WRITTEN STATEMENT OF

THE COUNCIL FOR AFFORDABLE HEALTH INSURANCE

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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.