

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

http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_aper.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

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

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_aper.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

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