MODERNIZING MEDICARE FOR THE 21ST CENTURY

Why Medicare is Outdated and Beneficiaries Deserve Better

Chairman Fred Upton
Energy and Commerce Committee

Chairman Dave Camp
Ways and Means Committee

Chairman Joe Pitts
Energy and Commerce Health Subcommittee

Chairman Kevin Brady
Ways and Means Health Subcommittee

August 29, 2013

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Since its enactment in 1965, the Medicare program has successfully provided access to health care services for our nation's seniors and disabled. However, this access is under threat as the program's outdated benefit structure, high expenditures and projected enrollment boom could threaten the availability of Medicare for current and future generations.

The number of beneficiaries coming into Medicare as the "baby boomers" head into retirement is dramatic. While the program served 50 million Americans in 2012, enrollment could reach over 63 million Americans by 2020 and over 80 million by 2030.[1] The swell of beneficiary enrollment levels will cause Medicare expenditures to rise dramatically, adding pressure to the already struggling Medicare trust funds. The 2013 Medicare Trustees report includes the seventh consecutive Medicare funding warning and estimate that without policy action, the Medicare trust fund could become insolvent in as early as 2026,[2] (while earlier estimates indicated an insolvency date as soon as 2016).[3]

While dramatic enrollment growth, increased expenditures and draining resources are important contributors to the program's solvency crisis, so too is the program's outdated benefit structure that fails to encourage consumer involvement and often leaves beneficiaries confused and exposed to high, unlimited out-of-pocket costs. The current program relies on a 1960's era old-fashioned and complicated benefit design. Seniors deserve a modern system that is easier to understand and that will save them money.

We can, and should, take measured, short-term steps to strengthen Medicare for America's seniors by focusing on policies that have long-standing bipartisan support from a wide range of policymakers, health experts and economists. This bi-committee discussion paper is the first in a series of Medicare policy proposals that will be released over the coming months that will (1) identify key flaws of the existing traditional Medicare framework and (2) further detail reform concepts for consideration and public feedback. Working together, Members of the House Energy & Commerce and Ways & Means Committees will further these ideas to initiate a discussion on how to protect seniors and place the Medicare program on sound financial footing.

This first joint paper will review (1) the traditional Medicare cost-sharing framework and the impact current thresholds have on beneficiaries – often leaving them unprotected against catastrophic costs; (2) the impact of supplemental coverage with low cost-sharing requirements

[1] Centers for Medicare and Medicaid Services Office of the Actuary, 2013. Included in MedPAC "A Data Book: Health Care Spending and the Medicare program." June 2013. Available online at http://www.medpac.gov/documents/Jun13DataBookEntireReport.pdf

[2] The Board of Trustees, Federal Hospital Insurance & Federal Supplementary Medical Insurance Trust Funds. "2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." Available online at http://downloads.cms.gov/files/TR2013.pdf

[3] Roy, Avik. "Trustees: Medicare will go broke in 2016, if you exclude Obamacare's Double-Counting." Forbes. April 23, 2012. Available online at http://www.forbes.com/sites/aroy/2012/04/23/trustees-medicare-will-go-broke-in-2016-if-you-exclude-obamacares-double-counting/

that reduce incentives to seek cost-effective care; and (3) how modernizing the traditional cost-sharing features could better align beneficiary incentives, ensure beneficiaries greater out-of-pocket predictability and reduce overall Medicare costs.

A 21ST CENTURY BIPARTISAN APPROACH: PROTECT BENEFICIARIES & REDUCE COSTS

With a redesigned Medicare benefit, beneficiaries will have relief from the existing structure that often leaves them exposed to catastrophic out-of-pocket costs and further incentivizes over-utilization of services that directly increase costs for Medicare. Reforms should follow three simple principles:

- ✓ Make Medicare easier to navigate;
- ✓ Protect seniors; and
- ✓ Reduce costs.

Modernization of the traditional benefit structure can begin with (1) the establishment of a single combined annual deductible for Medicare Parts A & B and (2) a simplified coinsurance rate that is applicable to spending above such deductible. Reforms must protect Medicare beneficiaries from any out-of-pocket costs that exceed a defined and reasonable catastrophic limit. Finally, reform proposals must consider how existing supplemental coverage trends impact overall Medicare costs and ensure maximum beneficiary engagement and accountability in the selection of Medigap and other supplemental plans.

An Outdated Cost-Sharing Framework that Leaves Beneficiaries Vulnerable to Catastrophic Costs

The nearly 50-year old design of the Medicare program was modeled after the separate Blue Cross (hospital services) plans and Blue Shield (physician services) plans that were prevalent throughout the nation at that time. Since then, private insurance coverage has transformed dramatically, coordinating these benefits, yet the traditional Medicare benefit has remained largely unchanged − resulting in an array of confusing coinsurance and deductible levels and a "traditional" Fee-For-Service (FFS) structure that inhibits care coordination, incentivizes overutilization and results in increased costs.

As the American Academy of Actuaries (AAA) has noted, "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 (hospital) and Part B (physician and outpatient) 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."[4] (emphasis added)

Figure 1 outlines the typical 2013 cost sharing levels for a beneficiary in the traditional Medicare FFS program, which includes just over 70 percent of all Medicare beneficiaries, with the remaining portion enrolled in Medicare's private-based Medicare Advantage program.[5] This existing cost-sharing structure for traditional Medicare is a confusing and disjointed collection of deductibles, copayments and coinsurance, and lacks any catastrophic spending protections, a staple of many insurance products.

Seeking protection from growing cost-sharing amounts, beneficiaries have increasingly sought supplemental coverage to protect themselves. MedPAC notes that the lack of comprehensive coverage is a contributing factor in over 90 percent of Medicare beneficiaries obtaining supplemental insurance.[6]

FIGURE 1: A CONFUSING AND OUTMODED BENEFIT DESIGN
Selected part a and part b cost-sharing requirements for 2013

Part A	
Hospital Stay	• $1,184 deductible for days 1-60 per benefit period • $296/day copayment for days 61-90 of the spell of illness period • $592 per day for days 91 and beyond of the spell of illness period (up to the maximum 60 "lifetime reserve days")
Skilled Nursing Facility Stay	• No deductible or copayment for first 20 days. • $141.50/day for days 21-100 of each benefit period • 100% of all costs each day beyond 100 days in a benefit period
Home Health	• No beneficiary cost-sharing
Part B	
Monthly Premiums	• $104.90 to $335.70 (depending on income)
Annual Deductible	• $147
Physician Services	• 20 percent coinsurance for most doctor services (including most doctor services when beneficiary is an inpatient), outpatient therapy, dialysis, and durable medical equipment
Outpatient hospital services	• 20 percent coinsurance (up to hospital deductible of $1,184)
Home Health	• No beneficiary cost-sharing

***Note**: There are additional cost-sharing requirements not noted here (including those for home health, hospice care, clinical laboratory and mental health services), which can be viewed at www.medicare.gov*

[4] American Academy of Actuaries Issue Brief. "Revising Medicare's Fee-For-Service Benefit Structure." March 2012. Available online at http://www.actuary.org/files/Medicare_FFS_Design_Issue_Brief_03_07_12_final.pdf

[5] See note 1.

[6] MedPAC. "Reforming Medicare's benefit design." June 2012. Available online at http://www.medpac.gov/chapters/Jun12_ch01.pdf

Understanding the Growth in Supplemental Coverage and Its Current Impact on Medicare Costs

According to America's Health Insurance Plans (AHIP), 2012 enrollment "in Medigap coverage increased to 10.2 million policies…up from 9.9 million Medigap policies in force in December 2011.[7]" Medigap, however, is just one form of supplemental coverage for Medicare beneficiaries.

Supplemental plans include Medigap plans and employer-sponsored retiree plans. Low-income beneficiaries can receive supplemental benefits through Medicaid and other programs. Finally, as a fully alternative model, most beneficiaries can also choose Medicare Advantage plans that include some supplemental benefits and variations on cost sharing that are integrated in to the Medicare benefit. In 2009, less than 10 percent of Medicare beneficiaries did not have some sort of supplemental coverage.[8]

In 2009, 21 percent of non-institutionalized beneficiaries nationwide had individually-purchased Medigap policies with another 33 percent having employer-sponsored supplemental coverage (including Medigap); the remaining beneficiaries had either Medicaid (12 percent) or were enrolled in Medicare Advantage (27 percent).[9]

BACKGROUND ON MEDIGAP PLANS:

- All Medigap plans cover some percentage of Medicare's cost-sharing. Some plans offer additions to these basics, including various combinations of greater coverage of Medicare cost sharing, and care associated with foreign travel emergencies.
- The most popular plans are the most comprehensive, and cover all deductibles, copayments, and coinsurance not covered by Medicare.
- Medigap policies are sold in both the individual and the group health insurance markets. Whether purchased in the individual or the group market, each Medigap policy covers one individual.
- Plans are identified by letter, and each plan is associated with a specific benefit package.
- Standard Medigap policies vary in how they wrap around Medicare's cost sharing and the most popular types of Medigap policies—standard Plan C and Plan F—fill in nearly all of Medicare's cost-sharing requirements, including the Part A and Part B deductibles.

Source: Rapaport, Carol. "Medigap: A Primer." Congressional Research Service. January 2013.

[7] AHIP. "Trends in Medigap Coverage and Enrollment, 2012." May 2013. Available online at: http://ahip.org/Trends-Medigap-Coverage-Enroll2012/

[8] See note 2.

[9] See note 1.

To determine the role of supplemental Medigap and employer-sponsored insurance on Medicare spending, MedPAC commissioned a study in 2009. Beneficiaries often purchase Medigap plans because of the certainty these plans bring: predictable copays instead of coinsurance and protection against high out-of-pocket costs. However, largely because of the first-dollar coverage provided (some Medigap plans cover all or part of the traditional Medicare deductible and/or coinsurance), MedPAC's study found that Medicare spending was 33 percent higher when beneficiaries had Medigap insurance and 17 percent higher when beneficiaries had employer-sponsored coverage. MedPAC further reported that the effects of the supplemental insurance were more pronounced for Part B spending, which ranged from 30 percent (employer-sponsored) to 50 percent (Medigap) higher. The analysis found smaller spending impacts on Part A services as a result of supplemental insurance, from 9 percent (employer-sponsored) to 18 percent (Medigap). [10]

Further, the 2009 MedPAC study found the greatest increase in Medicare spending was for beneficiaries with the most protection against Medicare's cost sharing. Specifically, the study found that beneficiaries who pay less than 5 percent of total Part B out-of-pocket costs had Medicare spending that was between 68 and 83 percent higher than those with traditional Medicare only. Those who paid more than 5 percent of the Part B cost sharing had Medicare spending that was 0 to 23 percent higher than Medicare-only beneficiaries. It is not surprising that those with little to no coinsurance responsibility have higher spending because if a beneficiary is already paying a monthly Medigap premium, there is an incentive for him/her to see the doctor more often because the beneficiary's out-of-pocket costs are covered by the Medigap plan (it's the "if you're paying for the coverage, you might as well use it" mentality).[11]

This over-utilization of services directly contributes to higher costs for all seniors in Medicare. As the American Academy of Actuaries notes, reforms to the Medigap structure could, "result in an increased understanding among beneficiaries of their benefit choices, lower insurance premiums…and avoid unnecessary care."

A Real World Translation: What Would a Catastrophic Cap Mean for Ms. Smith?

Navigating the existing Medicare program is complex and, as noted above, reforms should not build on those complexities, but rather modernize the program so that it reflects a 21st century insurance product that Medicare beneficiaries are familiar with and can easily transition from their pre-Medicare insurance coverage. Below is an example of what such reforms could mean for Medicare beneficiaries in the future.

> **Example:** Ms. Smith does not currently carry Medigap coverage. Ms. Smith has an annual household income of less than $85,000 per year. Medicare reimburses $7,500 for Ms. Smith's 10-day hospital stay and $70,500 for Ms. Smith's 100-day skilled nursing

[10] Hogan, Christopher. "Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly." Medpac. June 2009. Available online at http://www.medpac.gov/documents/Jun09_secondaryinsurance_CONTRACTOR_RS_REVISED.pdf

[11] See note 10.

facility (SNF) stay. While in the hospital and nursing home, Medicare also reimbursed $3,100 in physician payments for Ms. Smith. The illustrative example below compares Ms. Smith's cost-sharing obligations both with and without a benefit redesign.

MS. SMITH'S COST-SHARING OBLIGATIONS[A]		
	Current Medicare Benefit Out-Of-Pocket (OOP)	**A Proposed Medicare Benefit Re-Design OOP**
Hospital Stay *(assumes the hospital stay is the first claim CMS receives)*	**$1,184** [Medicare Part A deductible]	**$550** [Combined Medicare Parts A & B deductible][A] **$1,390** [($7,500-$550) = ($6,950)] [($6,950)* (20%)[B] = $1,390] **TOTAL = $1,940**
Skilled Nursing Facility *(assumes CMS receives the SNF claim prior to all physician visit claims)*	**$11,320** [($141.50 co-pay)*(80 days)]	**$14,100** [($70,500)* (20%)[B] = $14,100] *without OOP cap* **$3,560** [($5,500 OOP cap[B]) – ($1,940) = $3560] *Apply $3,560 rather than $14,100 because of OOP cap* **TOTAL = $3,560**
Physician Visits	**$147** [Medicare Part B Deductible] **$591** [($3,100 - $147) = ($2,953)*(20% co-insurance) = $590.60] **TOTAL = $738**	**NONE**
TOTAL	**$13,242**	**$5,500[C]**

[A] *– The monthly Part B premium would still apply under both scenarios.*

[B] *– Several organizations have recommended combining Medicare Parts A & B with: 1) a single $550 deductible, 2) uniform 20 percent cost-sharing, and 3) total OOP cap of $5,500.*

[C] *– With a total OOP cap this is the maximum Ms. Smith would pay for the full calendar year. However, under the current Medicare benefit design, Ms. Smith would still be paying additional cost-sharing for every service she receives through the remainder of the calendar year.*

Bipartisan Support

These reforms are not necessarily new ideas. In fact, in 1999, the National Bipartisan Commission on the Future of Medicare noted: "Under the plan, the traditional Part A and Part B fee-for-service deductibles would be combined…this will lower the hospital deductibles**,"**[12] and the AARP Policy Institute affirmed, "Indeed, a unified structure may be necessary to offer Medicare more flexibility to provide access to affordable, high quality care in a continually changing health care environment."[13]

These reforms carry long-standing bipartisan support from a wide range of policymakers, health experts, and economists. The below list is just a subset of the entities and proposals that have been released recently related to Medicare fee-for-service cost-sharing and supplemental coverage reform.

- **AMERICAN ENTERPRISE INSTITUTE (AEI):** In December 2012, AEI released a "Medicare Makeover" report that focuses on five reforms to make Medicare "healthy." As part of the proposal, AEI calls for an updating of Medicare's structure so patients understand the cost of care by encouraging policy-makers to consider combining Medicare Parts A & B, altering Medigap coverage so beneficiaries are more sensitive to the cost of their medical care and increased coordination of health care services in traditional Medicare by restructuring cost-sharing for beneficiaries.

- **BIPARTISAN POLICY CENTER,"THE DOMENICI-RIVLIN DEBT REDUCTION TASK FORCE PLAN 2.0":** Proposes unifying cost sharing for Medicare Parts A & B, creating an out-of-pocket maximum and prohibit Medigap plans from providing first dollar coverage.

- **BROOKINGS:** In April 2013, the Brookings Institute published "Bending the Curve," a report that focused on four major strategies including transitioning to "Medicare Comprehensive Care Organizations" and reforming Medicare benefits, including elimination of first dollar coverage from Medigap. Additionally, in February 2013, the Hamilton Project at Brookings proposed unifying Medicare Parts A & B with a combined annual deductible of $525 and set the coinsurance rate above the deductible equal to 20 percent up to an annual out-of-pocket maximum of $5,250, with higher out-of-pocket limits for higher income beneficiaries and lower out-of-pocket limits for lower income beneficiaries and would apply an excise tax of up to 45 percent on Medigap plan premiums and employer-sponsored retiree coverage for beneficiaries over age 65.

- **CONGRESSIONAL BUDGET OFFICE (CBO):** As part of its 2011 publication, "Reducing the Deficit: Spending and Revenue Options," CBO estimated the savings that would be associated with redesigning the Medicare benefit and limiting first dollar coverage.

[12] National Bipartisan Commission on the Future of Medicare. "Talking Points: Breaux-Thomas Proposal." 1999. Available online at http://rs9.loc.gov/medicare/talking.htm

[13] AARP Policy Institute. "The Effects of Merging Part A and Part B of Medicare." C.F. Caplan, D.J. Gross. 1999. Available online at http://assets.aarp.org/rgcenter/health/9901_medicare.pdf

Specifically, CBO looked at three options assuming implementation in 2013 (scores are over the 2012-2021 time period):

1. **Uniform Cost Sharing**: A combined Parts A and B $550 annual deductible; 20 percent coinsurance above the deductible (including inpatient); and annual $5,500 OOP cap. ***Estimated Savings: $32.2 billion***

2. **Medigap Restrictions**: Restrict Medigap plans from covering cost sharing below the deductible and limit the plan from covering no more than half of the cost-sharing between the deductible and the OOP cap. ***Estimated Savings: $53.4 billion***

3. **Uniform Cost Sharing and Medigap Restrictions**: This policy would implement the first two policies. Medigap plans would be restricted from paying the new $550 deductible and could only cover 10 percent of beneficiaries cost sharing up to the new out-of-pocket cap (i.e., half of the 20 percent coinsurance under Option 1). ***Estimated Combined Savings: $92.5 billion***[14]

- **HERITAGE FOUNDATION:** Proposes combining Medicare Parts A & B (with unified deductible and cost-sharing), adding a catastrophic limit and prohibiting first-dollar coverage the first $550 of Medicare patient cost sharing from coverage by supplemental insurance.

- **KAISER FAMILY FOUNDATION (FOUNDATION'S PROJECT ON MEDICARE'S FUTURE)**: One of the proposals discussed would restructure the Medicare's benefit design with a unified deductible, modified cost sharing, and a limit on out-of-pocket spending, possibly in conjunction with policies to discourage or restrict supplemental coverage.

- **MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC):** Proposes replacing the current benefit design with an out-of-pocket maximum; deductible(s) for Medicare Parts A & 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

- **PRESIDENT'S FISCAL YEAR (FY) 2014 BUDGET:** Proposes a Medigap proposal introducing a surcharge on Part B premiums equivalent to about 15 percent of the average Medigap premium for new beneficiaries that purchase Medigap policies with "particularly low cost-sharing requirements," beginning in 2017.

[14] *Assuming no changes to supplemental insurance (Option 1), CBO estimated that 25 percent of beneficiaries would see a reduction or no change in their cost sharing while 75 percent would see some increase. Looking at changes to cost sharing and Medigap (Option 3), CBO estimated that 61 percent of beneficiaries would see lower or no change to their out of pocket spending and 40 percent would see some level of increase in their out of pocket spending.*

- **PRESIDENT'S NATIONAL COMMISSION ON FISCAL RESPONSIBILITY & REFORM (SIMPSON-BOWLES):** Proposes unified cost-sharing for Medicare Parts A &B and prohibiting Medigap plans from covering the first $500 of cost-sharing and limit coverage to 50% of the next $5,000.

- **URBAN INSTITUTE:** In March 2013, the Urban Institute issued a "Timely Analysis of Immediate Health Policy Issues" report that focused on nine Medicare reforms, including a restructuring of premiums, cost-sharing and Medigap by instituting a unified Part A & B deductible that is means-tested, increasing Part B and D premiums to 40 percent, instituting a cap on cost-sharing for Medicare Parts A, B and D, and a limit on Medigap coverage.

Conclusion & Future Opportunities

The bipartisan nature of these proposals should encourage further development of policies that will modernize and improve the costly and outdated Fee-For-Service design structure and, instead, replace it with a 21st century framework that encourages consumer information and healthy behavior, protects beneficiaries against catastrophic costs and improves the overall fiscal health of the Medicare program.

In the coming months, the bi-committee process will continue its work promoting a modernized health care program for seniors by examining how reforms enacted within the last 10 years – most notably the creation of Medicare drug and insurance plans – have improved the quality and availability of health care for seniors. Such reforms are examples of the benefit that modernization can play in the health and welfare for seniors and highlight the need for additional measures to bring the program in line with the health care programs for younger Americans.