something in our focus groups that is seen almost universally as positive.

Ms. NEUMAN. Mr. Thompson, I think it would be a massive communication effort that would be required. In at least our polling, people, seniors are——

Mr. THOMPSON. To preserve the popularity and——

Ms. NEUMAN. To preserve the popularity of the program with what people perceive to be our increases in cost sharing. You know, for good or for bad, the public is pretty resistant to increases in cost sharing, perhaps because they are sensitive to the costs that seniors are already incurring.

So a catastrophic benefit, while very important for financial protection and would help more people if you look at it over a life span, it may be difficult to convince the public of that in the short term. And I am mindful of the experience of the catastrophic coverage program, which would have provided a catastrophic benefit, but it was a very tough sell and it was a very tough repeal, and despite efforts at communications, it just didn't work out.

Mr. THOMPSON. Thank you.

Mr. HACKBARTH. Could I just mention one other point on this I think may be useful to the committee? What we found in focus groups was that people who are not yet Medicare beneficiaries, may be in their 40s or 50s, early 60s seem to have different attitudes about redesign than current Medicare beneficiaries. The younger people are more receptive to the idea of, oh, I pay a little bit more at the front end in exchange for a better protection at the back end. So that may be something to consider also.

Chairman BRADY. Thank you, sir. Mr. Roskam is recognized.

Mr. ROSKAM. Thank you, Mr. Chairman. You know, I was interested in the exchange, Ms. Neuman, between you and Mr. Thompson a minute ago in that you were describing the popularity of Medicare, which I agree with, but it is sort of the smooth ride as we are going towards the cliff and then, yeah, the road can be smooth and you can't maybe perceive the problem, but 12 years out when insolvency is upon us, that is a stark reality that this committee, I am sure you appreciate, has to deal with. So popularity notwithstanding, there is a real challenge there in terms of the reality.

The other thing was, I sensed from you a little bit of an admonition and a word of caution about a massive effort being required

in terms of large changes, and yet at the very beginning of this hearing, Mr. McDermott pointed out there is going to be a massive effort and we were told to gird up in terms of the calls and so forth into our district offices as it relates to the implementation of the Affordable Care Act. So Congress hasn't shied away in the past from some massive efforts and it is upon us, but I think the reality is that these things are here. So I don't expect a reply, but just a word about the exchange.

Mr. Hackbarth, question. In your testimony, or in your report, you highlighted how a lot of the durable equipment doesn't have a copay, and that is basically a thing of the past. Could you elaborate on that? Or it should be a thing of the past?

Mr. HACKBARTH. Well, durable medical equipment does have a copay under the——

Mr. ROSKAM. I am sorry, home health.

Mr. HACKBARTH. Yes. Home health services is one of the few services under the current benefit that does not have any copay. A year or so ago, we recommended the addition of a copay on home health services. Again, we think part of any fee-for-service insurance program is to have modest, appropriate copays.

Mr. ROSKAM. And what is your hope and your expectation of having that?

Mr. HACKBARTH. Well, you know, we have seen very rapid growth in the number of home health episodes. And we are talking about not people being admitted to home health after hospital admissions, but admissions from the community. And that care is, to some degree, discretionary care, and so we think it is appropriate for the beneficiary to pay some contribution to that so they think carefully about whether this is needed versus other alternatives they might have.

Mr. ROSKAM. A minute ago you were referencing some of the—shifting gears—you were referencing some of the attitudes of younger——

Mr. HACKBARTH. Yes.

Mr. ROSKAM.—future beneficiaries. Could you speak to that? Could you give us a sense of sort of the range of their tolerance for change? The earlier you implement the change, sort of is there an arc to it, is there a science to it? Did you come to any conclusions?

Mr. HACKBARTH. Well, our information is based on focus groups, so it doesn't lend itself to quantifying this dynamic, but it was a pretty clear one that the younger population is used to thinking about these trade-offs, they have experienced change in their employer-based coverage perhaps, where, they have been asked to pay more front end copays in exchange for something else. So it is just more familiar, they are more receptive to it. They don't have the same reflex reaction that some existing beneficiaries might have.

Mr. ROSKAM. Thanks. And then, just another observation. It seems in the discussion that the three of you had a minute ago with Mr. Johnson, you know, there is this feeling that we have got a system essentially where it is very difficult to interact and get answers about price from a consumers point of view.

Dr. Fendrick, you used the phrase "soft paternalism," which makes us all very nervous, and, you know, sounds like slight discomfort during a medical procedure, but there is an inability on the part of a lot of patients to find out just sort of clear information. And we have—all of us are complicit in creating a health care system where asking a physician the cost of the procedure is almost—is a taboo question. And you can imagine going in, hey, doc, what is this going to run me? It is like, well, I don't—I don't know. It is almost as if we have asked, you know, how much does your spouse weigh or something. It is that kind of question. And we are admonished, no, you got to go to talk to the front office. I don't deal with this.

That is unsustainable, and that, I think, is one of the factors that is driving part of our challenge today. And I think that is why I appreciate the chairman having a hearing focused in on redesign with an idea of patient empowerment, setting aside the weaknesses of a market that isn't highly functional in some areas, but is highly functional in others.

And I see the red light, so I will yield back.

Chairman BRADY. Thank you.

Dr. FENDRICK. I will just briefly say that in this issue of deciding about clinical nuance or not, in a typical branded drug copayment system, you pay the same out of pocket for insulin, depression drugs, critically important drugs for health as you would for drugs for allergies and male pattern baldness and other types of things.

And terminology notwithstanding, when we talk to Medicare beneficiaries and ask them do they understand inherently that some physician visits are more important than others, that some medications that they take are more important than others, they universally say yes. And when asked, would you prefer to have your insulin and your depression drugs and your anti-seizure drugs to be lower cost because they are more important, as opposed to the current system that make them lower cost because they are lower cost and even though they might make you healthier, is almost universally accepted.

Chairman BRADY. Right.

Dr. FENDRICK. And I think that is why we have seen clinical nuance in terms of cost sharing recommended by all three of the witnesses and from management and labor and a number of organizations who see that one size fits all is truly archaic.

Chairman BRADY. Thank you, Doctor. Mr. Roskam, my favorite is, "You may feel a pinch with this." That means get ready for searing pain coming your way. Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman. And I want to thank our panelists today. But just to stay on the line of questioning about benefit redesign and greater cost sharing, Ms. Neuman, I think you are exactly right. I think there will be great resistance with current Medicare beneficiaries for any increased cost sharing that might be asked of them. I was taken aback a little bit with the stats that you were reading off at the beginning of your testimony. One half of current Medicare beneficiaries are surviving on $23,000 or less in the system? So to be talking about greater cost sharing with

that population is going to be met with fierce political resistance, I would predict.

And, Mr. Hackbarth, it is not surprising that the younger population might be more amenable to some changes and greater cost sharing or benefit redesign, but they are not the problem. I mean, if we continue to exempt current Medicare beneficiaries to any changes or the 55-and-above population, which is the Baby-Boom generation, we are really not advancing the ball that well and addressing the huge health care cost issue that we face with the budget. So to me it tells me we have got to continue today to move forward on delivery system and payment reform today with the eye towards cost saving while still enhancing quality and not jeopardizing access.

Dr. Fendrick, I understand your laudable goal of trying to drive consumer decisions to more value-based care and less low value care and have a price commensurate with that, but I have always found that the health care field is different. We do have asymmetrical information out there. I think the providers are the experts. I am reasonably astute when it comes to health care decisions, but when I go into a doctor's office, I don't know if I need a CT scan or an MRI and I don't know what the best course of treatment is going to be for me.

So at lot of this is going to have to be provider-driven, which means they are going to need information on what makes and what doesn't work, which brings us back to comparative effectiveness research. Do you think that is something we need to continue to go forward on, doing comparative effectiveness research and driving that into the hands of doctors and patients alike so they know what the most effective treatment option is?

Dr. FENDRICK. So obviously as an academic, I support research that will tell us the services that help patients and the services that harm patients. I think that we have to think very hard about this decision in understanding the asymmetry of information, but it is possible. The enormous popularity of the free preventative services in Medicare and in health care reform justify that.

I think, given the numerous studies that show the large amount of waste in the system, I have to go on record that I would like to see increased cost sharing for harmful care. And if—the initiative called Choosing Wisely, which I mentioned forward, is over 20 medical specialty societies, not bureaucrats, but physicians themselves saying that there are services that individuals should talk with their doctors very carefully about, because the evidence would suggest that not that we are not sure, which I am totally happy leaving the value-based cost sharing outside, but for those services where the evidence is of harm, I do believe that this is a conversation that we—all of the stakeholders are willing to engage in.

Mr. KIND. Well, Dr. Fendrick, I mean, we had some bruising battles, you know, discussing this over the last few years or so, whether it was funding for comparative effectiveness research under the American Recovery Act, under ACA. We actually instituted the Patient Center Outcome Research Institute to help sponsor clinical studies out there so we can get better information into the hands of providers. Do you think that was a good idea to move forward on?

Dr. FENDRICK. Research to answer the tough questions about how to spend our health care dollars are important, both from the private and public sector, but I think, Mr. Kind, what is really important to say is that our own work shows that even in the setting of solid scientific evidence, without the appropriate incentives for both patients and their providers, the best possible care is not provided. There are these no-brainers. You know, we are not talking about in the middle. There are these no-brainers: diabetic eye exams, physical therapy that people don't——

Mr. KIND. Doctor, you got me on that.

Dr. FENDRICK. Okay.

Mr. KIND. I am in complete agreement. This is where we need to be going as far as health care decisions and that, but I am you a little surprised that in the course of today's hearing and the questioning, the R word hasn't been mentioned yet, because we are really talking about rationing. I mean, if you are talking about changing the cost incentives within the system and that and driving people to high value care and away from less value care, that is a form of rationing, which I get, I understand. We need smart rationing within the health care system, because you don't want to be spending money on stuff that doesn't work or leave patients even worse off when they go in.

So I don't think we should be necessarily scared or frightened from that concept, yet it is such a political bludgeon around here. When you start talking about comparative effectiveness research and making smart decisions, suddenly it becomes rationing, and that is a big bugaboo that we can't approach and that.

So, you know, I commend your message and what you have been working on, but there are political minefields that, you know, all this too that I just caution you about.

Dr. FENDRICK. All I will say, is very quickly, is that the option that we have before us is whether the benefit design should be nuanced or not. And if you feel that Medicare beneficiaries should spend equal out-of-pocket amounts for things that hurt them and things that incredibly well benefit them, then I would keep the status quo.

What we have seen both in public and private plans thus far is that people really do prefer a nuanced approach, working from the edges for the things we are really certain on the things that help and the things that harm, and avoid the contentious issues that your committee and the public have dealt with over decades.

Mr. KIND. Okay.

Chairman BRADY. The time has expired. Mr. Price.

Mr. PRICE. Thank you, Mr. Chairman. And I want to thank you, congratulate you on chairing the Health Subcommittee and look forward to working with you, and I want to thank you for this most important hearing today, and I look forward to having many more.

People ought to be sitting up and taking notice as we use terms like "soft paternalism" and "rationing" within almost the same paragraph.

The real question is how does this affect patients? As a physician who took care of patients for over 20 years, I can tell you that when they felt that somebody else was making the decision that potentially adversely affected what their doctor could do for them,

that is when they said that this isn't the system I want to participate in. We need to be very, very careful in what direction we head.

The home health was talked about, I think, by Mr. Roskam. The current design of a new benefits package for home health is now in phase 2 by CMS. And I would suggest to you that it is harming patients, making access to home health care more difficult for patients. Is it going to cost less? Yeah. You know, we will pound our chests up here and say how wonderful it is because it costs less, but it is hurting people. And that is the challenge that we have, is to design a system that doesn't hurt people.

So then you have to ask the question, okay, well, who is going to decide whether it hurts or not? And that is where the whole issue of one-size-fits-all really gets to the heart of the issue.

Dr. Fendrick, you talked about the current system being one-size-fits-all, and it is. Do you have any concern that we trade one one-size-fits-all system that doesn't necessarily work for everybody for another one-size-fits-all system that doesn't necessarily work for everybody but may work better for government?

Dr. FENDRICK. My consideration is the Medicare beneficiary. And I look at exorbitant amounts, billions of dollars that could be spent on services that would improve the quality and length of life of those beneficiaries that are instead being wasted on things for which medical societies say harm patients.

So I understand that there are issues and challenges, but all I can tell you, the popularity among patients and physicians to see cost sharing removed for services that save lives, whether they be preventive services or management of chronic diseases, seems to me like something that we move forward in. And almost all the implementations thus far of clinically-nuanced benefit designs have been around subsidies of high value services. Because most high value services, as you well know, tend to increase costs in the short term instead of lower them, the fiscal pressures that we have confronted has required us to look at not just the motivation for me to get into this is to make the high value services more accessible to patients and their providers, but also understand this waste problem. And it is MedPAC and other organizations that continue to tell us the billions of dollars that are spent on harmful care.

And I think as—having some fiscal responsibility, we need to understand that we could reallocate these funds, maybe not perfectly, but in a better way than we currently are with no clinical oversight.

Mr. PRICE. Let's talk about the patient that we come up with this grand design for a new benefits package for folks and a system that is going to work better than the current system, and we say to our senior population, you have got to see do this, should there be any flexibility in that? Should a senior be allowed to, I don't know, opt out of that system?

Dr. FENDRICK. You are the legislator, I am not. All I am going to say is another——

Mr. PRICE. No. For the patient. You are talking about the patient.

Dr. FENDRICK. I think the important point that I may have glossed over is that these type of benefit designs never decide what is covered and what is not. And for you as a physician as well as

a congressman know that there is a multiplicity of small print in cost sharing, both in Medicare as well as in private plans. So this idea of confusion is going on already. And my simple point is instead of using profits or the cost of a service to generate how often it is done, that we think about taking advantage of the points that were made by a number of you moving from volume to value, and value must include clinical nuance.

Mr. PRICE. My time is short, but the concern that many of us have is that value is quality over cost. And quality is in the eye of the beholder, so what is quality for you as a patient, what is quality for me as a patient or another patient may be something completely different. That is not to say that there ought not be comparative effectiveness research, because there ought to be. As scientists, we all understand that you have got to—that you want to know the best thing to do for a patient. But at the end of the day, it is patients and families and doctors that ought to be making these decisions about what kind of care they receive, and not anybody else.

Dr. FENDRICK. I agree.

Mr. PRICE. Yield back.

Chairman BRADY. Thank you, sir. Mr. Blumenauer.

Mr. BLUMENAUER. Thank you. I find this very interesting and very helpful. I guess my concern is that we have a situation that too often it is not so much dictating services, we have a system where nobody decides, where we kind of are a captive of the original program design, add-ons that continue. I don't know about soft paternalism or hard paternalism like just cutting you off with money, or just going along till we run out, or somebody figures out how to game the system. And what I hear you saying is there may be some ways that we can do a better job of incenting everybody to make the right decisions, and I am comfortable with that.

We have had experience on this committee where people would not agree to allow the results of comparative effectiveness research to be used in determining how much the government is going to pay for what. Seems kind of goofy, but that is the political process. And the complexity that some people want is just going to add costs and water down the ability to deliver overall high quality service, which is, I think, in microcosm, why we pay more than anybody else in the world for results that are mediocre on average. And so I am intrigued with the—Mr. Chairman, with your bringing the witnesses here and for us to think about benefit structure and how it impacts it.

I want to just go back to something, Dr. Fendrick, you had when you talked about infusing clinical nuance into Medicare Advantage. That was the bold print that was 6-point type. But I wonder, Mr. Hackbarth, I don't think you referred to Medicare Advantage in your testimony. Would you react to that for a moment? I mean, this is kind of a grand experiment that we have had. We have found out that not all Medicare Advantage programs are equal. Some are hopeless rip-offs, where we found some people who figured out how to game the system. We had in the Affordable Care Act some incentives to try and reward better programs, and we are slightly ratcheting down the premium.

I am old enough to remember when Medicare Advantage was supposed to deliver the same quality and quantity of health care and it was supposed to be able to do so for 5 percent less, using the magic of private sector and unshackling. Didn't quite work out that way, but we are ramping down the subsidy and we are seeing, at least the conversations I am having, that some people are starting to take advantage of that platform.

But can you speak to ways from MedPAC that Medicare Advantage might be an area where we could make some adjustments to inject a little more nuance into the program and not sacrifice either quality or, again, lose cost control?

Mr. HACKBARTH. Yeah. We think that Medicare Advantage, offering a choice of private plans to the Medicare beneficiary is an important part of patient engagement. So beneficiaries ought to be able to go in that direction if they wish.

We do think that private plans have the opportunity to do some things that traditional Medicare finds difficult to do; for example, identify high value providers and steering beneficiaries to those providers, which is one of the points that Dr. Fendrick made. The regulations, we need to look at those regulations, make sure that they provide appropriate flexibility to private plans to identify high value providers. Similarly, they need to have appropriate discretion to vary the benefit structure.

So recently one of our recommendations was that rather than having chronic care SNPs, special needs plans, that are focused on particular chronic illnesses, what we ought to be doing is give all Medicare Advantage plans the opportunity to adjust their benefits for diabetics versus asthmatics versus patients with cardiovascular problems. And, again, I think that is something that Dr. Fendrick recommended.

Mr. BLUMENAUER. Thank you very much. Thank you, Mr. Chairman.

Chairman BRADY. Thank you. Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman. And thank you to our witnesses here today.

Dr. Fendrick, I know you are obviously well studied on a lot of things relating to Medicare Advantage and current limitations. Would you have specific recommendations on how to break down some of the barriers to flexibility perhaps that would end up improving care?

Dr. FENDRICK. I do. And I would just add on to what Mr. Hackbarth just said. I think they come into two most elemental buckets; is the first, the ability to allow the flexibility in MA plans to alter cost sharing, depending on the provider that chooses or where that is done. An example might be, for instance, a highly recommended service for individuals over 50 is colonoscopy. You could get a colonoscopy in a number of settings, as shown in the Pacific Northwest, at a cost between $700 and $7,000. And I think to be able—in those situations, when most people do believe that colonoscopy is performed at reasonable, same quality in most places, that you might wants to encourage people to go to the lower cost centers that provide the same quality as those that are high.

So provider and venue is the first, but the second and most important is this issue of allowing Medicare Advantage to alter cost

sharing for specific services based on clinical information. And to follow up on what Mr. Hackbarth said, I think that one of the easier things to say, given the comments about the size of my testimony type, is the recommendation of a diabetic to see an eye professional on an annual basis.

In Medicare Advantage, their current abilities now are to make eye exams either low cost or high cost regardless of your clinical condition. I would like to see a plan that offers annual low cost eye exams to diabetics but not offer that same benefit design for someone without that condition.

Mr. SMITH. Ms. Neuman.

Ms. NEUMAN. Medicare Advantage really could be an opportunity to learn more about benefit design changes that are being talked about today, because plans do have flexibility, not quite as much as might work, but there could be opportunities to learn more, and it may be something—the committee might want to consider perhaps giving the highly rated plans greater flexibility to modify the benefit design and use that as a learning opportunity to see what changes drive people to high value services and perhaps lower costs for the program.

Mr. SMITH. Sure. And I realize that, you know, the term "flexibility" is very vague and oftentimes even misunderstood, but the fact is representing a rural constituency, I know that things are done differently in rural America, and oftentimes more efficiently, but, you know, a supply of health care means mere access in rural areas and it means more competition in urban areas. And so in trying to balance many of those things, I was wondering if, Chairman Hackbarth, if you could reflect a bit on the impact to rural communities, rural health care in terms of, you know, recognizing some of those differences that are out there.

I mean, it amazes me how we empower medical professionals to make very intricate decisions based on their expertise, and yet in other areas of health care, we don't allow the judgment to be utilized of the very same medical professions.

Mr. HACKBARTH. So you are talking, Mr. Smith, more broadly about Medicare as opposed to just within Medicare benefit design——

Mr. SMITH. Right.

Mr. HACKBARTH.—how do we—Well, as you well know, Medicare has a large number of special provisions related to rural providers. It tries to address the particular, the unique needs of rural providers, for example, ensuring access to care for beneficiaries in isolated areas through the Critical Access Hospital Program.

One of the areas that we have started to look into a little bit, based on the interest of one of our commissioners who practices in South Dakota, is that medical professionals and staff are used differently in isolated rural facilities than they may be in an urban facility. And——

Mr. SMITH. And it would seem to me that oftentimes that is undermined given a one-size-fits-all approach coming from Washington.

Mr. HACKBARTH. Exactly. So I think that is one area to look at, and we have just begun to pay some attention to that, but we need to make adjustments to accommodate the unique cir-

cumstances that exist in, say, an isolated rural hospital and how they configure their staff and how they make decisions.

Mr. SMITH. Okay. Thank you. And, Mr. Chairman, I yield back.

Chairman BRADY. Thank you. Mr. Pascrell.

Mr. PASCRELL. Thank you, Mr. Chairman. Ms. Neuman, can I just get a clarification, if I may, on policy and demographics, particularly on the issue of home health copays? Who are these people?

Ms. NEUMAN. People who use home health services tend to be old, frail women. These are the oldest, the frailest that Medicare——

Mr. PASCRELL. The most vulnerable?

Ms. NEUMAN. Yes, sir.

Mr. PASCRELL. Would you use that word?

Ms. NEUMAN. Yes. I think that is fair.

Mr. PASCRELL. Okay. Look, you have heard it many times: health care reform is entitlement reform. You may not agree with it, some folks here. Not only did it reduce costs for Medicare, but it also reduced costs for beneficiaries. That is what we know.

The attempts to repeal reform and turn Medicare into some kind of other program will hurt the beneficiaries, that is my conclusion, because they have to pay more money out of their pocket. That has to be clarified. So I am not going to be disillusioned about the kinds of income seniors make. You mentioned in your testimony that the beneficiaries have an average income of close to $23,000, below $23,000, actually. They already spend 15 percent of their incomes on health care. And when you add that into how many people are living on their Social Security check and how that is increased over the last 10 years, paying more out of pocket is just not an option for many of our seniors. Would you agree with that?

Ms. NEUMAN. I would. And I want to come back to Mr. Hackbarth's comment when he talked about expanding coverage for the low income population and doing that in a targeted way. You know, while some with very low incomes do qualify for Medicaid, many low income Medicare beneficiaries are not on Medicaid——

Mr. PASCRELL. That is right.

Ms. NEUMAN [continuing]. Either because they are not eligible based on their assets or their income, but there are many people who would feel directly any change in cost sharing. So a lot of the proposals have talked about protecting the low income, but more work needs to be done on how that would be done and what vehicle would be used and who be helped.

Mr. PASCRELL. Now, your organization, the Kaiser Foundation, found that 70 percent of Americans prefer Medicare's guarantied benefits to any other kind of plan. I think that it provides a clear picture of how our Nation values the program. The average Medicare beneficiary has an annual income of $22,500.

So, Ms. Neuman, can you talk about these higher rates to some seniors that they have to pay disproportionate or whatever as you concluded?

Ms. NEUMAN. Well, there are certainly some people on Medicare who are wealthy by standards that——

Mr. PASCRELL. Right.

Ms. NEUMAN [continuing]. Generally would be considered wealthy, but only 5 percent of people on the program have incomes of $85,000 or more. So for people with modest incomes, an increase in out-of-pocket costs would be a real issue.

And what the research has shown is that it is people with lower incomes and people in poorer health who are disproportionately affected by increases in cost sharing, because higher people can probably absorb to pay more if it is worth to them.

Mr. PASCRELL. Or possibly leave the program. You may raise the rates on those higher income seniors, which is a relative term when we look at what they are making, they may move—leave the program altogether. What is that going to result in?

Ms. NEUMAN. Well, the issue there, I think, has to do with the Part B and Part D premiums——

Mr. PASCRELL. Right.

Ms. NEUMAN [continuing]. And the income-related premiums. And already today, people with higher incomes are paying higher premiums, and there is some discussion about expanding income premiums to cover more people.

Mr. PASCRELL. What do you think about that?

Ms. NEUMAN. What do I think about that? Well, I think, you know, the public certainly prefers to ask higher people to pay more than everybody else, but depending on what the policy looks like, it could scale back and start to hit middle income people.

Mr. PASCRELL. But when you talk about higher income, that is a relative term in terms of the seniors that we are talking about who are very vulnerable. It is a different kind of situation than we are talking about when we refer to our tax policies, general tax policies. It is a very different situation altogether.

We need to be very careful here about who we are helping and then what are the consequences of helping a few, and many people getting really hurt. So thank you, Ms. Neuman, for your testimony.

Ms. NEUMAN. Thank you.

Mr. PASCRELL. Thank you, Mr. Chairman.

Chairman BRADY. Thank you. Ms. Schwartz.

Ms. SCHWARTZ. Thank you. And I appreciate the invitation of the chairman to join you on this important discussion. And I do have to say, I have had some of these discussions a bit about redesign, benefits redesign, and I appreciate some of the work that you have done on this. And actually, the notion of simplifying the way we actually do this to make it more understandable is certainly important to include beneficiaries in this really very important debate we have about making sure that seniors have access to the benefits that they expect and they need, and doing it in the right way.

Everyone knows that I have done a lot of work on redesign of the way we pay physicians and providers as key to this, and potentially I think maybe more important, because as we have all heard this morning, it really is very much in the—if your doctor recommends it, you are sort of inclined to do it, and you should be, and the potential of having copays get in the way of necessary services, something that many of us are very concerned about, and yet the—and you talked about it earlier, we have to protect poorer seniors so that they actually don't—so they are able to get the care they need. And maybe $50 a copay is enough to say, I can't get it now. And

I am sure, Doctor, you have seen that. That we want to protect primary care. We have talked about already doing that; that we want to protect access to care of chronic—those with chronic diseases so they don't get sicker; that we also want to protect the sickest.

So we are starting to include a whole lot of seniors in this. We are narrowing the window of who we are actually asking to pay more.

So really my question and the real discussion I would want to have is how we really don't pay doctors to sit down and really talk to their patients about what they shouldn't get. I mean, I think Dr. Price said let's not get in the way of the doctor-patient relationship, but right now there is somewhat of an incentive to say, here is a prescription, because that is quicker than the conversation about, you know, you really don't have to take this and you can call me in 3 days if you are not better, than just giving them a prescription, which they may or may not fill, of course, or some of the other—or go have this test, and somebody might come in and say, I heard that it is really important for me to get an EKG every month.

Now, I don't know if that is true or not. I just made it up. I am not a physician. But, you know—but, in fact, maybe that is not such a necessary thing, and it may not be harmful, but it certainly is a cost to all of us. But taking time to say, no, here are the things that you ought to do instead of having these extra tests really does take more time.

So we don't reimburse very well, except under patients in medical homes to do that, but can you speak to how important it is for patients to, yes, take some responsibility in this and not demanding more from their doctors than they necessarily need, but for that communication between the doctor and patients, and for us to incentivize providers to take that time to really provide what is important and necessary, not more than important.

And right now, while Dr. Price will say, you know, one size doesn't fit all, right now we pay for everything, more or less, and that is what you are sort of trying to get to: how can we get the doctor and patient to actually engage in that conversation when in fact it is very difficult for patients to really know whether, in fact, they are asking for more than what is appropriate or less than is appropriate. It really is very much on the part of the provider.

I believe strongly we should pay providers differently under this, under Medicare, and we ought to do it, but could you speak to that, about whether we—the risk of redesign of benefits really putting the burden on beneficiaries who really have a difficulty making this judgment and really need that relationship with their provider, it may be a doctor, may be a nurse practitioner, and really having the information not just about a cost, but really more about the appropriateness of services and the utilization, excessive utilization potentially of some services.

And maybe, Mr. Hackbarth, do you want to start with that?

Mr. HACKBARTH. Sure. So I want to emphasize that we think that it isn't enough just to reform the Medicare benefit package. You also need to reform how physicians and other providers are paid.

Ms. SCHWARTZ. Yes.

Mr. HACKBARTH. And one dimension of that——

Ms. SCHWARTZ. Maybe first, even? I mean, do you think one comes before the other?

Mr. HACKBARTH. I think it has to happen simultaneously. I wouldn't put an order on it. And one dimension of that you have touched on, Ms. Schwartz, which is we need to pay physicians for communicating with patients. And there have been some positive developments in that recently. Some new codes have been added for transitional care, a big part of which is communication with patients as they make a very difficult transition from a hospital admission to the community. So I think that is a very important complement to this.

Other approaches you have alluded to are like medical home, where we are not even using the fee-for-service payment model exclusively, we are adding additional payments. They go hand in hand. It is not either/or, it is both are required.

Ms. SCHWARTZ. Okay. Thank you. Do we have time for others to comment?

Dr. FENDRICK. Yes. Briefly I will just say that the most important part is that we make sure that whatever is happening with the incentives on the physician side and the provider side, they must be aligned with the consumer side, because what I see in both the public and private programs, often they are in parallel, but often moving in the wrong direction.

Conceptually, though, speaking about it from the patient side, cost sharing is an insurance tool to encourage beneficiaries to think twice or thrice about things they may not need. So when we think about home care or hospitalizations or visits, it requires me to pause and think why would there be cost sharing on something that is absolutely essential for the patient's health, which is the entire motivation for clinical nuance.

So thus, I would like to close where I started, is that, I do believe that cost sharing has a role in Medicare and I think cost sharing should have a substantial role on those services that don't make beneficiaries any healthier.

Ms. SCHWARTZ. Well, it seems to me we have a fairly high threshold on what is harmful or not. I mean, right now it is not absolutely clear, we don't have all the information——

Dr. FENDRICK. I will just say——

Ms. SCHWARTZ.—about what is actually too much or——

Dr. FENDRICK. Very quickly, and why to the chairman's credit, this initiative called Choosing Wisely, which I suggest the staff learn about, is a physician-specialty society motivated initiative to identify services that may be overused. So this is a very important step not only for us to identify the services that we should make less expensive for which the evidence is strong, we also now have a physician-driven movement to identify those services that we may do less of.

Ms. SCHWARTZ. I agree that is important.

Chairman BRADY. Thank you. Dr. McDermott has asked for a question, and he is recognized.

Mr. McDERMOTT. Thank you, Mr. Chairman. And I want to say I have appreciated your slow gavel so that we could allow the witnesses to finish what they have to say, and I think the committee

is really interested in what happens. And one of the issues that I would like to ask a further question about is the whole question that you just raised, Dr. Fendrick, and beyond that, I would like for the committee, that you would submit to us, all of you, if you have it, evidence that backs up the theory that people go to the doctor more often than they need to, and if we put a copay on, they won't go.

And I want to give you an example to let you—and there are thousands of examples. Everybody who is anticoagulated, who is on Heparin or on Coumadin is supposed to go back in to the doctor and get a checkup as to whether they are at the proper level, too high or too low or just right. There are problems on being too high, there are problems on being too low. The patient has no sense of what that is. They don't feel anything particularly until they have got a problem.

So the idea that I have to pay $10 to go back in and put my finger out and have it stuck and have them then read it on a machine and tell me, yep, you are right in the right place, when I didn't feel anything, why would I do it if it is going to cost me 10 bucks?

And so what I am looking for is how you think you can design, and is there any evidence, is there any across-the-board—same way with—the Time magazine this month has tuberculosis on the front page. And taking pills, in my experience personally, and I think probably for everybody in this room, you take pills when you feel bad; when you don't feel bad, you stop taking them, whether the doctor said you should take all 10 days doesn't make any difference. Every drug cabinet in every bathroom in this country has half finished ten packs, or Z-Paks.

So what I am getting at is how do you—where is the evidence that people go to the doctor just because they don't have anything to do on Wednesday afternoon? That is really what I am looking at.

Dr. FENDRICK. I will just start briefly by, your comment basically hits the essence of clinical nuance, that someone on Warfarin must be not only be discouraged, but must be encouraged to follow the protocol to maximize the health of that beneficiary. I am not so sure that someone not on Warfarin should have the same ability to go to see the doctor to have their blood checked to see how thin their blood is. And that is, as I said, the essence of clinical nuance.

There is a lot of evidence that we are happy to supply to the committee, but one of the best examples in Medicare is The New England Journal of Medicine paper examining the impact of increases in cost sharing on ambulatory visits in Medicare Advantage.

As you might expect, Mr. McDermott, beneficiaries went to the doctor less often. Those beneficiaries who went to the doctor less often, went to the ER more and were hospitalized more, and, in fact, total costs went up, which is why our proposal is that primary care visits in Medicare Advantage and in Medicare should be free.

Now, there are other services actually where the money is, as Mr. Hackbarth knows better than anyone. It is not in primary care visits and it is not in prevention. It is in hospitalizations and the management of chronic diseases, for which—to respond to the chairman's question earlier, for those chronic diseases, we are fair-

ly certain in the services that should be encouraged for which cost sharing should be minimal or not at all.

Mr. HACKBARTH. So what I would highlight, Mr. McDermott, is the importance of doing both payment reform and appropriate cost sharing for patients. So one piece of evidence that we have that is relevant to your question is the prevalence of repeat testing of various types. There is a lot of it, a lot of it that exceeds all clinical guidelines, and there is huge variation across the health care system. Probably the most important reason for that is not patients demanding repeat testing, but physicians have incentives to do repeat testing. We need to change that, but when we change the physician incentive and they say, oh, well, maybe you don't need to be tested so often, you don't need so many return visits, we want the patient also to be aligned with that. We don't want the patient to say, well, I like the old pattern of, you know, I am going to come every month or every 2 months, whatever. If there is a modest appropriate copay, then the physician and patient are talking the same language.

I believe physicians care about their patients and will modify the recommendations if the patient has some cost sharing involved, and will recommend things differently than if it is absolutely free to the patient.

Ms. NEUMAN. Well, I would agree that there is a lot of evidence on the side that says if you increase cost sharing, it has an effect on utilization. I don't know about the evidence on decreasing utilization and whether there is, for example, too much of preventative services. And that might be something that one could take a look at, but it would be hard to imagine an effect like that in the literature, but we could take a look at it.

I also agree on areas of where there is evidence of overutilization, there are a number of ways to attack the issue, one of which is cost sharing. And even then, in the example of home health, there are different ways of doing that that would have different effects on people depending on how—whether it is, for example, a copayment or a co-insurance, which would disproportionately affect the sickest of the sick. But if the issue is that there are too many people using too many services, then I would also agree on going at it, going around and going at the provider side, the supplier side and think about how to make changes that would slow the growth in this benefit without necessarily asking beneficiaries to parse out whether or not they need a service that their doctor has told them they needed.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman BRADY. No. Thank you. I would like to thank all of our witnesses for their testimony today. Obviously there is a—the current structure of Medicare benefit design needs a hard look at, has its challenges. I hope we continue to work together in a bipartisan way, to explore how we can try to limit those out-of-pocket costs, make a little more rational sense out of the design, but just as Mr. Hackbarth has asked Ms. Neuman,—go back, and I will send a letter to this effect, take a look at again the changes of the design over the life of a Medicare senior I think is very important.

The other area, we sort of looked at one side of the ledger, okay, if you unify, A and B it may raise costs and some others, but what

we didn't explore is what is the impact of MediGap, you know, do you need it? Does it have a different side? Does it carry a different cost that offset some of that? Any information any of you all have to that regard would be very helpful.

As a reminder, any member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted to the witnesses, I request you answer them as promptly as possible, please.

With that, the subcommittee is adjourned.

[Whereupon, at 12:02 p.m., the subcommittee was adjourned.]

[Submissions for the record follow:]

Letter of the AARP

February 26, 2013

The Honorable Kevin Brady
Chairman
Ways & Means Subcommittee on Health
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member
Ways & Means Subcommittee on Health
Washington, D.C. 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of AARP's 37 million members and the millions of Americans with Medicare, thank you for holding a hearing to examine traditional Medicare's benefit design. Medicare continues to play a vital role in the health and financial security of older Americans. We have long recognized the need to strengthen and improve the program and appreciate that the committee is considering ways to do so. As Congress considers various proposals, we urge you to examine all the potential ramifications on beneficiary out-of-pocket spending, access to needed care, and total costs to the health care system.

As you know, the current Medicare fee-for-service (FFS) benefit structure requires beneficiaries to meet separate annual deductibles for Part A (hospital insurance) and Part B (medical insurance, including physician visits) services. For 2013, the Part A deductible is $1,184 and the Part B deductible is $147 respectively. After meeting the deductibles, a beneficiary faces wide variation in coinsurance, depending on the type of service he or she receives. For example, in Part A, a beneficiary pays for a daily rate if she requires more than 60 days in an inpatient hospital, and she pays a daily coinsurance starting on the 21st day in a skilled nursing facility (SNF). In Part B, a beneficiary pays for 20 percent of the cost of care except for home health services and some preventative care services, which are fully paid by Medicare.

There are notable gaps in current Medicare benefits, including the lack of a catastrophic cap and coverage for certain essential health benefits. In recent years, the creation of the Medicare Part D drug benefit in 2006 and the phasing out of the coverage gap, or "doughnut hole", in Part D – as required by the Affordable Care Act – have been major improvements. Yet, even with these improvements, out-of-pocket costs still remain a great burden for many Medicare beneficiaries. Analysis by AARP's Public Policy Institute finds that at least 50 percent of Medicare beneficiaries – who have incomes of roughly $20,000 – spent $3,100 on health care expenses, or nearly 17 percent of income, in 2007 (the most recent year for which Medicare Current Beneficiary Survey data were available). Ten percent of beneficiaries spend over $7,800 on health care costs.[1] The report also finds that out-of-pocket spending is higher for older and poorer beneficiaries: spending increases to over 20 percent of their income on health care.

[1] C Noel-Miller, "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care", AARP Public Policy Institute, Washington, DC, May 2012. Includes spending for Medicare and supplemental premiums, and for medical services and some long-term services and supports.
http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-beneficiaries-out-of-pocket-spending-AARP-ppi-health.pdf

Without an out-of-pocket cap, the traditional Medicare program currently leaves beneficiaries at risk for significant cost-sharing if they become seriously ill or need to manage chronic health conditions. No other public or private health insurance plan imposes the same level of risk on their participants: these plans generally limit the amount of cost-sharing that participants have to pay in a year or a lifetime. As a consequence, most Medicare beneficiaries rely upon other supplemental insurance to avoid the potential risk of significant out-of-pocket costs (e.g. employer-provided retiree health and Medigap) or rely on Medicaid. Not all beneficiaries have supplemental insurance coverage, however. About 4 million beneficiaries (8%) have no additional coverage, and potentially face significant health care expenses should they become seriously ill.

Since the enactment of the Medicare program, health care has changed significantly. Prescription drug treatments have grown substantially in importance, and technology has provided a range of new treatment interventions. Further, more treatments are provided on an outpatient basis and the cost of health care has grown dramatically. Reexamining the Medicare benefit package to evaluate options to better serve the health care needs of beneficiaries, maintain the affordability of the program, and improve program efficiency is an important goal.

In exploring any Medicare redesign, AARP believes that it is essential to look at any proposed changes from the perspective of beneficiaries, not just from the perspective of a budget score. Most beneficiaries already struggle to make ends meet, and are particularly sensitive to the high cost of health care and prescription drugs. An examination of Medicare redesign must take into account the economic status of seniors, as well as evaluate how benefit changes will interact with other potential changes to the Medicare program.

In addition, any redesign of Medicare cost-sharing will potentially affect various groups of Medicare beneficiaries differently. All too often, proposals are evaluated as if all beneficiaries are identical. In fact, they are not and they will be affected differentially. The impact will depend on the types of services they use, the intensity of their use, whether and what type of supplemental coverage they have, and their income. Those without supplemental coverage will be most directly impacted by increases in cost sharing. Research shows that individuals, particularly those who are sicker and poorer, react to higher cost sharing by avoiding or delaying use of health care services, including necessary care. In particular, this would apply to services that currently require no coinsurance or limited coinsurance, such as inpatient hospital services or hospice. The avoidance of needed care could lead to a faster or more serious decline in health, which not only has adverse consequences for the beneficiary, but potentially could end up costing the health care system more.

Beyond the immediate impact on beneficiary out-of-pocket costs, redesigning the Medicare benefit will have several other implications:

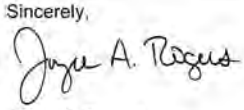
- Depending upon the new cost sharing design, other types of supplemental coverage (e.g., Medigap, TRICARE, VA) will also be affected. It will be important to analyze the interaction of multiple policy changes.
- State Medicaid programs could incur added liability for cost sharing of dually eligible beneficiaries.
- Employer plans that contribute towards the cost of retiree health insurance, which is the most prevalent form of supplemental coverage, could also see added liability.
- A catastrophic cap would put an annual limit on Parts A and B, but would likely be separate from the catastrophic coverage in Part D, and may not apply at all to non-Medicare costs, such as dental, hearing, vision and long term care.

Finally, Congress must consider Medicare benefit redesign in the context of broader reforms to the health care system. Even though redesigning the Medicare benefit package may reduce federal Medicare expenditures, it is likely to result in merely cost-shifting to beneficiaries and other payers,

and do little or nothing to reduce overall health care spending. In fact, Medicare spending growth is already moderating. According to the Congressional Budget Office, from 2007 to 2012, Medicare spending growth has averaged only 1.9 percent per year. In February 2013, the CBO reduced its estimate of projected 2013-2022 spending for the Medicare programs by about $143 billion. Moreover, Medicare spending increased only 0.4 percent per beneficiary in 2012; substantially below the growth in GDP of 3.4 percent per capita. With the rate of Medicare growth stabilizing, to focus solely on Medicare benefits to achieve health care savings misses the larger drivers of health care costs throughout the health care system.

Again, we thank you for holding a hearing to explore Medicare benefit redesign. Medicare reform should be done cautiously and deliberatively, in an effort to minimize impacting the beneficiaries who rely on the program for their health and financial security. If you have any questions, please feel free to call me, or have your staff contact Ariel Gonzalez of our Government Affairs staff at agonzalez@aarp.org or 202-434-3770.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

Statement of the AFL–CIO

Cover Sheet / Written Testimony

Hearing Title: Examining Traditional Medicare's Benefit Design

Attribute statement to: American Federation of Labor and Congress of Industrial Organizations (AFL-CIO)

Submitted by:
Tom Leibfried, Legislative Representative
American Federation of Labor and Congress of Industrial Organizations (AFL-CIO)
815 16th St. NW / Washington, DC 20006
(202) 637-5121
TLeibfried@aflcio.org

Statement

American Federation of Labor and Congress of Industrial Organizations

Subcommittee on Health of the House Ways and Means Committee

Examining Traditional Medicare's Benefit Design

February 26, 2013

We thank Chairman Brady, Ranking Member McDermott, and the members of the committee for the opportunity to submit this statement for the hearing titled, "Examining Traditional Medicare's Benefit Design." The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) is the nation's largest labor federation, representing more than 12.2 million workers, and we believe that it is important to discuss the adequacy of Medicare's benefit design.

Medicare plays a crucial role in preserving the middle class and lifting working families out of poverty. Before it was enacted in 1965, about half of all older adults did not have hospital insurance[1] and close to three-in-10 lived in poverty.[2] Now, health coverage for seniors is almost universal, and Medicare's support for their financial security has combined with improvements in Social Security benefits to decrease the poverty rate for seniors to 8.7 percent in 2011.[3]

Nonetheless, Medicare's benefit design does not meet all of beneficiaries' needs, as evidenced by the fact that most beneficiaries turn to supplemental coverage to fill in the program's significant coverage gaps and to protect themselves better against unpredictable out-of-pocket costs. Medicare generally covers only about 60 percent of health services costs for seniors, and a retired couple with median prescription drug needs would require $227,000 in savings to be fairly certain of covering just their health costs in retirement.[4] The lack of an out-of-pocket maximum and the as-of-yet-unfilled "donut hole" in prescription drug coverage represent two major gaps that create significant financial risk for beneficiaries.

We are concerned, however, that changes to Medicare's cost-sharing structure could be used as a guise to achieve deficit reduction by shifting costs to beneficiaries, not to improve benefits for older adults. We urge members to reject this approach and instead focus on ensuring that Medicare provides adequate coverage for seniors and people with disabilities.

Cost-Shifting to Beneficiaries to Reduce the Deficit

Some economists assert that Medicare beneficiaries are "overinsured," causing them to use more services than are needed. These economists have proposed that beneficiaries pay additional out-of-pocket costs each time they use a service, giving them more "skin in the game." A number of recent proposals would redesign Medicare's benefit structure to build in these extra charges. This is seen as

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[1] Health Care Financing Administration, *Medicare: A Profile*, p. 33 (July 2000).
[2] Census Bureau, http://www.census.gov/hhes/www/poverty/data/historical/people.html (downloaded 2/25/13).
[3] Id.
[4] Fronstin, P. Savings needed for health expenses for people eligible for Medicare. Employee Benefit Research Institute Notes. (October 2012) http://www.ebri.org/publications/notes/index.cfm?fa=notesDisp&content_id=5121

one way to address the incentives for providers to supply too much care in a fee-for-service system that rewards them for each procedure provided, not on the basis of outcomes for an episode of care.

However, a widely-cited review of the literature on cost-sharing by Harvard economist Katherine Swartz seriously questions the utility of charging consumers more for each service they use. While utilization of services is slowed, consumers tend to forgo appropriate care and inappropriate care in equal amounts.[5] This effect is acknowledged by the Medicare Payment Advisory Commission (MedPAC) in its June 2012 benefit redesign proposal.[6] Asking consumers to second-guess their doctor's recommendations is a flawed tool for ensuring that they are only getting the care they need.

The Swartz review also shows that cost-sharing's impact is more acute for vulnerable populations. A number of studies show that "low-income people in poor health are more likely to suffer adverse health outcomes, such as increased rates of emergency department (ED) use, hospitalizations, admission to nursing homes, and death, when increased cost-sharing causes them to reduce their use of health care…" For people with chronic illnesses, the literature finds that, "Increased cost-sharing disproportionately shifts financial risk to the very sick."

The National Association of Insurance Commissioners (NAIC) recently arrived at a similar understanding of the current evidence on cost sharing. The NAIC was charged by the Affordable Care Act (ACA) with devising an approach for nominal cost sharing in Medigap Plans C and F. NAIC, however, could not devise a workable approach for nominal cost-sharing based on existing research. In a letter to Health and Human Services (HHS) Secretary Sebelius, the Commissioners explained, "We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost sharing designed to encourage the use of appropriate physician's services." The Commissioners further explained that vulnerable beneficiaries could suffer poor health outcomes:

> None of the studies provided a basis for the design of nominal cost sharing that would encourage the use of appropriate physicians' services. Many of the studies caution that added cost sharing would result in delayed treatments that could increase Medicare program costs later (e.g., increased expenditures for emergency room visits and hospitalizations) and result in adverse health outcomes for vulnerable populations (i.e., elderly, chronically ill and low-income).[7]

Equity issues also arise from many of the proposals to impose first-dollar cost sharing requirements on all beneficiaries. For retirees that have supplemental health benefits provided to them by an employer, a multiemployer plan, or a Voluntary Employee Beneficiary Association (VEBA), the retirees have already sacrificed wages during their active working years on the promise that they would receive additional protection from health costs during retirement. If first-dollar coverage is prohibited outright, retirees in poor health would face unexpected, substantial out-of-pocket costs. If the limitation on first-dollar coverage was imposed through a surcharge on plans providing the coverage, many retirees could see reduced benefits in other areas. In addition, people with Medigap plans might have to change plans in response to the new costs. These beneficiaries would lose the protection of guaranteed renewal requirements, and face medical underwriting of their premiums.

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[5] Swartz, K. Cost-sharing: Effects on spending and outcomes. RWJ Foundation (December 2010) http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf402103/subassets/rwjf402103_1

[6] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. (June 2012) pp. 14 - 15. http://www.medpac.gov/chapters/Jun12_Ch01.pdf

[7] National Association of Insurance Commissioners. Letter to HHS Secretary Kathleen Sebelius, December 19, 2012 http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf.

Cost sharing is a blunt instrument that does more harm than good for the very sick, for the old, and for the poor. Medicare was designed, of course, to care for these very groups. Changing Medicare's benefit design to impose higher copays or coinsurance on beneficiaries may decrease federal expenditures on the program in the short run, but it represents a simple cost shift from the government to beneficiaries.

Medicare Beneficiaries are Lower-Income, have High Health Care Needs, and Already have More "Skin in the Game" than Most Consumers

Medicare beneficiaries can ill-afford to take on greater health care costs. According to AARP, "In 2010, half of all Medicare beneficiaries had annual income below $22,000, or below 200 percent of the federal poverty level."[8] Beneficiaries also tend to have a substantial need for medical services, as 46 percent of seniors covered by Medicare have three or more chronic conditions and 23 percent are in fair or poor health.[9] Because Medicare beneficiaries have modest incomes and high health care needs, changing the Medicare benefit structure to increase cost sharing will have a serious impact on the standard of living of millions with Medicare. Either they will pay the cost sharing directly, or their premiums will increase significantly for supplemental coverage.

In addition, seniors and people with disabilities already spend a greater share of their income on health care than other consumers. Medicare households have a lower average budget than the average household ($30,818 vs. $49,641 respectively) but devote a substantially larger share of their income to medical expenses than does the average household (14.7 percent vs. 4.9 percent respectively).[10] It is hard to argue that Medicare beneficiaries are insulated from the costs of their health care and need to shoulder more of the burden.

Improving the Capacity of the Medicare Program to Contain Costs

It is not necessary to impose increased cost sharing on Medicare beneficiaries in order to restrain spending in the program. For most of its history, Medicare has out-performed private insurance in containing health care costs. Between 1970 and 2009, Medicare spending per enrollee grew one percentage point less each year than comparable private health care premiums—or one third less over four decades. Medicare succeeds because of its low administrative costs and the use of bargaining power to hold down payment rates to providers.[11] Medicare is expected to out-perform private insurance over the next decade as well, with per capita spending growth of 3.1 percent compared to 4.9 percent for private insurance.[12]

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[8] AARP Public Policy Institute (March 2012): http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-program-brief-overview-fs-AARP-ppi-health.pdf

[9] Kaiser Family Foundation. Key issues in understanding the economic and health security of current and future generations of seniors. (March 2012) http://www.kff.org/medicare/upload/8289.pdf

[10] Kaiser Family Foundation. Health care on a budget: The financial burden of health spending by Medicare households. (March 2012) http://www.kff.org/medicare/upload/8171-02.pdf

[11] Van de Water, P. Converting Medicare to premium support would likely lead to two-tier health care system. Center on Budget and Policy Priorities (September 2011), p. 1. http://www.cbpp.org/files/9-26-11health.pdf

[12] Kaiser Family Foundation. Medicare spending and financing. (November 2012) http://www.kff.org/medicare/upload/7305-07.pdf

Medicare is a market leader in the health care system, providing benchmarks for the pricing of services and innovating important delivery system reforms. Delivery system reforms in the Affordable Care Act have already enhanced its capacity to restrain costs. However, Medicare is currently unable to fully use its leverage as a bulk purchaser of services to bargain for lower health care prices. Allowing Medicare to negotiate drug prices for beneficiaries and to employ competitive bidding for health products could yield major savings – $230 billion over ten years from reduced drug prices[13] and $38 billion over the same span from lower costs for health products.[14] Similarly, moving from fee-for-service reimbursement to bundled payments and value-based purchasing are examples of approaches that help ensure that services are cost effective, lowering spending growth in the program. It is important that lawmakers provide Medicare with greater authority to negotiate prices for services, drugs, medical devices, and laboratory services on behalf of beneficiaries and taxpayers. Unleashing Medicare to pursue these savings would obviate the need to shift costs to beneficiaries.

Improving Medicare's Benefit Structure

The AFL-CIO sees benefit in improving Medicare's cost sharing structure so that beneficiaries can better predict the financial risks they face from future health care needs. There is important potential value in providing beneficiaries with an out-of-pocket cap, filling the prescription drug "donut hole" faster, and combining the outpatient and inpatient deductibles. Any rationalization of the cost sharing structure, however, will create winners and losers among the beneficiary population. We look forward to working with Congress to find an approach that is fair and ensures the health security of all Medicare beneficiaries.

Conclusion

Congress must not wrap benefit cuts in the guise of rationalizing Medicare's cost-sharing structure. Discussions that focus on "restructuring Medicare to preserve the program for future generations" should focus on improving Medicare's ability to bargain for cost-effective, high-quality services. To achieve this goal, Congress must grant Medicare greater authority to negotiate with providers, drug makers, medical device manufacturers, and equipment suppliers. Today's Medicare beneficiaries should fully benefit from the health security they earned in their working years while the program is put on a sound financial footing.

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[13] Center for Economic and Policy Research. Reducing waste with an efficient Medicare prescription drug benefit. (February 2013) http://www.cepr.net/documents/publications/medicare-drug-2012-12.pdf
[14] Center for American Progress. Senior protection plan. (November 2012) p. 5

Statement for the Record
by the
American Federation of State, County and Municipal Employees (AFSCME)
for the Hearing
on
Examining Traditional Medicare's Benefit Design

Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
February 26, 2013

Statement for the Record
by the
American Federation of State, County and Municipal Employees (AFSCME)
For the Hearing on
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This statement is submitted on behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME).

AFSCME is proud of labor's historic role in the creation Medicare, a federal social insurance program that is indispensable to our country. When President Johnson signed Medicare into law on July 30, 1965, he spoke of its profound promise:

> "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

For today's 50 million Medicare beneficiaries and the millions who will depend on this program in the future, the need for Medicare to remain a bulwark against financial ruin caused by the caprice of illness and disability rings as true in 2013 as it did nearly five decades ago.

The Affordable Care Act Improved Medicare Benefits in Two Key Ways

The Affordable Care Act (ACA) changed Medicare to better protect beneficiaries from unexpected health costs. Thanks to the health care reform law, 6.1 million Americans with Medicare who reached the coverage gap in Part D (known as the *donut hole*) have saved over $5.7 billion on prescription drugs.

In 2012, the savings to beneficiaries in the donut hole helped a significant number purchase drugs managing chronic conditions such as high blood sugar, high blood pressure and high cholesterol. By reducing the prescription drug coverage gap, the ACA helped to create incentives for beneficiaries to adhere to a medication regimen prescribed by their doctors. Closing the gap in benefit coverage improves the health and quality of life of beneficiaries and saves money for Medicare. According to the Congressional Budget Office (CBO), the costs for increased prescription drug use in Medicare can offset Medicare spending in medical services, like hospitalizations.

The ACA also redesigned Medicare's incentives for beneficiaries to stay healthy by preventing disease, detecting and treating health problems early, and monitoring health conditions. Eliminating the cost-sharing barrier of co-payments and Part B deductibles for recommended preventive services has succeeded in increasing preventive services. In 2012 alone, an estimated 34.1 million people with Medicare benefited from Medicare's coverage of preventive services with no cost sharing.

These two ACA improvements in the cost structure of Medicare benefits are particularly important for a population that cannot afford more cost sharing. Most Medicare beneficiaries have low incomes and spend a larger portion of their meager household income on health care. Half of all people with Medicare live on incomes of less than $22,000 per year, and families on Medicare spend 15% of total health care costs compared to the just 5% spent by non-Medicare households. In short, Medicare beneficiaries have *too much* "skin in the game" and are often forced to choose between making ends meet and getting the medical care they need. Increasing cost shifting onto beneficiaries will jeopardize the health of seniors and individuals with disabilities who rely on Medicare.

Changes to Medicare Should be Aimed at Improving Coverage, Not Deficit Reduction

As Congress looks at changes in Medicare's structure and benefit design, the focus must be on improving and expanding benefits. Medicare benefit design must not be a diversion to disguise the shifting of costs on to beneficiaries or employers who provide retiree coverage.

While the details may vary, the underlying premise of many proposals is that Medicare beneficiaries are over-insured and increased cost sharing is an appropriate means of limiting unnecessary health care services.

Increasing beneficiary cost sharing (either directly or by constraining supplemental policies that cover Medicare cost sharing) is a misguided approach to benefit redesign because it will limit beneficiary access to necessary care. Building in extra costs and charges for beneficiaries will likely reduce utilization; tragically, it will force beneficiaries from getting the appropriate care they need. This troubling implication is acknowledged by the Medical Payment Advisory Commission (MedPAC) in its June 2012 benefit redesign proposal. The National Association of Insurance Commissioners (NAIC) has strongly recommending against adding further cost sharing to Medicare supplemental insurance policies, known as Medigap plans, because of the harm to the health of beneficiaries and the Medicare program in the long run.[1]

Moreover, it seems dubious at best (and potentially cruel at worst) to ask consumers to second-guess their doctor's recommendations or to shoulder the full responsibility of evaluating the extent to which they need medical care in the first place. Cost sharing is a defective tool that does more harm than good for the very sick, for the old and for the poor. While asking beneficiaries to pay higher co-pays or coinsurance may reduce federal expenditures in the short run, it simply moves these costs from the government onto beneficiaries.

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[1] National Association of Insurance Commissioners, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011).

Similarly, changing Medicare to a premium support plan is a benefit structure redesign that gives less and less purchasing power to beneficiaries. Even if one viewed a premium support plan as a form of competitive bidding, it ludicrously demands that every individual senior single-handedly muster more clout in negotiations with doctors, hospitals and the insurance industry then the combined forces of 50 million beneficiaries acting through the federal government. A premium support redesign puts the health of individual seniors and individuals with disabilities at risk if they cannot control health care costs better than Congress and Medicare can now. Offering both private plans and traditional Medicare uses the promise of choice and the false lure of competition to disguise the diminishment of Medicare's function to deliver guaranteed benefits, pool resources and protect beneficiaries from unexpected health care costs.

Conclusion

Medicare is an amazing success story – providing health and financial security to millions of Americans even during the worst economic crisis since the Great Depression. AFSCME urges Congress to reject proposals to redesign Medicare in a way that builds in extra cost sharing for beneficiaries. This would allow sick and older seniors and individuals with disabilities, who are on limited incomes, to be denied the needed health care because of additional out-of-pocket costs.

While we oppose achieving short run federal savings through beneficiary cost savings, because such savings are shortsighted, we do support eliminating sweetheart deals for the pharmaceutical industry that cost Medicare. For example, when Congress enacted the Medicare Part D drug benefit, it prohibited Medicare from negotiating lower drug prices with drug companies. Ending this prohibition could save Medicare more than $200 billion over ten years. In addition, the Medicare Part D law resulted in a substantial drug manufacturer windfall because it ended the then existing requirement that manufacturers pay rebates for beneficiaries who are eligible for both Medicare and Medicaid (known as dual eligible) and low-income Part D enrollees. Reinstating the rebates that were required before 2006 would ensure that taxpayers and the Medicare program do not overpay for Part D drugs.

We would be remiss if we did not point out that Medicare excludes the vital services that many seniors and individuals with disabilities need to maintain their independence – such as long-term supports and services. Medicare provides limited post-acute care and few Americans can afford private long-term care insurance. Medicaid is by default the provider of long-term care services but requires seniors and individuals with disabilities to impoverish themselves to get the services they need to complete life's daily activities. As America ages, the gaps in coverage for long-term care will further strain and challenge families, communities and our country. We urge Congress to support efforts by the Commission on Long-term Care to address this urgent and growing need for long-term supports and services.

In sum, Medicare has helped generations of Americans keep a toehold in the middle class. As Congress considers the adequacy of Medicare's benefit design, we urge Congress to reject proposals that seek to shift costs from the government onto beneficiaries. The goal of benefit redesign should be to ensure that benefits are adequate, not to achieve deficit reduction.

Statement of the Alliance for Retired Americans

STATEMENT FOR THE RECORD
SUBMITTED TO THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS & MEANS, SUBCOMMITTEE ON HEALTH

HEARING ON

"EXAMINING TRADITIONAL MEDICARE'S BENEFIT DESIGN"

FEBRUARY 26, 2013

ALLIANCE FOR RETIRED AMERICANS
815 16TH STREET, NW
WASHINGTON, DC 20006
www.retiredamericans.org

815 16th Street, NW, 4th Floor • Washington, DC 20006 • (202) 637-5399 • www.retiredamericans.org

The Alliance for Retired Americans appreciates the opportunity to submit comments to the Committee on Ways and Means, Subcommittee on Health for the hearing entitled "Examining Traditional Medicare's Benefit Design," which will focus on MedPAC's recommendations to redesign Medicare benefits. While the concept of a cap on out-of-pocket costs is appealing, the Alliance has real concerns with other aspects of MedPAC's recommendations and the full implications of implementing such a plan.

Founded in 2001, the Alliance is a grassroots organization representing more than 4 million retirees and seniors nationwide. Headquartered in Washington, D.C., the Alliance and its 33 state chapters work to advance public policy that strengthens the health and economic security of older Americans by teaching seniors how to make a difference through activism.

Before discussing MedPAC's proposal, one must consider who would be impacted by this policy. While many in Congress believe that Medicare beneficiaries are well off and can afford to pay a little more, it is important to note that only 5% of Medicare beneficiaries are considered higher income -- meaning they have incomes of $85,000 or above -- and those beneficiaries already pay more for their Part B and Part D premiums. Half of all Medicare beneficiaries have annual incomes under $22,000 and one third of beneficiaries have annual incomes under $16,755. A typical Medicare household has a lower average budget than the average household ($30,818 versus $49,641 respectively) but spends three times (14.7 percent versus 4.9 percent respectively) as much on medical expenses than does the average household. Given this sobering reality, it is difficult to comprehend how anyone can expect Medicare beneficiaries to pay more.

The Alliance views the combined deductible as a huge shift in cost to beneficiaries who are relatively healthy and do not need hospital services. According to data from CMS, in 2006, only 17% of beneficiaries had hospital visits. If the combined deductible had been in place then, 83% of Medicare beneficiaries would have paid a higher deductible. According to a report by the Kaiser Family Foundation, if the combined deductible were coupled with a uniform co-insurance rate, 75% of Medicare beneficiaries would experience increased out-of-pocket spending. While MedPAC's plan uses a tiered co-insurance rate, MedPAC admits that, under their plan, more beneficiaries would see their out-of-pocket spending increase by $250 rather than decrease in spending. This includes 42 percent of the 4.1 million beneficiaries who do not have supplemental policies in 2013.

The Medigap supplemental policy surcharge proposed by MedPAC is also troubling. The idea behind the surcharge is that beneficiaries overutilize services because it doesn't cost them anything and that beneficiaries need to have more "skin in the game". The surcharge is designed to impact beneficiaries' medical spending habits. This thinking is flawed in many ways. First, Medigap policies are expensive. In

fact, two-thirds of the medical spending by Medicare households goes to premiums for Part B, Medicare Advantage, Part D, and/or supplemental coverage. The suggestion that Medigap policyholders are getting a free ride is absurd. Second, medical decisions are made by doctors and not beneficiaries, so spending decisions are driven by doctors not patients. Thus, the belief that beneficiaries can control health spending is a notion that needs to be dispelled. Most beneficiaries do not have the expertise to make medical decisions. Furthermore, the current medical system is too complex. In order for consumers to be involved in the medical decisionmaking process, the system should be easier to navigate. There should be a one-stop shop where patients can compare prices. Third, while the surcharge may initially reduce demand for care and reduce government spending, it could come at a high cost to beneficiaries, many of whom may forgo treatment due to higher costs. In the long run, the government could end up spending more if such individuals experience complications or require more costly care later.

Another troubling aspect is that the surcharge will not only affect seniors with Medigap plans, but also those with employer-sponsored supplemental plans. Those individuals often received health benefits in lieu of pay raises. They agreed to forfeit pay for health benefits, because it gave them peace of mind, knowing the benefits would be there for them when they needed it. It is unconscionable that Congress would now take that away from them.

Another troubling provision in MedPAC's proposal is the establishment of a tiered-copayment for different services. This will result in beneficiaries paying co-payment for services where none was required before. Currently, there is no co-insurance for the first 60 days of a hospital visit or hospitalization in an inpatient psychiatric facility or the first 20 days in a skilled nursing facility. Nor is there any co-insurance for home health or hospice. Under MedPAC's proposal, those individuals would for the first time pay co-insurance as follows: $750 per hospital admissions, $80 per day for skilled nursing facility stays, $150 per episode for home health care. The new co-insurance could force some seniors to forgo needed medical care endangering their health.

The Alliance agrees that restructuring the Medicare benefit could be beneficial for seniors and people with disabilities if done to help seniors with high costs. Medicare benefits are less generous than those under the government's FEHBP plans or those under large employer plans. A cap on out-of-pocket spending would benefit beneficiaries who are chronically ill and experience numerous hospitalizations, but increasing cost-sharing for healthier beneficiaries at the same time is not something we can support. The Alliance is especially apprehensive when such a plan is being offered in the context of deficit reductions.

If Congress is, in fact, looking for health savings, there are other areas that it should consider. One example is pharmaceutical costs. According to a study by the

Center for Economic and Policy Research, if Medicare used its bulk purchasing power to buy prescription drugs, the government could potentially save over $500 billion and beneficiaries could save over $100 billion over 10 years. Numerous bills are before Congress that would reduce drugs cost for the government and Medicare beneficiaries, those include rebates for low-income Medicare beneficiaries, negotiating lower prices for all beneficiaries, ending pay-for-delay agreements between pharmaceutical companies and generic manufacturers and reducing the exclusivity period for biologics. These options would save the program billions of dollars and would not negatively affect Medicare beneficiaries or shift costs to them.

On behalf of its 4 million members, the Alliance for Retired Americans appreciates the opportunity to submit this testimony on this critically important issue.

Statement of the American Academy of Actuaries

AMERICAN ACADEMY *of* ACTUARIES

Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives

Hearing on
Examining Traditional Medicare's Benefit Design

February 26, 2013

Statement of
Cori E. Uccello, MAAA, FSA, MPP
Senior Health Fellow
American Academy of Actuaries

The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

1850 M Street NW Suite 300 Washington, DC 20036 Telephone 202 223 8196 Facsimile 202 872 1948 www.actuary.org

On behalf of the American Academy of Actuaries' Health Practice Council, I appreciate the opportunity to submit the following written testimony to the House Ways and Means Health Subcommittee for the record related to its hearing on changes to the Medicare fee-for-service (FFS) benefit design.[1]

Improving the quality and cost-effectiveness of care under the Medicare program is a key health policy challenge. Many Medicare reform proposals in recent years have focused on realigning financial incentives in Medicare's provider payment and delivery system. However, a comprehensive package of reforms to improve Medicare sustainability also should consider better aligning incentives on the beneficiary side. To accomplish this, there have been calls to update the program's traditional fee-for-service (FFS) benefit design (i.e., its cost-sharing features) and to address other issues related to beneficiary incentives. Such changes could deal with some of the shortcomings of the current benefit structure, including its lack of a cost-sharing maximum, and could help encourage Medicare beneficiaries to seek more cost-effective care.

Current Medicare Fee-For-Service Benefit Design

Like most other health insurance plans, Medicare uses patient cost-sharing requirements, such as deductibles, copayments, and coinsurance, to help balance the cost of the program with the comprehensiveness of the benefits provided (see below). Patient cost sharing directly lowers Medicare spending by shifting a share of medical costs to the beneficiary. In addition, cost sharing can lower spending overall by reducing health care utilization.

Selected Part A and Part B Cost-Sharing Requirements

Part A	
Hospital stay:	$1,184 deductible for days 1–60 per benefit period $296/day copayment for days 61–90 $592/day copayment for days 91–150
Skilled nursing facility stay:	$0 for the first 20 days each benefit period $148 per day for days 21–100 each benefit period All costs for each day after 100 each benefit period
Part B	
Annual deductible:	$147
Physician services:	20 percent coinsurance
Outpatient hospital Services:	20 percent coinsurance (up to hospital deductible of $1,184)

Note: See www.medicare.gov for cost-sharing requirements for additional Medicare covered services.

[1] This testimony is based on two Academy issue briefs, *Revising Medicare's Fee-For-Service Benefit Structure* (March 2012) and *An Actuarial Perspective on Proposals to Improve Medicare's Financial Condition* (May 2011).

While Medicare's patient cost-sharing requirements perform the same basic functions as similar requirements in other health insurance programs, their structures vary greatly. Medicare's hybrid nature—which combines a mandatory hospital insurance program with voluntary coverage for physician and outpatient services as well as voluntary prescription drug coverage—is directly reflected in the structure of the Medicare fee-for-service benefits. Whereas private health insurance programs typically have integrated benefit structures that are designed to manage hospital and non-hospital expenses in a coordinated fashion, the Medicare Part A (inpatient hospital) and Part B (physician and outpatient hospital) benefits are structured very differently from each other—and the patient cost-sharing provisions are not coordinated between the two. This lack of coordination in the design of Medicare's FFS benefits has important consequences for both beneficiaries and taxpayers.

In an ideal situation, patient cost-sharing requirements align beneficiary incentives with program goals to provide high-quality and cost-effective care. Medicare's current FFS cost-sharing requirements, however, are not well structured to meet these goals and have other drawbacks. In particular:

- Medicare does not place an annual limit on beneficiary cost-sharing liability. The lack of an annual limit on cost sharing under the FFS option leaves beneficiaries unprotected against catastrophic health costs.

- Most Medicare beneficiaries have supplemental policies. Because there is no cost-sharing limit, supplemental coverage is a necessity for beneficiaries who desire protection against the costs associated with catastrophic illness. Most Medicare beneficiaries have supplemental coverage that also fills in the FFS cost-sharing requirements for non-catastrophic illnesses, which reduces the incentives for beneficiaries to seek cost-effective care.

- The FFS deductibles are higher for inpatient care. Cost-sharing requirements aim, in part, to influence consumer behavior. Medicare's cost-sharing provisions, however, are not structured in an ideal way to do this. Part A inpatient stays, which are less likely to be influenced by cost-sharing requirements, require fairly high deductibles—$1,184 in 2013 and additional copayments for hospital stays lasting beyond 60 days. In contrast, Part B physician and outpatient services, which are more likely to be influenced by cost-sharing requirements, require a fairly low annual deductible of $147 in 2013. Thereafter, a 20 percent coinsurance is required on most Part B services.

In contrast to traditional Medicare FFS plans, Medicare Advantage plans have some flexibility on how to structure cost-sharing requirements—and very few use the FFS cost-sharing structure. In addition, all Medicare Advantage plans now are required to provide an annual cost-sharing limit, which in 2013 can be no more than $6,700.

Restructuring the Fee-For-Service Benefit Design

To address the problems with the current FFS benefit design, proposals have been developed that would combine a new cost-sharing limit[2] with a unified Part A and Part B deductible. The copayment and coinsurance requirements also could be restructured. These changes would result in more coordinated Part A and B cost-sharing requirements and would bring the FFS benefit design more in line with the structure of private health insurance programs.

Unifying the Part A and B deductibles has the potential to better align beneficiary incentives designed to reduce unnecessary care and promote more cost-effective care. But, as discussed in more detail below, the majority of Medicare beneficiaries have supplemental coverage that can limit the effectiveness of the incentives in Medicare's cost-sharing requirements. In addition, beneficiaries need more access to price and quality information to better facilitate more cost-effective beneficiary behavior. And perhaps most important, provider incentives need to be consistent with beneficiary incentives and more information regarding treatment effectiveness is needed.

Adding an annual cost-sharing limit could be a significant benefit enhancement that would, absent other changes, increase the cost of the program. When combined with the introduction of a unified Part A and B deductible, however, such a restructuring could be achieved in a budget neutral way. In other words, the out-of-pocket limit and combined deductible could be chosen so that costs to the Medicare program would be the same under the new structure as they are projected currently. As an alternative, this restructuring can be done in a way that reduces (or increases) Medicare costs. An annual out-of-pocket limit would reduce cost-sharing for those beneficiaries with the highest health care spending. In any year, however, even if the plan design changes are made to be budget neutral, the majority of beneficiaries who have lower health care spending would face higher cost-sharing amounts.[3]

Beneficiary Cost-Sharing Liability vs. Out-of-Pocket Costs

Medicare beneficiaries who receive medical services are responsible for meeting any applicable cost-sharing requirements. These beneficiary cost-sharing liabilities, however, may not reflect what a beneficiary actually pays out of pocket to meet those requirements. For instance, beneficiaries with supplemental coverage (e.g., Medigap, employer-sponsored retiree health coverage) have all or a portion of their cost-sharing liabilities covered. A full accounting of how a change in the Medicare FFS plan design would affect beneficiary out-of-pocket costs (including premiums for supplemental coverage) therefore would need to incorporate not only the specific changes to the benefit design, but also whether and how changes in Medicare supplemental coverage are required and whether and how beneficiaries change their supplemental coverage purchases and health care utilization in response to the changes.

[2] Even with a cost-sharing limit, beneficiaries would remain responsible for all costs associated with benefits that are not covered by Medicare.

[3] Setting the unified deductible below the "budget neutral" level would reduce the number of beneficiaries who would face higher cost-sharing requirements, but would increase the cost of the Medicare program unless offset by other spending reductions or revenue increases.

A report from the Medicare Payment Advisory Commission (MedPAC) provides insights on the effects of adding a catastrophic limit on cost sharing and combining the Part A and B deductibles, assuming other cost-sharing requirements remain unchanged (Table 1). Under current law, which does not include a cap on cost sharing, a combined deductible of $595 would have been required in 2011 to remain budget neutral compared with the separate plan deductibles. Under this approach, 6 percent of Medicare beneficiaries would have experienced a reduction in out-of-pocket spending of $50 or more and 28 percent would have experienced an increase in spending of $50 or more. About two-thirds of beneficiaries would have experienced no change or a change of $50 or less.

Implementing a cap on cost sharing would require higher combined deductibles to remain budget neutral. The lower the cost-sharing cap, the higher the combined deductible and the more likely it is that beneficiaries would experience an increase in out-of-pocket costs. For instance, a $3,000 cap on cost-sharing would have required a $1,635 combined deductible and 36 percent of beneficiaries would have faced increased out-of-pocket costs of $50 or more. Nevertheless, the increased catastrophic protection would result in large savings for many of those exceeding the cap.

Table 1. Level of combined FFS deductible required to hold constant Medicare program spending in 2011

Catastrophic limit on cost sharing	Combined deductible required to break even	How FFS beneficiaries' out-of-pocket spending would differ from baseline			
		Nonspenders	Change of $50 or less	Spending increase of $50 or more	Spending decrease of $50 or more
None—current law	$595	5%	61%	28%	6%
$7,000	960	5	56	33	6
$5,000	1,170	5	54	34	7
$4,000	1,328	5	53	35	6
$3,000	1,635	5	52	36	7

Notes: Out-of-pocket spending includes only cost-sharing amounts paid by the beneficiary. It excludes spending paid by supplemental coverage as well as premiums for Medicare and supplemental coverage. Changes in out-of-pocket spending incorporate changes in utilization due to the revised cost-sharing requirements, but not any changes in supplemental coverage. Categories may not sum to 100 percent due to rounding.
Source: Actuarial Research Corporation (as published by MedPAC in *Report to the Congress: Medicare and the Health care Delivery System*, June 2011, Chapter 3).

With a combined deductible and a cap on cost sharing, beneficiaries who are more likely to face increased cost sharing include those with no hospitalizations and high Part B spending, but not enough to exceed the catastrophic cap, since the combined deductible exceeds the current Part B deductible. Beneficiaries who are more likely to face a reduction in cost sharing are those with hospitalizations and spending exceeding the cap.

Note that this analysis reflects the change in cost-sharing liability over a one-year period only. Over a longer time period, it is likely that beneficiaries would have some years during which they are hospitalized and would incur a lower cost-sharing liability under a combined deductible

and cost-sharing cap, and some years during which they would have a lower cost-sharing liability under the current FFS plan design. In other words, using a one-year basis to estimate the change in cost sharing understates the value to beneficiaries of adding a cost-sharing cap on a budget neutral basis.

When adding a cost-sharing limit along with a unified deductible, other cost-sharing requirements could remain unchanged. As an alternative, service-specific copayment and coinsurance requirements could be replaced with a uniform coinsurance rate for all services. Or, flat copayments, which are more typical among Medicare Advantage plans, could be used. Moving toward flat copayments in FFS Medicare could have the advantage of being more understandable and predictable to beneficiaries than coinsurance, in which cost sharing varies depending on the cost of the service. Depending on the copayment levels set, however, moving toward copayments rather than coinsurance could require higher unified deductibles to stay budget neutral. Although not the focus of this issue brief, the costs of adding a cost-sharing limit could be offset in ways other than increasing other cost-sharing requirements, such as through premium increases.[4]

An issue that would need to be addressed if Part A and B deductibles are combined is how to treat beneficiaries who sign up for Part A coverage but not Part B coverage (or vice versa). Applying the combined deductible would allow Part A-only beneficiaries to meet a lower deductible, but they would not be subject to potentially higher cost sharing under Part B. Moreover, allowing Part A-only beneficiaries to benefit from the addition of a cost-sharing limit could create equity concerns. An alternative would be to maintain the current higher Part A deductibles for beneficiaries choosing to enroll only in Part A and not allow them to benefit from the cost-sharing limit.

Impact on Medicare Trust Funds and Part B Premiums

A redesign of the Medicare FFS benefit package that is budget neutral still could have important implications for the funding of the Medicare program. This would occur, for instance, if a combined deductible and cost-sharing cap shifts costs between Parts A and B. In turn, this could affect not only the trust fund finances, but also Part B premiums.

For instance, a combined deductible that is less than the Part A deductible and greater than the Part B deductible could mean that Medicare spending (net of cost sharing) would shift from Part B to Part A. How costs shift between the two parts is complicated by the cost-sharing cap, which could change the distribution of net costs between Part A and Part B.

In addition, issues arise regarding the timing of claims during a year. If a beneficiary has physician care early in the year and inpatient care later in the year, the deductible first would apply to the physician care, with any remaining deductible applicable to the inpatient care. This would result in different net spending in the Part A and Part B programs than if inpatient care was received earlier in the year with the deductible first applying to that care. With hospital stays early in the year, which are usually accompanied by physician services, it may be difficult to determine how to split the deductible between Part A and Part B. Which services are received after the cost-sharing cap is reached, rather than before, similarly could affect the distribution

[4] In addition, cost-sharing requirements could be increased without moving to a unified deductible.

between Part A and Part B spending. It may be appropriate for CMS to perform a retrospective adjustment at the end of the year to redistribute spending between Parts A and B to better reflect the true split between Part A and B spending, rather than the timing of claims.

If the implementation of a combined deductible and a cost-sharing cap results in a net shift in Medicare spending from Part B to Part A, then Part B premiums, which are set at a percentage of Part B costs, would be lower than they are under current law. If a plan design change were to shift costs from Part A to Part B, however, Part B premiums would be higher. The Part A trust fund exhaustion date also could be affected.

An increase in Part B premiums could result in a decrease in Part B enrollment. Part B is a voluntary program, and, although the vast majority of Medicare Part A enrollees also enroll in Part B, participation rates have been declining somewhat over the years. The Medicare trustees project that participation rates will continue to fall due to the higher premiums that apply to higher-income beneficiaries as well as the younger aged who are still working and have coverage from an employer.[5] Nevertheless, Part B participation rates are projected to exceed 90 percent throughout the current 75-year projection period.

If Part B participation rates decline more substantially, Part B premiums could increase even further, assuming that those enrolling would have higher health care needs than those who forgo coverage. At some point, it might be appropriate to consider additional measures to increase participation. Such measures could include increasing the penalty for those forgoing coverage, mandating Part B coverage, or allowing individuals to choose higher cost-sharing requirements in return for lower premiums. The latter approach, which also could allow individuals to choose lower cost-sharing requirements in return for higher premiums, in effect could combine FFS plan design changes with a premium support approach.

Aside from any potential shifts in costs between the Medicare Part A and Part B programs associated with changing the FFS cost-sharing requirements, it is also important to consider any interactions between Medicare and Medicaid. Although changing the Medicare cost-sharing requirements likely would have little or no direct effects on beneficiaries dually eligible for Medicare and Medicaid, there is a potential shift in costs between the two programs.

Medicare Supplemental Insurance

Because Medicare imposes significant cost-sharing requirements, most beneficiaries have some type of supplemental coverage to fill in the gaps. According to data compiled by MedPAC, 89 percent of FFS beneficiaries in 2007 had supplemental coverage: 43 percent had employer-sponsored coverage; 29 percent had individually purchased Medigap coverage; 16 percent had Medicaid, and 1 percent had other public coverage.[6]

Supplemental coverage can remove the financial incentives for beneficiaries to control their health spending, and some research suggests that filling in Medicare's cost-sharing gaps results

[5] See Table V.B3 of the 2012 Medicare Trustees Report.

[6] Percentages calculated from Figure 3-1 in MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2011.

in higher Medicare spending than would have been incurred otherwise.[7] As a result, there have been calls to limit the extent to which Medigap plans are allowed to cover Medicare's cost-sharing requirements. Other proposals would levy a surcharge on Medigap plans or Part B premiums for beneficiaries with Medigap plans with low cost-sharing requirements. Such a surcharge would be a way for Medicare to recoup some of the costs of higher utilization among beneficiaries with Medigap plans and would encourage beneficiaries to choose plans that fill in less of Medicare's cost-sharing requirements. If changes to the FFS plan design are implemented, insurance products that coordinate with Medicare may need to be modified so that they do not limit the desired impact of any FFS restructuring. For instance, Medigap plans could be prohibited from covering the higher deductibles. Or, the cost-sharing caps could be implemented on a true out-of-pocket basis, meaning that beneficiary cost sharing covered through supplemental coverage would not count toward the cost-sharing limit.

Reducing the richness of Medigap plans available to beneficiaries, either directly through legislative/regulatory changes or indirectly through levying a Medigap or Part B premium surcharge, could result in an increased understanding among beneficiaries of their benefit choices, lower insurance premiums (due to reduced plan generosity and increased administrative and marketing efficiencies), and a reduction of unnecessary utilization. Reducing the share of costs that Medigap plans can cover would shift costs at the point of service to beneficiaries, increasing the incentives to seek more cost-effective care and avoid unnecessary care. This has the potential to lower both Medicare and beneficiary costs, but the extent to which costs would decline is unclear. Changes in the rules governing Medigap plans should be structured carefully to avoid unintended consequences. Research suggests that broad increases in cost sharing, rather than targeted increases, reduce not only unnecessary care, but also necessary care, especially among the low income and chronically ill.[8] Preventive care could be exempted from any new cost-sharing requirements, and additional protection for low-income and/or chronically ill beneficiaries who are not eligible for Medicaid should be considered.

Other issues that should be addressed when considering changes to Medigap plan requirements include:

- Policymakers would need to decide whether required changes in Medigap plans would apply to new coverage purchases only or to all existing policies as well. Medigap benefits are contractually guaranteed and cannot be cancelled for reasons other than premium non-

[7] Although much research agrees that Medicare spending is higher among beneficiaries with supplemental coverage, there is less agreement regarding whether this difference is due to cost-sharing differences or other factors, such as the tendency of beneficiaries with higher health care needs to obtain supplemental coverage. For a review of the literature, see MedPAC *Report to the Congress: Aligning Incentives in Medicare* (Chapter 2, June 2010).

[8] The RAND Health Insurance Experiment found that although the reduction in services resulting from higher cost sharing did not lead to poorer health outcomes for the average person, low-income individuals in poor health were more likely to suffer poorer health outcomes. See Joseph P. Newhouse and the Health Insurance Experiment Group. *Free for all? Lessons from the RAND Health Insurance Experiment*. Cambridge, Mass: Harvard University Press (1993). More recently, Amitabh Chandra et al found evidence that the savings associated with raising cost sharing for physician visits and prescription drugs is offset modestly by increased hospital utilization. The offsets are more substantial, however, for the chronically ill. See "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," *American Economic Review* 100(1): 193-213 (2010).

payment. Besides the potential legal issues that may arise due to a violation of the contractual agreement, customer and insurer issues arise from changes to existing policies. A consumer's premiums collected to date might have reflected prefunding for future services. Accordingly, insurers have accounted for this prefunding in the form of reserves. If changes are made to policies already in force, a clear transition plan to maintain fairness to insureds and reserve adequacy for insurers would need to be developed.

- Many Medicare beneficiaries may be enrolling in Medigap plans to make their cost sharing more predictable and to avoid the inconveniences and complexities associated with paying providers directly. Any changes to Medigap plans, and to Medicare cost-sharing requirements more broadly, should incorporate ways to minimize beneficiary inconvenience or confusion as well as additional administrative burdens on providers for payment collections.
- Medigap plans are only one source of private supplemental coverage. Even more beneficiaries are covered by employer-sponsored supplemental policies. While employer-sponsored plans typically do not provide first dollar coverage, it still may be appropriate to consider the role of employer-sponsored plans in supplementing Medicare and whether changes are needed.[9] Note that employer-sponsored supplemental plans often include drug coverage and take the place of Part D as well as supplementing Parts A and B.
- The addition of a cost-sharing limit for the traditional FFS program in itself could reduce the demand for supplemental coverage. Reducing the ability of supplemental plans to provide first dollar coverage further could reduce enrollment in these plans. Lower enrollment in supplementary coverage would mean that more beneficiaries would face the financial incentives inherent in the FFS benefit design, without those incentives being limited by supplemental coverage that fills in cost-sharing requirements.

Value-Based Insurance Design

Redesigning the FFS benefit structure could be a step in the direction of better aligning beneficiary incentives to seek cost-effective care. As discussed earlier, broad changes in cost sharing, however, will not necessarily target reductions in unnecessary or ineffective care. In the longer-term, moving to a value-based insurance design (VBID) could structure beneficiary financial incentives more effectively. A VBID approach would lower the cost sharing for high-value services and increase the cost sharing for low-value services. The ACA moved Medicare in this direction by covering certain preventive services with no cost sharing.

Adjusting cost sharing to align incentives with effective use of services has shown promise in reducing spending in the non-Medicare market—most often for prescription drugs.[10] Comparative effectiveness research can provide more guidance to help distinguish low-value and

[9] In the same manner, it may be appropriate to consider the role of Medicare when it is the secondary payer to other coverage, such as employer coverage for active workers aged 65 and older. In these instances, Medicare coverage in effect supplements other coverage. There are limits, however, as to how much Medicare will pay, and therefore, the extent to which Medicare fills in cost-sharing requirements. For instance, if the primary plan already pays more for a service than Medicare does, then Medicare would pay nothing more.

[10] See for instance, "Evidence That Value-Based Insurance Can Be Effective," Michael E. Chernew, et al. *Health Affairs* 29(3): 530-536, March 2010.

high-value services. Although lowering cost sharing for high-value services could gain widespread acceptance, it likely would be more difficult to implement higher cost-sharing requirements for treatments deemed of lower value. One potential way to increase cost sharing for lower-value services is to use reference pricing. Under reference pricing, Medicare would pay the costs of the lowest-price option when multiple treatment options achieve similar results. Beneficiaries choosing a higher-cost option would pay the difference.

Conclusion

The current Medicare FFS benefit design has several drawbacks. It lacks a cap on cost sharing, making supplemental coverage a necessity if beneficiaries are to be protected against the costs associated with catastrophic illnesses. Since most beneficiaries have supplemental policies to cover their FFS cost-sharing requirements, their incentives to seek cost-effective care are reduced. In addition, the Medicare FFS cost-sharing requirements are skewed toward less discretionary services. Restructuring the FFS benefit design by unifying the Part A and B deductibles and adding a cost-sharing limit would provide protection against catastrophic health costs and has the potential to encourage beneficiaries to seek cost-effective care.

Restructuring the FFS benefit design could be done in a budget neutral manner, or it could be done in a way that reduces Medicare spending overall. For Medicare to achieve savings beyond the amounts shifted to beneficiaries, the plan design changes would need to encourage beneficiaries to take a more active role in their health care, seek care when necessary, and learn more about the cost and expected outcomes of their care. Restructuring, however, will affect only the few beneficiaries who do not have supplemental coverage, unless insurance products that coordinate with Medicare are modified so that they do not limit the desired effects of any FFS restructuring. In addition, provider incentives need to be consistent with beneficiary incentives and more information regarding costs, quality, and treatment effectiveness is needed.

Redesigning the FFS plan design is more of a short-term solution, with transitioning to a VBID a longer-term approach. Even under a VBID approach, however, a more comprehensive restructuring of not just the benefit design but also the payment and delivery systems is needed to move Medicare toward a more integrated, coordinated, and cost-effective system.

Statement of the California Health Advocates

UNITED STATES HOUSE of REPRESENTATIVES
COMMITTEE on WAYS & MEANS, SUBCOMMITTEE on HEALTH
HEARING on "EXAMINING TRADITIONAL MEDICARE'S BENEFIT DESIGN"
February 26, 2013

WRITTEN TESTIMONY SUBMITTED JOINTLY by
CALIFORNIA HEALTH ADVOCATES,
CENTER for MEDICARE ADVOCACY,
and MEDICARE RIGHTS CENTER

Introduction

Mr. Chairman and Members of the Committee:

California Health Advocates, the Center for Medicare Advocacy, Inc., and the Medicare Rights Center are all independent, non-profit organizations with extensive experience representing older adults and people with disabilities who rely on Medicare for basic health and economic security.

Our three organizations also served as consumer representatives to a subgroup of the Senior Issues Task Force (SITF) of the National Association of Insurance Commissioners (NAIC) tasked with reviewing a provision of the Affordable Care Act (ACA) relating to Medigap policies. We offer this testimony through our perspective as beneficiary advocates and members of this deliberative NAIC process that included a range of stakeholders.

In December 2012, as a result of the work of the NAIC subgroup, the NAIC strongly recommended against adding further cost-sharing to Medigap plans in a letter to the U.S. Department of Health and Human Services.[1] In short, the research conducted by the subgroup roundly rejects the basic assumption that limited cost-sharing afforded by Medigap plans leads to overutilization of health care services. The subgroup concluded:

> The proposals [to add cost-sharing to Medigap plans] focus on overutilization by beneficiaries but do not consider the potentially serious and unintended impacts for beneficiaries and the Medicare program. Namely, in response to increased costs, beneficiaries may avoid necessary services in the short-term that may result in worsening health and a need for more intensive care and higher costs to the Medicare program in the long-term. In addition, research indicates that once beneficiaries seek care, doctors and other medical providers, not patients, generally drive the number and types of services delivered to beneficiaries. Further, the proposals do not address the fact that Medicare determines which services are reimbursed and therefore, by law, covered by Medigap insurance policies.[2]

[1] National Association of Insurance Commissioners letter to Secretary Sebelius (December 2012), available at: http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf.
[2] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011), available at:

The NAIC determined that increased cost-sharing in Medigap plans was likely to prohibit the use of both necessary and unnecessary health care services. Both the Medicare Payment Advisory Commission (MedPAC) and the Congressional Budget Office (CBO) have acknowledged this same concern in reference to proposals that increase beneficiary out-of-pocket costs.[3] By way of the subgroup's conclusion, the NAIC rebuffed the notion that increased cost-sharing is an appropriate tool to limit unnecessary use of health care services.

Although this NAIC subgroup focused on potential changes to Medigap plans, the research reviewed and the resulting conclusions are applicable to a range of Medicare reform proposals, including the subject of this testimony—Medicare benefit redesign. Through our work representing individuals with Medicare, we know that the Medicare program has significant, complicated out-of-pocket costs and can be simplified. While taking a measured look at the program outside of the context of deficit reduction would be a welcome exercise, we fear that the following suggested Medicare reform proposals would have harmful, unintended consequences for beneficiaries:

- Benefit redesigns that would redistribute cost burdens;
- Prohibiting or taxing Medigap "first-dollar coverage";
- Increasing the share of and/or further means-testing Medicare premiums;
- Raising the age of Medicare eligibility;
- Adding or increasing costs for services, such as home health benefits; and
- Premium support or competitive bidding models that weaken Traditional Medicare.

Each of these proposals might save federal dollars in the short run, but would do so through significant cost-shifting to beneficiaries. At the same time, none of these proposals address the long-term challenge of systemic health care inflation that threatens our nation's ability to provide affordable health care, both in public and private markets.

Our organizations recognize the need to bring down the nation's deficit and reduce health care spending system-wide. We support Medicare savings mechanisms that eliminate wasteful spending and build on the efficiencies of the ACA. At a time when Medicare spending is growing at historically low rates, and innovations through the ACA hold considerable promise of continuing to keep costs down, we oppose implementing unwise policies that seek federal savings by way of cost-shifting on the backs of Medicare beneficiaries.

Our testimony focuses on how the most discussed Medicare redesign frameworks would impact the lives of people with Medicare. We believe that these proposals threaten the health and economic security of beneficiaries. Under the proposed redesign concepts, too many would lose

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http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.

[3] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf; Congressional Budget Office, "Budget Options Volume 1: Health Care" (December 2008), page 155, available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf.

access to affordable coverage, and too many would be discouraged from seeking needed health care services.

Current Expenses and Coverage for Medicare Beneficiaries

Before considering proposals that would alter what Medicare beneficiaries pay for their health care, it is necessary to understand the current fiscal challenges faced by this population. The vast majority of Medicare beneficiaries have low or moderate incomes. In 2010, half of all Medicare beneficiaries had annual incomes below $22,000, or below 200 percent of the federal poverty level (FPL).[4] Half of beneficiaries had just $53,000 in personal savings.[5] One-third of Medicare beneficiaries have annual incomes below $16,755—150% of the FPL for a single person in 2011.[6]

Medicare beneficiaries pay relatively more than other groups for their health care. Medicare households have a lower average budget than the average household (about $30,800 vs. $49,600 respectively) but devote a substantially larger share of their income to medical expenses than does the average household (15% vs. 5% respectively). Two-thirds of the medical spending by Medicare households goes to premiums for Part B, Medicare Advantage, Part D, and/or supplemental coverage.[7]

Medicare beneficiaries also tend to have greater health needs than other groups. Nearly half (46 percent) of older adults covered by Medicare have three or more chronic conditions, and nearly one-fourth (23%) are in fair or poor health.[8] Typical out-of-pocket health spending for someone in fair or poor health without any supplemental benefits is about $4,500 per year.[9]

Because the current Medicare benefit is not overly generous and requires considerable out-of-pocket costs, approximately 90% of Medicare beneficiaries have some type of coverage that supplements Medicare. Some have retiree benefits through former employment (30%), Medicare Advantage plans (29%), Medicaid (14%) and Medigap (18%), and others who have only Medicare (8%) are also entitled to benefits through the Veteran's Administration.[10] Many of

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[4] AARP Public Policy Institute, "The Medicare Program: A Brief Overview" (March 2012), available at: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-program-brief-overview-fs-AARP-ppi-health.pdf.

[5] Kaiser Family Foundation, "Projecting Income and Assets: What Might the Future Hold for the Next Generation of Medicare Beneficiaries?" (June 2011), available at: http://www.kff.org/medicare/upload/8172.pdf.

[6] General Accounting Office (GAO), "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment" (September 2012), available at: http://www.gao.gov/assets/650/648370.pdf.

[7] Kaiser Family Foundation, "Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare Households. An Updated Analysis of Health Care Spending as a Share of Total Household Spending" (March 2012), available at http://www.kff.org/medicare/upload/8171-02.pdf.

[8] Kaiser Family Foundation, "Key Issues in Understanding the Economic and Health Security of Current and Future Generations of Seniors" (March 2012), available at: http://www.kff.org/medicare/upload/8289.pdf.

[9] MedPAC, "A Data Book: Health Care Spending and the Medicare Program" charts 5-6 (June 2012), available at: http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf.

[10] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), "Variations and Trends in Medigap Premiums" (December 2011), available at: http://aspe.hhs.gov/health/reports/2011/medigappremiums/index.pdf.

these supplemental types of insurance, in effect, limit out-of-pocket expenses. Even with these supplemental coverage options, people with Medicare lack coverage for particular services, including most long-term care services and supports and dental care.

Most Medicare beneficiaries cannot absorb more costs without facing significant hardship. To borrow a crude metaphor often used to discuss the intersection between the use of health care and an individual's personal financial risk, Medicare beneficiaries already have too much "skin in the game," and as a group, are very aware of the high cost of health care services based on the bills they receive and Medicare's summary notice of payment.

Proposals to Redesign Medicare's Benefit Structure

Over the last few years, there have been several proposals offered by various lawmakers, commissions and other entities that seek to alter Medicare's benefit structure. Although they have been offered within the context of debt and deficit reduction, some proposals claim to have the plight of Medicare beneficiaries firmly in mind. These proposals appear benign on their face in that they simplify Medicare's structure; however, upon closer scrutiny, they merit significant concern because they increase beneficiaries' costs and thereby limit their access to care.

As noted by Chairman Brady in the announcement for this hearing, MedPAC made recommendations in its June 2012 Report to Congress to redesign the Traditional Medicare benefit package, including redistributing cost-sharing through the use of tiered copayments, coinsurance and a combined deductible for Medicare Parts A and B, along with an out-of-pocket maximum for beneficiaries in Traditional Medicare. For illustrative purposes, not as a recommendation, MedPAC modeled a $500 combined deductible, varying copayments and a $5,000 spending limit, along with a 20% surcharge on supplemental plan premiums.[11]

Various other proposals to redesign Medicare's benefit structure contain similar elements, including: creating a single, combined deductible for Parts A and B (ranging from $500 to $550); a uniform 20% coinsurance rate; an out-of-pocket cap on beneficiary expenses (ranging from $5,500 to $7,500); and various piecemeal proposals, such as introducing home health copayments.[12]

Often proposals to redesign Medicare's benefits are coupled with proposals to restrict Medigap "first-dollar coverage." Medicare supplemental insurance policies, also known as Medigap plans, are individual standardized insurance policies designed to fill some of the coverage gaps of Traditional Medicare. In exchange for a monthly premium, these policies offer financial security and protection against high and sporadic out-of-pocket costs for one in four Medicare

[11] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.
[12] Kaiser Family Foundation, "Policy Options to Sustain Medicare's Future" (January 2013), available at: http://www.kff.org/medicare/upload/8402.pdf.

beneficiaries.[13] Policies that provide coverage for Medicare cost-sharing once Medicare has paid its portion are sometimes referred to as providing "first-dollar coverage."

Economic and Health Risks Posed by Medicare Redesign Proposals

Proposed Medicare Redesign Shifts Costs to Beneficiaries

At first glance, combining the Part A and B deductibles and adding a catastrophic cap on out-of-pocket expenses seems like a worthwhile concept. While details are lacking in most proposals, the broad outlines of those currently under discussion would increase costs for most people, and significantly so for those whom can least afford it. Some of these proposals purport to operate under the premise of "budget neutrality," or claim "no change in beneficiaries' aggregate cost-sharing liability."[14] Yet, changing cost-sharing structures in the manner proposed redistributes the burden of health care costs onto the most vulnerable, including those with low- and moderate-incomes and those with persistent and chronic health needs.[15]

In particular, individuals who are "near poor"—beneficiaries with incomes too high to qualify for low-income programs but still living on limited incomes—are most at risk. Additional upfront costs of a higher deductible for Part B services as well as any higher ongoing costs, such as new and/or higher coinsurance amounts, will make necessary care unaffordable and lead many people to forego such care.

In 2011, the Kaiser Family Foundation issued a report analyzing the impact of a benefit redesign proposal modeled on one offered by Erskine Bowles and Alan Simpson (Bowles-Simpson), co-chairs of the National Commission on Fiscal Responsibility and Reform (a unified Part A and B deductible of $550, 20 percent coinsurance on most Medicare-covered services, and a $5,500 annual limit on out-of-pocket spending). The study shows that 71% of beneficiaries in Traditional Medicare would have higher out-of-pocket spending—even with a spending cap—and 5 percent would have lower out-of-pocket spending. Five million beneficiaries among this group would experience increased costs greater than $250 annually, with a total average increase of $660 per year.[16]

Under MedPAC's analysis of their own illustrative benefit redesign package, at least 20% of beneficiaries would pay an additional $250-$999 per year; their proposal coupled with a surcharge on Medigap plans would lead to 70% paying additional costs within this range.[17] To

[13] Kaiser Family Foundation, "Medigap: Spotlight on Enrollment, Premiums and Recent Trends" (February 2013), available at: http://www.kff.org/medicare/upload/8412.pdf.
[14] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.
[15] Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at: http://www.kff.org/medicare/upload/8256.pdf.
[16] Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at: http://www.kff.org/medicare/upload/8256.pdf.
[17] MedPAC Presentation, "Reforming Medicare's Benefit Design" (March 2012), slide 10, available at: http://www.medpac.gov/transcripts/benefit%20design%20mar2012%20public.pdf .

cite an individual example, under the MedPAC and Bowles-Simpson proposals, a person with Medigap Plan F paying an average annual premium of about $2,050 today would pay more than twice as much in out-of pocket costs, while couples would pay two and a half times more.[18]

Cost-Shifting to Beneficiaries Limits Access to Necessary Care

While increased cost-sharing poses significant financial risks for beneficiaries, particularly for those living on low- and moderate-incomes, it is also shown to limit access to necessary health care services. This was a primary finding of the NAIC subgroup convened to explore adding cost-sharing to specific Medigap plans on which our organizations served.

Pursuant to the ACA, the NAIC was directed to "review and revise the standards for benefits in Medigap Plan C and Plan F" and to update those standards to include cost-sharing, if practicable, so as to "encourage the use of appropriate physicians' services…"[19] Toward this end, the NAIC convened the Medigap PPACA (B) Subgroup that included state insurance regulators, insurers and trade associations, consumer advocates and other Medicare experts. This subgroup spent almost two years reviewing available literature on cost-sharing and patient behaviors.[20]

Mid-way through its deliberations, the NAIC subgroup issued a discussion paper on more expansive proposals to diminish Medigap coverage and increase Medicare cost-sharing.[21] Based on mistaken notions that protection from out-of-pocket costs cause "overuse" of services, Medigap policies have been singled out by some policymakers who aim to either: 1) add a surcharge or tax to policies that offer first-dollar coverage; or 2) impose a deductible and limited coverage of additional cost-sharing, essentially prohibiting first-dollar coverage outright. Proposals to redesign Medicare's benefit structure, such as the one offered by MedPAC and Bowles-Simpson, often couple combining the Medicare Part A and B deductibles with restrictions on Medigap benefits or increasing the cost of owning a Medigap plan. The dollar amount of savings in some proposals would entail applying restrictions and/or increased costs on current beneficiaries as well as those who purchase coverage in the future, raising legal issues for insurance policies that are guaranteed renewable.

The subgroup's research demonstrates that cost-sharing has dubious utility in holding down health care spending and can actually lead to increased total spending on health care if people forego medically necessary services. For example, a major Harvard School of Public Health

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[18] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), "Variations and Trends in Medigap Premiums" (December 2011), available at: http://aspe.hhs.gov/health/reports/2011/medigappremiums/index.pdf.

[19] Patient Protection and Affordable Care Act, §3210.

[20] National Association of Insurance Commissioners, "Medigap PPACA (B) Subgroup" webpage, available at: http://www.naic.org/committees_b_sitf_medigap_ppaca_sg.htm; See under heading "Cost-sharing Research and Literature" for summary of much of this literature (as of June 2011) available at: http://www.naic.org/documents/committees_b_senior_issues_110628_summary_dist_research.pdf.

[21] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011), available at: http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.

review of the research on cost-sharing made several conclusions about its utility in controlling health care costs, including: "We do not know if increased patient cost-sharing would reduce the growth in total national health care spending;" "Increased cost-sharing disproportionately shifts financial risk to the very sick;" "Low-income older adults with chronic conditions are at increased risk for poor health outcomes due to increased cost-sharing."[22]

In 2008, the CBO similarly determined that a proposal to restrict Medigap coverage of Medicare cost-sharing would lead beneficiaries to face "uncertainty about their out-of-pocket costs." Given this, the CBO further acknowledged that the corresponding "…decline in the use of services by Medigap policyholders (which would generate the federal savings under this option) might lead beneficiaries to forego needed health services and so might adversely affect their health."[23]

Due in large part to these findings, in a letter to Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services, the NAIC concluded, "We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost-sharing designed to encourage the use of appropriate physicians' services. Therefore, our recommendation is that no nominal cost-sharing be introduced to Plans C and F."[24]

In addition, the NAIC letter to Secretary Sebelius stated, "We do not agree with the assertion being made by some parties that Medigap is the driver of unnecessary medical care by Medicare beneficiaries. As you are aware, Medigap plans pay benefits only after Medicare has determined that the services are medically necessary and has paid benefits. Medigap cannot alter Medicare's coverage determination and the assertion that Medigap coverage causes overuse of Medicare services fails to recognize that Medigap coverage is secondary and that only Medicare determines the necessity and appropriateness of medical care utilization and services."

Our organizations strongly support the NAIC's determination. The conclusions drawn by this subgroup are applicable not only to Medigap reform proposals, but also to proposals that would increase beneficiary out-of-pocket costs, including the benefit redesign frameworks noted above.

Low-Income Protections

Medicare's low-income protections, including the Low-Income Subsidy of Medicare Part D (Extra Help) and the Medicare Savings Programs (MSPs), are woefully inadequate. In their current form, these benefits do not fully extend to those who cannot afford to pay for necessary health care services. We believe that these protections should be strengthened, regardless of

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[22] Katherine Swartz, "Cost-Sharing: Effects on Spending and Outcomes" (December 2010), Robert Wood Johnson Foundation Research Synthesis Report No. 20, available at: http://www.naic.org/documents/committees_b_senior_issues_110628_rwjf_brief.pdf

[23] Congressional Budget Office, "Budget Options Volume 1: Health Care" (December 2008), page 155, available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf.

[24] National Association of Insurance Commissioners letter to Secretary Sebelius (December 2012), available at: http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf.

other reform proposals that might be implemented. Any attempt to redesign the Medicare benefit must begin with the modernization of these critical low-income protections.

Congress should take steps to strengthen these subsidy programs for low-income Medicare beneficiaries. Currently, full Part A, B and D subsidy protection is provided only for those with incomes up to 100% of FPL, about $11,500 in 2013. In order to assist more people who truly cannot afford to pay for their health care, the income thresholds for full subsidy protection should be increased to 200% of FPL. Similarly, the asset tests for these programs should be eliminated, similar to the elimination of asset testing for Medicaid expansion under the ACA. In addition, individuals enrolled in an MSP are automatically enrolled in LIS without further action on their part, but the reverse is not true. In order to fix this problem, eligibility requirements for MSP and LIS should be fully aligned to allow for cross-deeming. If program requirements were fully aligned, enrollment in one could serve as enrollment in both.

Taking these steps would help reduce the current cost burdens on many low-income Medicare beneficiaries. Any discussion of redesigning Medicare's benefit structure, even one that is budget neutral, must include proposals to strengthen programs for those with low-incomes.

Conclusion

We remain deeply concerned about the effects of further cost-shifting onto people with Medicare, and we believe these proposals pose substantial risks to the health and economic security of beneficiaries, namely those with low- and modest-incomes and people with significant health needs. We acknowledge, however, that we must find savings in the Medicare program to sustain this guaranteed health benefit for today's generation and future generations.

Towards this end, we support prudent cost containment to help solve the real threat to our nation's fiscal health: rising health care costs system-wide. To realize this goal, we endorse cost-saving solutions that eliminate wasteful spending and promote the delivery of high value care—meaning better quality at a lower price. Proposals our organizations support include:

Reduction of wasteful spending on drugs, medical equipment and private health plans: Significant cost-savings can be achieved by allowing the Medicare program to secure lower prices on pharmaceutical drugs. Congress should expand the tools available to the federal government to achieve this end, including restoring Medicare drug rebates, allowing the federal government to directly negotiate with pharmaceutical companies and introducing a public drug benefit in Medicare.

In addition, Congress should expand the cost-savings already achieved by the Centers for Medicare & Medicaid Services (CMS) through the successful competitive bidding demonstration for durable medical equipment. Expansion of the competitive bidding on a national scale should be accelerated and extended to other types of medical equipment, such as lab tests and advanced imaging services.

The ACA took major strides to reduce sizable overpayments to Medicare Advantage. More should be done to equalize payments between Traditional Medicare and private Medicare plans. Private plans should be reimbursed no more than Traditional Medicare.

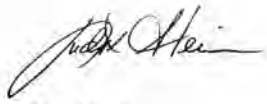
Advance Medicare delivery system reforms made possible by health reform:
The ACA includes many opportunities to test delivery system reforms designed to enhance health care quality while simultaneously driving down the cost of care. These reforms are meant to improve care quality by promoting better coordination among providers, patients and caregivers to prevent harmful drug interactions, unnecessary hospitalizations and more.

Congress should maximize the Administration's authority to test these reforms in a timely manner. At the same time, Congress should avoid dramatically altering Medicare benefits, so as to allow time for these advancements to yield results, meaning both improved care coordination and better cost-effectiveness.

We look forward to working with the Committee and members of Congress to examine additional cost-saving options in the Medicare program that simultaneously address the systemic issue of rising health care costs that concern not only Medicare, but also to the private health insurance market. We implore you to reject proposals that fail to address this systemic issue and instead achieve only short-term savings by shifting costs onto people with Medicare. As such, we ask that you carefully weigh the significant risks posed to Medicare beneficiaries by the redesign proposals discussed above and to steer clear of these models.

We appreciate this opportunity to submit these comments.

Elaine Wong-Eakin
Executive Director
California Health Advocates



Judith A. Stein
Executive Director
Center for Medicare Advocacy

Joe Baker
President
Medicare Rights Center

Please direct questions regarding this testimony to:

Bonnie Burns
Training and Policy Specialist Consultant
California Health Advocates
5380 Elvas Avenue, Suite 221
Sacramento, CA 95819
Phone: (831) 438-6677
Email: bburns@cahealthadvocates.org
www.cahealthadvocates.org

David A. Lipschutz
Policy Attorney
Center for Medicare Advocacy, Inc.
1025 Connecticut Avenue NW, Suite 709
Washington, DC 20036
Phone: (202) 293-5760
Email: dlipschu@medicareadvocacy.org
www.medicareadvocacy.org

Stacy Sanders
Federal Policy Director
Medicare Rights Center
1224 M Street NW, Suite 100
Washington, DC 20005
Phone: (202) 637-0961 ext. 5
Email: ssanders@medicarerights.org
www.medicarerights.org

Statement of the Center for Fiscal Equity

Comments for the Record

U.S. House of Representatives

Committee on Ways and Means

Subcommittee on Health

Hearing on Examining Traditional Medicare's Benefit Design

Tuesday, February 26, 2013, 10:30 AM

By Michael G. Bindner

Center for Fiscal Equity

Chairman Brady Ranking Member McDermott, thank you for the opportunity to submit these comments for the record to the House Ways and Means Committee. We remain available to brief members and staff on our proposals for retirement and health care reform.

It is always important to note when discussing reform options that the whole purpose of social insurance is to prevent the imposition of unearned costs and payment of unearned benefits by not only the beneficiaries, but also their families. Cuts which cause patients to pick up the slack favor richer patients, richer children and grand children, patients with larger families and families whose parents and grandparents are already deceased, given that the alternative is higher taxes on each working member. Such cuts would be an undue burden on poorer retirees without savings, poor families, small families with fewer children or with surviving parents, grandparents and (to add insult to injury) in-laws.

Recent history shows what happens when benefit levels are cut too drastically. Prior to the passage of Medicare Part D, provider cuts did take place in Medicare Advantage (as they have recently). Utilization went down until the act made providers whole and went a bit too far the other way by adding bonuses (which were reversed in the Affordable Care Act). There is a middle ground and the Subcommittee's job is to find it.

Resorting to premium support, along with the repeal of the ACA, had been suggested to save costs. It is our hope that the election results took this off the table, however we will reprise our analysis of this option if and when it comes up.

One option is resorting to single-payer catastrophic insurance with health savings accounts. It would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded

The bigger question is whether private insurance survives the imposition of pre-existing condition reforms. We do not have to wait until implementation to examine this question. Now that the Supreme Court has spoken, the stock market will examine it for us. There may well be a demand for reform before the Act is fully implemented if the prospects for private insurance are found wanting. Conversely, if stock prices are maintained, it is the market expecting mandates to be adequate. This question is by far more important than the design of the traditional system.

If mandates are seen as inadequate, the questions of both premium support and the adequacy of provider payments are moot, since if private insurance fails the only alternatives are single-payer insurance and a pre-emptive repeal of mandates and consumer protections in favor of a subsidized public option. The funding of either single-payer or a public option subsidy will dwarf the requirement to fund adequate provider payments in Medicare and Medicaid.

.Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related.

Recent reforms have essentially turned the Medicare Part A Payroll Tax into a virtual consumption tax by taxing non-wage income above $250,000 a year. It would be as easy to shift from a payroll tax to a value added or VAT-like net business receipts tax (which allows for offsets for employer provided care or insurance) and would likely raise essentially the same amount of money, as most non-wage income actually goes to individuals now liable for increased taxes. If a VAT system is used, tax rates can be made lower because overseas labor will essentially be taxed, leaving more income for American workers while raising adequate revenue.

One form of increased funding could very well be higher Part B and Part D premiums. This has been suggested by both the Fiscal Commission and the Bipartisan Policy Center. In order to accomplish this, however, a higher base premium in Social Security would be necessary. Our proposal is that to do this, the employee income cap on contributions should actually be lowered to decrease the entitlement for richer retirees while the employer income cap is eliminated, the employer and employee payroll taxes are decoupled and the employer contribution credited equally to each employee at some average which takes in all income. If a payroll tax is abandoned in favor of some kind of consumption tax, all income, both wage and non-wage, would be taxed and the tax rate may actually be lowered.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding), regardless of whether Part B and D premiums are adjusted. If the same consumption tax pays both retirement income and government health plans, the impact on the taxpayer is exactly nil in the long term.

We will now move to an analysis of funding options and their impact on patient care and cost control. The committee well understands the ins and outs of increasing the payroll tax, so we will confine our remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The NBRT can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax benefit, either by providing insurance or hiring health care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets.

Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

Michael Bindner
Center for Fiscal Equity
4 Canterbury Square, Suite 302
Alexandria, Virginia 22304
571-334-8771
fiscalequity@verizon.net

Hearing on Examining Traditional Medicare's Benefit Design

Tuesday, February 26, 2013, 10:30 AM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

Statement of the Council for Affordable Health Insurance

WRITTEN STATEMENT OF

THE COUNCIL FOR AFFORDABLE HEALTH INSURANCE

SUBMITTED FOR THE RECORD

FOR A HEARING HELD ON

FEBRUARY 26, 2013

BY THE SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

Mr. Chairman and Members of the Subcommittee,

Thank you for the opportunity to provide written comments on the issue of redesigning the traditional fee-for-service Medicare benefits package. Federal health policymakers face extraordinary challenges, but perhaps none more important than the issue of developing a plan for the future of Medicare that reflects the importance for the long-term success or failure of ensuring that beneficiaries receive appropriate and quality care for their dollars.

Who We Are

The Council for Affordable Health Insurance (CAHI) is a national research and advocacy organization devoted to market-based health care reforms that preserve freedom of choice for individuals and encourage a competitive health insurance market. CAHI members include health insurers, physicians, actuaries, agents and small business owners. Our member companies are active in the Medicare Supplement, individual, small group, health savings account, and senior markets.

Since 1992, CAHI and its members have worked with various states' departments of insurance and legislatures, the National Association of Insurance Commissioners (NAIC), the Society of Actuaries and the American Academy of Actuaries on health care reform issues. For the past 20 years, we have reviewed the Medicare program and ways to improve and sustain the safety net program for future generations. We have asked experts from our Medicare Working Group, Senior Issues Committee, Health Care Reform Working Group, and Research and Policy Committee about their expectations for sustaining the Medicare and Medigap programs. We have looked at short-term solutions, long-term solutions and federal and state budget solutions for both the over-age and under-age 65 markets.

CAHI Concerns

CAHI's experts have reviewed all of the existing proposals that would redesign the Medicare benefits package. **CAHI's members have serious concerns with proposals that would impose a surcharge or other restrictions on Medicare supplement insurance policies.**

Despite the recent projections by the Congressional Budget Office indicating that projections for Medicare spending have fallen by more than $500 billion since 2010, the Medicare program faces serious budget challenges. As a way to rein in future Medicare spending, several proposals would reform the traditional Medicare program and the supplemental coverage provided by Medigap insurance policies by instituting some cost-sharing incentives for Medicare beneficiaries. Some of the proposals include raising the beneficiary share for Medicare Part B from 25 percent to 35 percent, altering the Medigap deductibles and copayments, and raising the Medicare eligibility age. Many of these recommendations CAHI fully supports.

However, CAHI's members believe that simply broadly changing cost-sharing will not necessarily produce reductions in unnecessary care, and may have a negative impact on overall Medicare spending if beneficiaries delay necessary care and drive up long-term costs. Depending on the policy selected, Medicare supplement insurance encourages earlier and less expensive treatment that catches medical issues sooner rather than waiting and having Medicare pay high-dollar or even catastrophic claim expenses. CAHI's members feel strongly that the Congress needs to make targeted changes to the Medicare program that take into account incentives for both providers and beneficiaries to seek cost-effective care.

Medigap and Cost-Sharing

According to America's Health Insurance Plans (AHIP), 9.7 million people have Medigap plans as of 2011. Surveys have consistently shown that seniors are happy with their Medigap coverage. Medicare beneficiaries purchase supplemental coverage to make their health care costs more predictable. They budget their out-of-pocket spending through the purchase of Medigap.

CAHI cautions that as a society, we need to tread lightly as we move forward with Medicare benefit reform because such changes in the program, particularly to the Medigap program, could increase out-of-pocket exposure that could be devastating to an aging population that has very limited income to begin with. For example, the Medicare Payment Advisory Commission's (MedPAC) benefit design recommendations may increase out-of-pocket spending for more than 50% of those enrolled in private fee-for-service Medicare, which is sure to be unpopular and politically untenable.

CAHI believes that the rationale behind proposals to change cost-sharing for Medicare beneficiaries is flawed. Most proposals that modify cost-sharing for Medicare and/or Medigap beneficiaries rely on the conclusions from the RAND Health Insurance Experiment (HIE) that was conducted in 1971 and funded by the Department of Health, Education, and Welfare (now the Department of Health and Human Services). The RAND HIE was a 15-year, multimillion-dollar effort that to this day remains the largest health policy study in U.S. history. While the study has provided the nation with concrete utilization data, **it only looked at the under-age 65 market and not the Medicare population**. This is an important distinction because the utilization for the under-age 65 market is quite different from that of the over-age 65 market.

The main issue at hand is that **there is little *empirical* evidence of the demand-side approach of focusing on the beneficiary incentives and behavior for the over-age 65 population**. We are well aware of the price sensitivity of medical consumption for the under-age 65 population due to the RAND HIE – which, despite becoming the standard of policy research for looking at the impact of beneficiary cost-sharing and health insurance benefit design, is more than forty years old.

In fact, over the past few decades, the Congress has primarily looked at controlling the Medicare program cost growth on the supply side – focusing on provider reimbursement

rate reductions rather than looking at the demand side – which would focus on instituting higher patient consumption and price sensitivity in medical spending/consumption. According to the March 2012 American Academy of Actuaries issue brief, *Revising Medicare's Fee-For-Service Benefit Structure*:

> *"[a] comprehensive package of reforms to improve Medicare sustainability also should consider better aligning incentives on the beneficiary side. To accomplish this, there have been calls to update the program's traditional fee-for-service (FFS) benefit design (i.e., its cost-sharing features) and to address other issues related to beneficiary incentives. Such changes could deal with some of the shortcomings of the current benefit structure, including its lack of a cost-sharing maximum, and could help encourage Medicare beneficiaries to seek more cost-effective care."*

Exacerbating the demand side is the amazing changes in health care delivery, such as the availability of life saving prescription drugs, diagnostic tools and less need for invasive surgery due to technological advances. Demand for these services has increased as they have become more readily available in the marketplace and have produced better patient outcomes. Such demand has increased utilization and therefore costs to the Medicare program.

What is the best way to get Medicare beneficiaries to control their health spending? Is the right answer to impose incentives for providers and/or beneficiaries to control their health spending? Is it to put limitations on Medigap insurers and/or beneficiaries either through cost-sharing requirements like deductibles and copayments or levy a subsidy (like the 20 percent surcharge MedPAC proposes) on private insurance or a Part B premium rate increase? How much of an impact will a subsidy have on Medicare program spending? What are the unintended consequences to a vulnerable and aging population if you do?

Unintended Consequences

The American Academy of Actuaries explores these questions in their *Revising Medicare's Fee-For-Service Benefit Structure* issue brief, concluding,

> *"Reducing the share of costs that Medigap plans can cover would shift costs at the point of service to beneficiaries, increasing the incentives to seek more cost-effective care and avoid unnecessary care. This has the potential to lower both Medicare and beneficiary costs, but the extent to which costs would decline is unclear. Changes in the rules governing Medigap plans should be structured carefully to avoid unintended consequences."*

Self-Selection

CAHI believes that Medicare supplemental plans now attract a poorer risk group and that this has exacerbated Medicare spending over time as Medicare Advantage plans have

become more attractive due to benefit design. In turn, this has created higher utilization in these plans as well. Benefit changes designed to decrease utilization will not necessarily recoup a presumed subsidy in this group, but instead may simply shift costs to seniors who choose supplemental coverage because of their higher health care needs. The forced design of Medigap plans with its integration with Medicare has likely created still further utilization increases. But so do the continual price controls used by the federal government (e.g., the RBRVS, APCs and DRGs) as well.

Where Do We Go From Here?

Our actuaries advise us that Medicare over the past 46 years has contributed to raising the quality of life for the elderly. Without changes to the program, however, Medicare will require resources that are likely to severely pressure the health care system and potentially other sectors such as education, public infrastructure or defense. Without timely action, strain on the federal budget is likely to grow substantially in the coming years, threatening funding of many programs outside of Medicare.

Alternatively, or in combination with squeezing funding of other national programs, Congress may continue to increase payments to providers under Medicare by less than inflation would warrant, as is being discussed currently and as has been done in the past to some extent. But this approach will likely lead to diminished access to care for seniors over time.

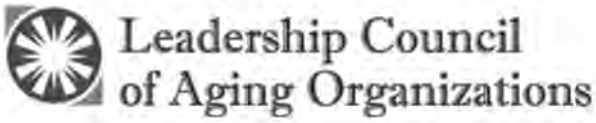
Hence we believe there is an urgent need for serious national debate before changes are made to the Medicare benefit structure. However, the focus should not be on short-term fixes to a long-term problem. There are many lessons that can be learned from the private sector. We need to determine which ones might be of help.

If we don't proceed with caution, our actuaries warn us that Medicare will become more like Medicaid relative to access over time if the fee schedules become more like those of Medicaid. Controlling spending in the name of efficiency will mirror that of Medicaid. Further, Medigap plan beneficiaries are enrolled in Medigap plans to make their cost-sharing more predictable, if not more affordable. A surcharge, for example, does not accomplish the task of solving Medicare's utilization and cost issues.

Conclusion

CAHI members feel strongly that the focus needs to be on reducing Medicare spending by making targeted changes to the Medicare program that change incentives for both providers and beneficiaries to seek cost-effective care. Simply broadly changing cost-sharing will not achieve this goal and could exacerbate existing spending problems.

Letter of the Leadership Council of Aging Organizations



James P. Firman, Chair

March 12, 2013

The Honorable Kevin Brady
Chairman
Ways & Means Subcommittee on Health
Washington, D.C. 20515

Re: House Ways & Means Health Subcommittee Hearing "Examining Traditional Medicare's Benefit Design" (2/26/13)

Dear Chairman Brady:

On behalf of the Leadership Council of Aging Organizations (LCAO), a coalition of national non-profit organizations representing over 60 million older Americans, we submit this testimony in response to the above-referenced hearing.

In recent years, there have been several proposals that seek to alter Medicare's benefit structure, often with similar elements, including creating a single, combined deductible for Parts A and B, a uniform coinsurance rate of 20%, an out-of-pocket cap on beneficiary expenses and various piecemeal changes, such as introducing home health copayments. Often these proposals to redesign Medicare's benefits are coupled with proposals to restrict Medigap "first-dollar coverage."

At first glance, making changes such as combining the Part A and B deductible and adding a catastrophic cap seem like a sensible endeavor. Many of the proposals to do so, however, would redistribute the burden of health care costs to those least able to afford it. LCAO supports measures to bring down costs in the Medicare program that address the systemic causes of health care inflation, not by shifting costs to people with Medicare. The most discussed Medicare benefit redesign proposals fail to meet this standard. We are writing to express the following concerns about current benefit redesign proposals:

Most Medicare beneficiaries have low- or moderate- incomes, and cannot afford to pay more for their health care. In 2012, half of all Medicare beneficiaries had annual incomes below $22,500 and Medicare households, in general, devote a substantially larger share of their income to medical expenses than does the average household (15% vs. 5% respectively).[1] Most Medicare beneficiaries cannot absorb more costs without facing significant hardship. To borrow a crude reference, in short, people with Medicare already have too much "skin in the game."

Increased cost sharing is an inappropriate tool to limit unnecessary use of health services, and limits access to necessary care. Many proposals to reform Medicare, including several benefit redesign frameworks, purport to achieve federal savings by shifting costs to Medicare beneficiaries. Research demonstrates that increased cost sharing for health care services leads individuals to forgo needed health care services in the short-term. This trend is shown to result in worsening health, the need for more intensive care and higher costs to the Medicare program in the long-term.[2]

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[1] See, e.g., LCAO Fact Sheet: "Medicare Beneficiary Characteristics and Out-of-Pocket Costs" (December 2012), and citations therein, available at: http://www.lcao.org/files/2013/02/LCAO-Medicare-Characteristics-Costs-Fact-Sheet-Dec2012.pdf

[2] See, e.g., National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental Insurance First Dollar Coverage and Cost Shares Discussion Paper" (October 2011), available at: http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf; Congressional

1901 L Street, NW, 4th Floor, Washington, DC 20036 ♦ (202) 479-1200 ♦ (202) 479-0735 (Fax)
Email: LCAO@ncoa.org ♦ Website: www.LCAO.org

Current protections for low-income individuals are inadequate. Currently, full Part A, B and D subsidy protection is provided only for those with incomes up to 100% of the federal poverty level. In order to assist more people who truly cannot afford to pay for necessary health care services, the income thresholds for full subsidy protection should be increased and asset tests should be eliminated. Any discussion of redesigning Medicare's benefit structure, even one that is budget neutral, must include proposals to strengthen programs for those with low-incomes.

Limiting Medigap coverage and/or adding a surcharge to such policies is not a solution for savings. Instead of driving "overuse" of health services, these policies provide financial security and protection from high, unexpected out-of-pocket costs due to unforeseen medical care. Once beneficiaries seek care, medical providers—not beneficiaries—drive the number and types of services delivered. Further, it is the Medicare program—not Medigap plans—that determine which services are covered and are medically necessary.[7]

For these reasons, the undersigned members of the LCAO urge you to reject Medicare redesign proposals that shift additional costs to Medicare beneficiaries. Any efforts to redesign the Medicare benefit structure should be done as part of a thoughtful, deliberative process instead of part of the debt and deficit reduction debate.

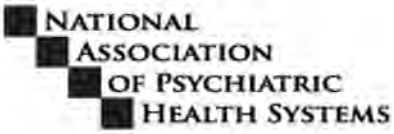
Sincerely,

AFSCME Retirees
Alliance for Retired Americans
Alzheimer's Foundation of America
American Association for International Aging (AAIA)
Association for Gerontology and Human Development in Historically Black Colleges and Universities (AGHDHBCU)
Association of Jewish Aging Services (AJAS)
B'nai B'rith International
Center for Medicare Advocacy, Inc.
Easter Seals
International Union, UAW
LeadingAge
Lutheran Services in America (LSA)
Medicare Rights Center
Military Officers Association of America (MOAA)
National Academy of Elder Law Attorneys (NAELA)
National Asian Pacific Center on Aging (NAPCA)
National Association for Home Care and Hospice (NAHC)
National Association of Area Agencies on Aging (n4a)
National Association of Professional Geriatric Care Managers (NAPGCM)
National Association of Social Workers (NASW)
National Association of States United for Aging and Disabilities (NASUAD)
National Committee to Preserve Social Security and Medicare (NCPSSM)
National Consumer Voice for Quality Long-Term Care
National Hispanic Council on Aging (NHCOA)
National Senior Citizens Law Center (NCSLC)
OWL – The Voice of Midlife and Older Women
PHI – Quality Care *Through* Quality Jobs
Services and Advocacy for GLBT Elders (SAGE)

Budget Office, "Budget Options Volume 1: Health Care" (December 2008), page 155, available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf.

[7] See LCAO Issue Brief: "Reforming Medigap Plans: A Flawed Approach to Achieve Medicare Savings" (December 2012) http://www.lcao.org/files/2013/02/LCAO-Medigap-Issue-Brief-Dec2012.pdf; also see NAIC Discussion Paper, *supra*.

Statement of the National Alliance on Mental Illness



Statement of

Michael Fitzpatrick, Executive Director,
National Alliance on Mental Illness (NAMI)

and

Mark Covall, President and CEO,
National Association of Psychiatric Health Systems (NAPHS)

on the

"Medicare 190-Day Lifetime Limit"

to the

House Ways and Means Health Subcommittee

Hearing on "Examining Traditional Medicare's Benefit Design"

February 26, 2013

Statement of

Michael Fitzpatrick, Executive Director,
National Alliance on Mental Illness (NAMI)
and
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"Medicare 190-Day Lifetime Limit"

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House Ways and Means Health Subcommittee
Hearing on "Examining Traditional Medicare's Benefit Design"

February 26, 2013

Mr. Chairman and members of the Subcommittee, we want to thank you for holding this hearing on "Examining Traditional Medicare's Benefit Design."

On behalf of our respective memberships, we are pleased to provide perspective on the need for Medicare modernization that could play a critical role in improving the lives of millions of Americans who live with serious mental and addictive disorders.

Together, our associations represent America's treatment providers, consumers, and families.

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need.

The National Association of Psychiatric Health Systems (NAPHS), which was founded in 1933, advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. NAPHS members are behavioral healthcare provider organizations that own or manage more than 700 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral healthcare divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks.

Medicare Modernization Is Necessary.

As you know, Medicare was established in 1965 when our healthcare delivery system and insurance system were very different than today's.

This is even more the case for mental health and addiction coverage. In 1965, most care for people living with mental illnesses was provided in state mental hospitals. Inpatient stays were counted in months and years, and much of the care was custodial in nature. Diagnosis and treatment was in its infancy for psychiatric illnesses. So when Congress was considering establishing the Medicare program, this was the framework that Congress had to work within in establishing coverage for mental illnesses. This resulted in a very limited benefit for mental illnesses under the original Medicare program and a benefit that provided much less coverage compared to that for other medical disorders. The benefits for mental illnesses included just inpatient hospital and outpatient office-based visits, but more importantly these benefits had limits in duration, scope, and cost-sharing. For example, outpatient psychiatric care had a 50% cost-sharing requirement (compared to an 80% cost-sharing requirement for all other Medicare outpatient services). Also, inpatient psychiatric care provided in freestanding psychiatric hospitals was limited to 190 days during the lifetime of a Medicare beneficiary.

These discriminatory benefits for mental illnesses remained in place until 2008 when Congress made the first change in mental health coverage since 1965. In 2008, Congress changed the cost-sharing for outpatient mental health services from 50% to 80% (phased in over several years) to make cost-sharing for mental health just like that for all other Medicare outpatient services. Yet the Medicare 190-day lifetime limit for inpatient psychiatric care in freestanding psychiatric hospitals remains unchanged to this day.

During the 1980s, there was a growth in the number of community private psychiatric hospitals that provided short-term, acute, inpatient psychiatric care. At the same time, the downsizing and closing of state mental hospitals intensified. During this period, diagnosis and treatment of mental illnesses dramatically improved and new medications became available. This resulted in briefer inpatient stays compared to the longer-term care that was provide in the 1960s when Medicare was first established. The 1990s saw a decline (more than 30%) of the overall inpatient psychiatric bed capacity. The decline in beds was in all settings, including state mental hospitals, community private psychiatric hospitals, and general hospitals' psychiatric units. Today, many communities do not have enough inpatient psychiatric beds—leading to an increase in emergency room visits, longer time spent in the emergency departments, and patients needing to travel long distances to receive inpatient psychiatric care.

In 2008, Congress passed landmark legislation called the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (MHPEA). This legislation changed the landscape of coverage for mental and addictive disorders by requiring private commercial health plans that offered coverage for mental health and addictive services to provide that coverage on par with all other medical disorders. However, the major governmental health insurance program for seniors and the disabled—the Medicare program—still has discriminatory coverage for inpatient psychiatric care. It is long past due to bring the

Medicare program up to the standard of all other insurance plans and to – once and for all – eliminate Medicare's 190-day lifetime limit for inpatient psychiatric care delivered in community private psychiatric hospitals.

The need to get rid of this long-standing discriminatory provision for inpatient psychiatric care is not just about fairness and equity, but it is about real people who are dealing with debilitating, but very treatable diseases who so desperately need this care.

Who Are These Medicare Beneficiaries? Why Is Elimination of the 190-Day Lifetime Limit Critical?

The Medicare Payment Advisory Commission[1] has outlined key characteristics of Medicare beneficiaries who receive inpatient psychiatric care.

Unlike beneficiaries seen in other types of hospitals, most Medicare beneficiaries treated in inpatient psychiatric facilities (known as "IPFs") qualify for Medicare because of disability. Patients being treated in inpatient psychiatric facilities tend to be younger and poorer than the typical Medicare beneficiary.

In 2008, 65% of discharges in IPFs were for beneficiaries under age 65, and almost 29% were for beneficiaries under age 45.

As baby boomers have aged, the number of IPF beneficiaries between the ages of 45 and 64 has grown, rising 18% between 2002 and 2009.

In 2008, 28% of beneficiaries admitted to an IPF had more than one admission during the 12-month period.

Beneficiaries with multiple stays were more likely than other IPF patients to be under the age of 65 (70% compared with 52%) and to be diagnosed with psychoses (78% compared with 66%).

These demographics provide a picture of Medicare beneficiaries who have serious mental illnesses (such as schizophrenia and bipolar disorder) and who are living with these disorders from a relatively young age. These illnesses are chronic and will require ongoing treatment and care over lifetimes, including hospitalization when in crisis.

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[1] Medicare Payment Advisory Commission (MedPAC). "Inpatient psychiatric care in Medicare: Trends and issues." Chapter 6 in *Report to Congress*. June 2010. See http://www.medpac.gov/chapters/Jun10_Ch06.pdf.

Care for these sickest patients continues to have complexity and barriers that don't exist for other complex or chronic illnesses. These Medicare beneficiaries can easily exceed the 190-day lifetime limit because the chronicity of their illness.

The 190-day lifetime limit restricts access to critical, life-saving treatment just when it is most needed.

The 190-day lifetime limit also impacts the continuity of care for people living with serious mental illnesses. Just when they need crisis stabilization in a hospital setting, they may not be able to go to the hospital and doctors who have been treating them for many years because of the arbitrary lifetime limit.

Legislation has been introduced in previous Congresses to eliminate the 190-day lifetime limit, and it has been both bipartisan and supported by broad coalition of national organizations.

In closing, the science and knowledge base about mental illnesses has grown exponentially in recent years. These illnesses can be diagnosed and treated effectively. People can recover and live productive lives. What we need to do as a society is to give people the hope and help they deserve – just as we would for someone who has a heart condition or cancer.

Eliminating the 190-day lifetime limit will equalize Medicare mental health coverage with private health insurance coverage, expand beneficiary choice, increase access for the most seriously ill, improve continuity of care, and create a more cost-effective Medicare program.

Mr. Chairman, again, thank you for holding this very important hearing. We look forward to working with you and the entire Subcommittee to ensure that Medicare beneficiaries living with serious mental illnesses are able to have coverage that is comparable to what is available for all other Medicare beneficiaries.

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Statement of the National Association for Home Care and Hospice

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

STATEMENT SUBMITTED BY THE

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

TO THE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FEBRUARY 26, 2013

The National Association for Home Care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

As the House Ways and Means Subcommittee on Health examines traditional Medicare's benefit design, NAHC appreciates this opportunity to provide our views on proposals to restructure cost sharing within Medicare. Some policymakers have suggested adding copayments for Medicare home health and hospice services as a means of both reducing the deficit and preventing overutilization of home health and hospice services.

Congress eliminated the home health copayment in 1972 for the very reasons it should not be resurrected now. The home health copayment in the 1960s and 1970s deterred Medicare beneficiaries from accessing home health care and instead created an incentive for more expensive institutional care. Reinstating the home health copay today would undo the progress made in efforts to reduce unnecessary hospitalizations and nursing home stays.

Moreover, home health services and hospice care already have the highest cost-sharing in Medicare. On a daily basis, millions of spouses, family, friends, and community groups contribute the equivalent of billions of dollars worth of care and support to keep their loved ones at home. Further, care in the home means that the Medicare beneficiary provides all the financial

support in terms of room and board that are otherwise paid for by Medicare and Medicaid in an institutional setting.

Numerous studies have concluded that a copay can discourage use of necessary and beneficial care, resulting in the deterioration of a patient's condition and ultimately leading to higher costs for the Medicare program through acute care interventions in higher cost settings. With hospice patients, barriers to comfort at the end of life add both avoidable costs and avoidable pain.

We respectfully submit that Congress should oppose any copay proposal for Medicare home health and hospice services.

HOME HEALTH CARE

Proposals to impose a home health copay should be rejected for the following reasons:

- **Home health copayments would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall.** The Urban Institute's Health Policy Center found that home health copays "…would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays."[i] Similarly, a study in the *New England Journal of Medicine* found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes, and greater expense.[ii] The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copay. Studies have shown that Medicaid copays can backfire with beneficiaries avoiding care leading to higher Medicaid overall costs.[iii] According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by $6-13 billion over ten years.[iv]

- **The burden of a home health copayment would disproportionately impact the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries.** About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30 percent 85 or older. Sixty-three percent are women.[v] Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.[vi] The Commonwealth Fund cautioned that "cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs."[vii]

- **Most people with Medicare cannot afford to pay more.** In 2010, half of Medicare beneficiaries—about 25 million seniors and people with disabilities—lived on incomes below $22,000, just under 200 percent of the federal poverty level.[viii] Medicare households already spend on average 15 percent of their income on health care costs, three times as much as the non-Medicare population.[ix]

- **Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100 percent of poverty ($11,412 for singles, $15,372 for couples) and non-housing assets below just $6,940 for singles and $10,410 for couples. In sharp contrast, eligibility for cost sharing assistance for individuals under age 65 is set at 138 percent of poverty, with no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third actually have it.[x]

- **Individuals receiving home care and their families already contribute to the cost of their home care.** With hospital and nursing home care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services are provided by family members or paid out-of-pocket by individuals without family support. Family members are frequently trained to render semi-skilled support services for home health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated $450 billion a year in unpaid care to their loved ones,[xi] and too frequently having to cut their work hours or quit their jobs.

- **Copayments as a means of reducing utilization would be particularly inappropriate for home health care.** Beneficiaries do not "order" home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary, that beneficiaries are homebound and meet other stringent standards. There is no evidence of systemic overutilization. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.[xii]

- **Home health copayments would shift costs to the states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by the Medicare Payment Advisory Commission (MedPAC)) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.

- **Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copay and only 17 percent of Medicare beneficiaries have Medigap coverage. For the 34 percent of Medicare beneficiaries who have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree coverage.[xiii] Likewise, the 25 percent of beneficiaries enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.

- **Copayments would impose costly administrative burdens and increase Medicare costs.** Home health agencies would need to develop new accounting and billing procedures, create

new software packages, and hire staff to send bills, post accounts receivable, and re-bill. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care. Home health agencies cannot absorb these costs as nearly 50 percent of home health agencies are projected to be paid less than their costs by Medicare. Overall home health agency margins from a combination of Medicare, Medicaid, Medicare Advantage and other payment sources average less than zero.[xiv]

HOSPICE

The Medicare hospice benefit was created under the Tax Equity and Fiscal Responsibility Act of 1982 to expand the availability of compassionate and supportive care to Medicare's many beneficiaries suffering from terminal illness at the end of life. Eligibility for hospice is based upon a physician's certification that the patient has a terminal illness with a life expectancy of six months or less if the illness runs its normal course. When a patient elects hospice under Medicare, he or she agrees to forgo other "curative" treatment for the terminal illness. While the cost of most hospice care is covered by Medicare, the patient may be responsible for copayments related to drugs for symptom control or management and facility-based respite care. The patient is also responsible for copayments related to any regular Medicare services unrelated to the terminal diagnosis.

Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit. The average Medicare hospice beneficiary receives care at a cost of approximately $11,500. With the cost sharing changes that have been proposed, a 20 percent copay would impose a charge of approximately $2,300 on terminally ill individuals in the last days of their lives. Given the requirement that a patient be determined to be terminally ill with a plan of care developed by an interdisciplinary team, there is no need for an additional check on utilization of care. Implementing a Medicare copayment for these services would cause many terminally ill patients to second guess their physician and care team in the last days of their life.

Historically, copayments have been imposed on health care services to reduce overutilization of services. While use of hospice services has grown significantly through the years, many Medicare beneficiaries are referred to hospice too late to reap its full benefit, and many more lack sufficient knowledge or understanding of hospice to consider it a viable option at the end of their lives. This is particularly the case for minority and low-income Medicare populations – who are the least likely to be able to afford additional cost-sharing burdens.

Beneficiaries who elect Medicare hospice services must agree to forego curative care for their terminal illness. Given that many "curative" interventions for terminal illnesses can involve administration of costly new medications and treatments, it is not surprising that numerous studies have documented that appropriate use of hospice services can actually reduce overall Medicare outlays while at the same time extending length and quality of life for enrolled beneficiaries.[xv]

While valid concerns have been raised about the length of time some Medicare beneficiaries are on hospice service, the median length of stay under the hospice benefit is about 17 days,

and 95 percent of hospice care is provided in the home. Congress has already addressed concerns relative to extended length of stays in hospice care by requiring a face-to-face encounter prior to the start of the third and later benefit periods. Through that change, ineligible individuals are screened out and improper Medicare payments are avoided. In lieu of imposing additional beneficiary cost-sharing that could discourage appropriate and desirable use of the hospice benefit, Congress and other policymakers should explore additional ways to ensure that hospice services are being ordered for patients that are truly eligible, such as through physician education.

PROPOSALS TO ADDRESS CONCERNS ABOUT PROGRAM INTEGRITY

Rather than applying a copay to address concerns that have been raised about possible overutilization and wasteful spending on home health services in certain parts of the country, NAHC suggests targeted approaches that do not restrict access to care and penalize Medicare beneficiaries and ethical home health providers. It is essential that Medicare operate with integrity and compliance as millions of Americans depend on this program every day to meet their health care needs. Eliminating wasteful spending should be the highest priority in that regard. For too long, honest and compliant providers and beneficiaries have had to pay through increased costs, reduced benefits, and payment rate reductions for the misdeeds and criminal conduct of bad actors that seek to take advantage of systemic weaknesses in Medicare. NAHC fully supports efforts to address these weaknesses with constructive and well-focused action. The home care and hospice community recognizes that they must be responsible stewards of the limited resources available to Medicare. We also recognize that it is a privilege to be a participating provider in these programs and that we can be effective partners with government in combatting fraud, waste, and abuse.

In recent years, new policies and administrative practices have been instituted to address care overutilization concerns. For example, Medicare has added oversight and "real-time" predictive modeling to target aberrant providers, using its contractors such as the Zone Program Integrity Contractors (ZPICs) and Recovery Audit Contractors (RACs) in addition to its longtime claims reviews by the everyday Medicare Administrative Contractors (MACs). Also, an industry-developed restriction on home health outlier episodes in home health services eliminated abusive claims, reducing unnecessary Medicare spending by $1 billion in in its first year, 2010.

Other measures have been instituted by Medicare, including more stringent provider participation standards, a periodic professional therapist assessment requirement prior to continued care, and a physician face-to-face encounter requirement to initiate covered home health services. These and other changes have led to an actual reduction in Medicare home health spending, a phenomenon unique in the Medicare program in recent years. In fact, home health spending and utilization is less today than in 1997. In today's dollars, Medicare home health spending is about 40 percent lower than in 1997 while all other sectors have significantly increased. Still, home care and hospice wish to lead rather than follow in program integrity innovations.

In that spirit, we offer ten recommendations that we believe can further reduce wasteful spending and prevent fraudulent conduct. These recommendations include a combination of steps that are directed to the primary reason that concerns about fraud and abuse exist – the system permits bad actors and parties without adequate competencies to enter Medicare program. In addition, these recommendations also offer a series of improvements focused on existing providers of care designed to ensure ongoing and continuous compliance. These recommendations are designed to address both deliberate fraud and abuse and harm caused by ignorance or lack of competence..

1) **Implement a targeted, temporary moratorium on new home health agencies.** CMS has expressed growing concerns about the entry of fraudulent providers into the Medicare program. With respect to Medicare home health services, there is strong evidence that much of the fraud, waste, and abuse stems from the entry of new providers in areas of the country already saturated with existing home health agencies. CMS has not exercised its authority to impose targeted moratoria on new home health agencies in spite of the evidence that certain areas of the country already have too many providers. Congress should mandate the implementation of a temporary, targeted moratorium on new home health agencies in geographic areas where there is a highly disproportionate number of providers relative to the number of beneficiaries in an area. It should apply certain standard exceptions to a moratorium such as where the state has a Certificate of Need program and the state determines that there is a need for additional providers; the provider is establishing a branch office or multiple locations within its geographic service area; or the provider has submitted the appropriate CMS Form 855A prior to the public notice of any moratorium.

2) **Require credentialing of home health agency executives.** Strengthen Medicare program participation standards to include experience, credentialing and competency testing of home health agency owners, managers, and personnel responsible for maintaining compliance with Medicare standards. Competency credentialing should be made part of the Medicare provider screening model and applied to both new and existing providers of home health services. The credentialing should include minimum training and competency testing of owners and managers in all areas of Medicare/Medicaid operations including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions.

3) **Expedite refinements to the Medicare home health payment system to eliminate incentives to over-utilize care.** The current home health prospective payment system (HHPPS) includes higher reimbursement for episodes with more therapy visits. Reimbursement for episodes increases incrementally as the number of therapy visits increase. Any episodic prospective payment system that relies on the volume of services to determine payment amounts raises the risk of service overutilization. The current case mix adjustment model for home health services payment should be modified to eliminate the use of a payment modifier based on the volume of therapy visits. Sufficient Medicare resources should be invested to expedite refinements to the Medicare home health payment system so that the provision of services is better aligned with patient characteristics and costs of providing care, rather than the number of visits provided per episode for any service.

4) **Require all Medicare participating home health agencies to implement a comprehensive corporate compliance plan.** Congress should require expedited implementation of corporate compliance plans by home health agencies to ensure adherence to all federal and state laws with proper funding support. Compliance program implementation, development and maintenance should include the following: corporate compliance plan frameworks based on the elements put forth in the Sentencing Guidelines; tailored to address specific risk areas; periodically re-evaluated; taken into consideration by CMS when making payment rate changes; outreach and education activities by CMS for providers to implement a compliance plan; and 12 months to fully implement a compliance plan following the publication of any rule.

5) **Strengthen admission standards for new Medicare home health agencies through probationary initial enrollment, prepayment claims review, increased initial capitalization requirements, and early-intervention oversight by Medicare surveyors.** CMS has implemented provider screening, including fingerprinting. However, participation standards should be established to further reduce the risk that unscrupulous, as well as inexperienced providers continue to manage to obtain Medicare participation agreements on the front-end. Congress should increase the initial capitalization requirements to the equivalent of one year operation; establish a "probationary enrollment" for new providers during which all new home health agencies are subject to 100 percent medical review for at least 30 days, followed by a minimum of 10 percent medical review for the first year in the program; establish a mandatory in-service training requirement during the probationary period on regulations and policies including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions; conduct State Agency full resurveys of all new home health agencies at 6 months of operation; and require training for all State surveyors in coverage standards, with reporting of questionable billing practices to the MACs.

6) **Create a joint Home Health Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries.** Congress should establish a Medicare Home Health Benefit Program Integrity Advisory Council appointed by the Secretary of HHS with representation from Medicare beneficiaries, home health agencies, organizations representing beneficiaries and home health agencies, the Centers for Medicare and Medicaid Services, the Office of Inspector General of the US Department of Health and Human Services, and the US Department of Justice. Its purpose is to: evaluate and assess existing compliance oversight systems and system performance within the Department of Health and Human Services and its contractors regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; recommend compliance oversight system improvements that should be developed and implemented by the Secretary; evaluate and assess existing compliance oversight systems within home health agencies and system performance regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; and recommend compliance

oversight system improvements that should be developed and implemented by home health agencies.

7) **Require criminal background checks on home health agency owners, significant financial investors, and management.** A key to program integrity in Medicare and Medicaid home care starts at the top. Congress should require criminal background check requirements on all individuals seeking to open and operate an agency and those who finance the creation of the agency. Medicare participation should be denied to any prospective owner where that owner or party providing the financial capital to open the home health agency has a criminal background that involves patient abuse, neglect, or misappropriation of patient property or involves a financial related crime that indicates a risk to the integrity of Medicare.

8) **Establish authority for a self-policing compliance entity to supplement and complement federal and state oversight.** Government enforcement entities do not have sufficient resources to address all concerns regarding fraud, waste and abuse in federal health care programs. Congress should authorize the establishment of private enforcement and sanction power by an industry-sponsored entity as an adjunct and complement to existing federal enforcement powers. The entity would be industry-financed, subject to operational standards developed by HHS, and open and transparent in a manner equivalent to a federal agency. The private enforcement entities would be authorized to impose monetary and operational sanctions on Medicare/Medicaid participating providers of care, including suspension of the provider participation agreement, institution of corporate integrity agreements, and fines for noncompliance. The entities would have audit authority in order to engage in an investigation of alleged noncompliance.

9) **Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of program standards.** The Medicare home health benefit is governed by complex laws and regulations that lead to misinterpretation of coverage, payment, and program integrity rules. In addition, providers frequently receive conflicting information from various sources involved in enforcing program integrity. Congress should ensure that education and training of the Medicare program is a joint effort among home health providers, regulators, state surveyors, and Medicare contractors by taking the following steps: develop education sessions to be conducted nationally and open to all stakeholders; provide educational resources that are accessible and that provide clear interpretations to CMS regulations and policies; require greater transparency on instructions provided to the Medicare contractors on payment, coverage, and program integrity policies; and abandon use of local coverage decisions (LCD) and require that only national coverage decisions be used for coverage and payment guidelines.

10) **Utilize targeted provider edits for application of claims reviews and oversight activities. In Medicare home health services, the variation in utilization warrants careful attention**. While the benefit may offer a wide range of services to be covered and permit coverage of extended periods of care, extreme instances of high levels of

utilization should be subject to increased scrutiny. For example, MedPAC has highlighted the 25 counties with the highest level of utilization. In some instances, providers have twice the national average in the number of episodes per beneficiary per year. Although beneficiaries can qualify for an unlimited number of 60 day episodes in a calendar year, the extraordinary difference between national average utilization and these providers should trigger claims reviews, including a prepayment authorization process. Such an episode volume process edit will require providers to prove that their claims meet coverage standards.

In relationship to hospice care, NAHC's affiliated Hospice Association of America (HAA) has developed a similar list of program integrity recommendations that we would be happy to supply to the Committee.

MEDICARE INNOVATIONS TO PROMOTE HIGH QUALITY CARE AT LOWER COST

NAHC suggests the following reforms in the Medicare benefit structure that would incentivize high quality care while saving Medicare dollars:

1) **Ensure home care and hospice participation in transitions in care, accountable care organizations, chronic care management, health information exchanges, and other health care delivery reforms.** Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS's implementation of the health care delivery reform provisions in the Patient Protection and Affordable Care Act (PPACA) to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

2) **Allow nurse practitioners and physician assistants to sign home health plans of care.** Congress should enact the bipartisan Home Health Care Planning Improvement Act that would allow Nurse Practitioners (NP) and Physician Assistants (PA) to certify and make changes to home health plans of treatment. NPs and PAs are playing an increasing role in the delivery of our nation's health care, especially in rural and other underserved areas. Medicare reimburses NPs and PAs for providing physician services to Medicare patients. NPs and PAs can certify Medicare eligibility for skilled nursing facility services, but not more cost effective care in the home.

3) **Recognize telehomecare interactions as bona fide Medicare services.** Congress should: 1) establish telehomecare services as distinct benefits within the scope of Medicare coverage guided by the concepts embodied in the Fostering Independence Through Technology (FITT) Act, which should include all present forms of telehealth

services and allow for sufficient flexibility to include emerging technologies; 2) clarify that telehomecare qualifies as a covered service under the Medicare home health services and hospice benefits and provide appropriate reimbursement for technology costs; 3) expand the list of authorized originating sites for telehealth services by physicians under section §1834(m)(3)(C) to include an individual's home; and 4) ensure that all health care providers, including HHAs and hospices, have access to appropriate bandwidth so that they can take full advantage of advances in technology appropriate for care of homebound patients.

4) **Ensure appropriate development of performance-based payment for Medicare home health services.** MedPAC has recommended application of a "pay for performance" (P4P) system for home health and other Medicare provider payments. Starting in 2008, Medicare began a P4P demonstration project operating in seven states. Under that demo, home health agencies qualify for incentive payments based on high quality of care performance or improvement in performance from the previous year. The incentive payments are based upon the impact that the performance has had on reducing Medicare costs in other health care sectors, including hospital care. This approach recognizes the dynamic value that high quality home health services can have in reducing overall health care spending. Congress should monitor the progress of the ongoing P4P demonstration and use the findings to guide its consideration of a full-fledged value-based payment system for Medicare home health services.

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Statement of the National Committee to Preserve Social Security and Medicare

United States House of Representatives
Committee on Ways and Means, Subcommittee on Health
Hearing on Examining Traditional Medicare's Benefit Design
Tuesday, February 26, 2013

Mr. Chairman and Members of the Subcommittee:

I am Max Richtman, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare (NCPSSM), and I appreciate the opportunity to submit this statement for the record. With millions of members and supporters across America, the National Committee is a grassroots advocacy and education organization devoted to preserving and promoting Social Security, Medicare, and Medicaid. As you know, these programs are the foundation of financial and health security for older Americans. Today, I will address our views about proposals to restructure the traditional Medicare benefit design.

In testimony I submitted for the Subcommittee's June 19, 2012 hearing, I stated, "Medicare could be improved for beneficiaries by simplifying its cost-sharing requirements and adding a catastrophic cap. The current Medicare fee-for-service (FFS) program is complicated because there are different deductibles, copayments, and coinsurance for different types of services. In many cases the cost-sharing is quite high, and Medicare does not have a limit – a so-called "catastrophic cap" – on annual out-of-pocket spending, which is found in most large employer plans. Many Medicare beneficiaries are paying premiums for Medigap insurance or retiree health coverage to help with Medicare's costs-sharing requirements. They are also paying a large share of their incomes for health care services not covered by Medicare such as vision, dental and eye care as well as long-term care."

I would like to reiterate this statement because Medicare beneficiaries have modest incomes and they cannot afford higher out-of-pocket costs for the health care services they need to treat their multiple chronic conditions and cognitive/mental impairments. People from communities of color have a higher risk than whites for certain chronic conditions such as diabetes. According to the Kaiser Family Foundation, over half of Medicare beneficiaries had incomes of $22,500 or less in 2012, lower than 200 percent of the federal poverty level, and their savings are very modest. Two-thirds of African American and Hispanic beneficiaries have incomes below this amount, and they make up a large share of beneficiaries who have incomes below 100 percent of the federal poverty level. On average, Medicare households spend 15 percent of their income on health care, which is three times more than non-Medicare households spend.

For these reasons, we are opposed to proposals to restructure Medicare's benefits that would reduce federal spending by requiring beneficiaries to pay more. These proposals, such as one included in the 2010 Bowles-Simpson report, *The Moment of Truth*, and likely to be included in the upcoming report they have recently outlined, would raise costs for most beneficiaries by combining the Part A and B deductible; establishing a catastrophic cap so high that it would only help a small percentage of beneficiaries each year; requiring coinsurance on all services, including some such as home health that currently do not require beneficiary cost sharing; and

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restricting Medigap first-dollar coverage, which is important for many lower-income people who need as much predictability as possible regarding their out-of-pocket health costs.

Our concerns also apply to the proposal in the June 2012 MedPAC report to reform Medicare's benefit design. We support the inclusion of a catastrophic cap on Medicare's cost sharing that is set at a level which would give beneficiaries some assurance that they would be helped with high out-of-pocket costs. However, although a catastrophic cap would give beneficiaries some certainty about the limits on their health spending, many people would likely retain their Medicare supplemental policies to make their out-of-pocket costs, especially increased coinsurance, before reaching the cap more predictable. Therefore, we have concerns about implementing a surcharge on both Medigap and employer-provided supplemental policies that would increase costs for beneficiaries, including those with policies they have had for many years.

Supporters of proposals that shift costs to beneficiaries believe people will make wiser choices about using health care services, or will seek more high-value services, if they have to pay more of the cost. We oppose these proposals because we believe additional costs could lead many seniors to forego necessary care, which could lead to more serious health conditions and higher costs down the road. Also, once a person seeks care, it is physicians and other health care providers who make the decisions about the care, tests and other services they receive.

Medicare beneficiaries are already paying a great deal for their health care, and many cannot afford to pay more. The National Committee to Preserve Social Security and Medicare believes we can strengthen Medicare's financing and improve the quality of care provided without adversely affecting beneficiaries. Specifically, we support:

- Building on the Affordable Care Act (ACA). Savings in the ACA are slowing Medicare's per capita growth and have extended the solvency of the Medicare Part A Trust Fund. The ACA also includes provisions leading to changes in the way care is delivered and paid for that improve quality and reduce costs. We support efforts to expand these improvements, including better care coordination, reforms to fee-for-service payments, and enhanced support for primary care providers.

- Requiring Part D drug rebates and allowing the federal government to negotiate prescription drug prices. The Congressional Budget Office (CBO) has estimated savings of $137 billion over 10 years if drug manufacturers were required to provide rebates for drugs used by beneficiaries who are dually eligible for Medicare and Medicaid as they were required to do before passage of the Medicare Modernization Act.

- Improving initiatives to prevent, detect and recover improper payments, including fraud, waste and abuse.

Thank you again for this opportunity to submit our views on proposals to restructure the current Medicare benefit design.

Statement of the UAW

February 26, 2013

For the Record
House Ways and Means Health Subcommittee

"Examining Traditional Medicare's Benefit Design"

Testimony by Josh Nassar, Legislative Director, International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW).

This testimony is submitted on behalf of the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW) in connection with the hearing that will be held by the Subcommittee on Health of the House Ways and Means Committee on February 26, 2013 to examine proposals to change Medicare's traditional benefit design. The UAW represents over 1.2 million active and retired workers across the United States in the auto, aerospace, education and public sectors. About two thirds of our retired members receive their primary health care coverage from Medicare. Many of these retirees also receive supplemental health care benefits from their former employers or from Voluntary Employee Beneficiary Associations (VEBAs) that have resulted from court-ordered settlement agreements.

Medicare has been one of the most successful social programs in our nation's history. The program is highly effective in that it delivers high quality care at a fraction of the cost to deliver that same care through the private market. When Medicare was created in 1965, slightly more than half of America's seniors had health insurance and many more were living in poverty and were forced to go without health care due to costs.

Today, nearly all of America's seniors have access to affordable health care through the Medicare program. We must build on the program's success and the UAW strongly supports the addition of catastrophic coverage under Medicare. This has long been a glaring omission in the program. Providing protection against catastrophic medical expenses would help seniors who would otherwise face potentially devastating costs due to the treatments required for serious illnesses.

We recognize the need to update and simplify the deductibles, co-insurance and other cost sharing requirements. This could make it easier for retirees to understand these cost sharing requirements. It also could ease the administrative burdens both on Medicare and on employers/VEBAs that provide supplemental coverage.

However, the UAW has serious concerns about MedPAC's proposals that shift health care costs to seniors. MedPAC's proposals for changing the Medicare benefit package would impose substantial additional cost sharing on most seniors. We understand that the MedPAC proposals are intended to maintain **in the aggregate,** the same level of cost sharing as the traditional Medicare benefit package. But in order to pay for the catastrophic protection for a small number of seniors, this means the MedPAC

proposals will substantially increase the cost sharing that will have to be borne by most beneficiaries.

The UAW opposes this shifting of substantial new costs to most seniors. In 2010, half of all Medicare beneficiaries had annual incomes below $22,000 (200% of the federal poverty level). Medicare households have a lower average budget than the typical household ($30,818 vs. $49,641 respectively), but devote a substantially larger share of their income to medical expenses than does the average household (14.7% vs. 4.9% respectively). Thus, many seniors simply cannot afford the cost sharing implicit in the MedPAC proposals, and would experience significant hardship if they had to pay for these additional costs. Some UAW retirees could see their income reduced by up to a quarter if they had to pay the cost sharing proposed by MedPAC.

The UAW also is skeptical that this increase in cost sharing for most seniors would be effective in restraining the growth in health care spending. To begin with, most retirees already are paying significant health care costs, and thus have substantial "skin in the game." Furthermore, because most health care expenditures are incurred by a small percentage of the sickest individuals, increasing cost sharing for the majority of persons will not have any impact on the largest component of health care costs. In fact, increasing cost sharing for persons with chronic conditions may be counterproductive, as it may result in individuals delaying treatment and ending up with higher expenditures for costly hospitalizations and greater use of emergency department services. Instead of trying to control utilization by shifting costs to individuals, it makes more sense to focus on providing incentives for health care providers to deliver care based on quality rather than quantity. The reforms contained in the Affordable Care Act have already started to make progress in this direction. The UAW submits that we should be redoubling and accelerating those efforts, rather than shifting more costs to seniors.

The UAW is particularly troubled by the part of the MedPAC benefit proposal that would increase the cost sharing for inpatient hospital stays to $750 per stay. This would impose significant hardship on many seniors and it would have little impact on utilization and health care costs, since providers rather than individuals normally make the decision to admit someone to a hospital.

We also oppose the MedPAC proposal to restrict supplemental "Medigap" coverage for seniors, and similar proposals made by other parties. Sometimes these proposals are designed as an outright prohibition on so-called "first dollar" coverage. Sometimes they are structured as a surcharge on the Part B premiums paid by seniors, or as a surcharge/excise tax on the supplemental policies themselves. Whatever the structure of the proposals, the net effect is to expose seniors to substantial additional health care costs. In our judgment, this would cause significant hardship for many seniors who simply cannot afford to bear these costs. In addition, as the National Association of Insurance Commissioners recently indicated in a December 19, 2012 letter to Secretary Sebelius, Medigap coverage is not a driver of unnecessary medical care by seniors. Peer reviewed studies do not indicate that increased cost sharing would promote a

more "appropriate" use of physicians' services. Instead, this more likely would result in delayed treatments that could increase Medicare program costs.

The UAW believes it would be particularly problematic to apply surcharges or benefit prohibitions to supplemental health care benefits provided to retirees by employers, Taft Hartley plans or VEBAs. With individual Medigap policies, the individual always has a choice about whether to prospectively purchase the supplemental coverage. But in the case of supplemental health care benefits provided to retirees by employers, Taft Hartley plans or VEBAs, the retirees have already given up wages during their active working years based on the promise that they would receive this additional health care protection during their retirement. It would be manifestly unfair to now change the rules and deprive the retirees of the bargain that they negotiated many years ago and that they effectively paid for by foregoing part of their wages. For this reason, if there were going to be some type of surcharge or benefit prohibition, we believe it should be structured as proposed by the Obama administration; so it would only apply to individual Medigap policies purchased by beneficiaries who enroll in Medicare after some future date.

In conclusion, the UAW appreciates the opportunity to submit our views to the Subcommittee on Health of the Ways and Means Committee regarding proposals to change Medicare's traditional benefit design. We look forward to working with Members of the Subcommittee and the entire Congress as you consider these important issues.

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Statement of the USW

Submission for the Record

EXAMINING TRADITIONAL MEDICARE'S BENEFIT DESIGN
Tuesday, February 19, 2013
US House of Representatives
Committee on Ways and Means
Health Sub-Committee

This testimony is submitted on behalf of the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (USW) in connection with the hearing being held by the Subcommittee on Health of the House Ways and Means Committee on February 26, 2013 to examine proposals to change Medicare's traditional benefit design. The USW represents over 1.2 million active and retired workers in the steel, aluminum, rubber, paper, energy, mining, and health care sectors across the United States. Approximately 65-70 percent of our retired members receive their primary health care coverage from Medicare. Many of these retirees also receive supplemental health care benefits from their former employers or from Voluntary Employee Beneficiary Associations (VEBAs) that have resulted from court-ordered settlement agreements.

The USW recognizes the need to modernize and rationalize the benefit package provided under Medicare. In particular, it would be important to update and simplify the deductibles, co-insurance and other cost sharing requirements. This could make it easier for retirees to understand these cost sharing requirements. It also could ease the administrative burdens both on Medicare and on employers/VEBAs that provide supplemental coverage.

The USW also strongly supports the addition of catastrophic coverage under Medicare. This has long been a glaring omission in Medicare. Providing protection against catastrophic medical expenses would help seniors who would otherwise face potentially devastating costs due to serious illnesses.

However, the USW is concerned that the MedPAC proposals for changing the Medicare benefit package would impose substantial additional cost sharing on most seniors. We understand that the MedPAC proposals are intended to maintain **in the aggregate** the same level of cost sharing as the traditional Medicare benefit package. But in order to pay for the catastrophic protection for a small number of seniors, this means the MedPAC proposals will substantially increase the cost sharing that will have to be borne by most beneficiaries.

The USW opposes this shifting of substantial new costs to most seniors. In 2010, half of all Medicare beneficiaries had annual incomes below $22,000 (200% of the federal poverty

level). Medicare households have a lower average budget than the typical household ($30,818 vs $49,641 respectively), but devote a substantially larger share of their income to medical expenses than does the average household (14.7% vs 4.9% respectively). Thus, many seniors simply cannot afford the cost sharing implicit in the MedPAC proposals, and would experience significant hardship if they had to pay for these additional costs. Some USW retirees could see their income reduced significantly if they had to pay the cost sharing proposed by MedPAC.

The USW also is skeptical that this increase in cost sharing for most seniors would be effective in restraining the growth in health care spending. To begin with, most retirees already are paying significant health care costs, and thus have substantial "skin in the game." Furthermore, because most health care expenditures are incurred by a small percentage of the sickest individuals, increasing cost sharing for the majority of persons will not have any impact on the largest component of health care costs. In fact, increasing cost sharing for persons with chronic conditions may be counterproductive, as it may result in higher expenditures for costly hospitalizations and greater use of emergency department services. Instead of trying to control utilization by shifting costs to individuals, it makes more sense to focus on providing incentives for health care providers to deliver care based on quality rather than quantity. The reforms contained in the Affordable Care Act have already started to make progress in this direction. The USW submits that we should be redoubling and accelerating those efforts, rather than shifting more costs to seniors.

The USW is particularly troubled by the part of the MedPAC benefit proposal that would increase the cost sharing for inpatient hospital stays to $750 per stay. This would impose significant hardship on many seniors. And it would have little impact on utilization and health care costs, since providers rather than individuals normally make the decision to admit someone to a hospital.

The USW also opposes the MedPAC proposal to restrict supplemental "Medigap" coverage for seniors, and similar proposals made by other parties. Sometimes these proposals are designed as an outright prohibition on so-called "first dollar" coverage. Sometimes they are structured as a surcharge on the Part B premiums paid by seniors, or as a surcharge/excise tax on the supplemental policies themselves. Whatever the structure of the proposals, the net effect is to expose seniors to substantial additional health care costs. In our judgment, this would cause significant hardship for many seniors who simply cannot afford to bear these costs. In addition, as the National Association of Insurance Commissioners recently indicated in a December 19, 2012 letter to Secretary Sebelius, Medigap coverage is not a driver of unnecessary medical care by seniors. Peer reviewed studies do not indicate that increased cost sharing would promote a more "appropriate" use of physicians' services. Instead, this more likely would result in delayed treatments that could increase Medicare program costs.

The USW believes it would be particularly problematic to apply surcharges or benefit prohibitions to supplemental health care benefits provided to retirees by employers, Taft Hartley plans or VEBAs. With individual Medigap policies, the individual always has a choice about whether to prospectively purchase the supplemental coverage. But in the case of supplemental health care benefits provided to retirees by employers, Taft Hartley plans or VEBAs, the retirees have already given up wages during their active working years based on the promise that they would receive this additional health care protection during their retirement. In our judgment, it would be manifestly unfair to now change the rules and deprive the retirees of the bargain that they negotiated many years ago and that they effectively paid for by foregoing part of their wages. For this reason, if there were going to be some type of surcharge or benefit prohibition, we believe it should be structured as proposed by the Obama administration, so that it would only apply to individual Medigap policies purchased by beneficiaries who enroll in Medicare after some future date.

In conclusion, the USW appreciates the opportunity to submit our views to the Subcommittee on Health of the Ways and Means Committee regarding proposals to change Medicare's traditional benefit design. We look forward to working with Members of the Subcommittee and the entire Congress as you consider these important issues.

Respectfully submitted on behalf of,

UNITED STEEL, PAPER and FORESTRY, RUBBER, MANUFACTURING, ENERGY, ALLIED INDUSTRIAL and SERVICE WORKERS INTERNATIONAL UNION
By
United Steelworkers, Legislative Department
1150 17th Street, NW, Suite 300
Washington, DC 20036
202-778-4384 (phone)
202-293-5308 (fax)

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