

UNITED STATES HOUSE of REPRESENTATIVES
COMMITTEE on ENERGY & COMMERCE, SUBCOMMITTEE on HEALTH
HEARING on “A 21st CENTURY MEDICARE: BIPARTISAN PROPOSALS to REDESIGN
the PROGRAM’S OUTDATED BENEFIT STRUCTURE”

June 26, 2013

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

Mr. Chairman and Members of the Committee:

California Health Advocates, the Center for Medicare Advocacy, Inc., and the Medicare Rights Center are 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 (DHHS).¹ In May 2013, DHHS accepted this recommendation, bringing the subgroup’s deliberations to a final close.²

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. 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. 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

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 Secretary Sebelius’ May 28, 2013 letter to NAIC is available on the NAIC website at: http://www.naic.org/documents/committees_b_senior_issues_related_docs_sebelius_response_letter.pdf.

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...³

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 cost sharing.⁴

Although this NAIC subgroup focused on potential changes to Medigap plans, the research reviewed and the resulting conclusions are applicable to a range of reform proposals, including the subject of this testimony—Medicare cost sharing and benefit design. Through our work representing people with Medicare, we know that the Medicare program has significant, complicated out-of-pocket costs and can be simplified. With the aim of securing savings, however, restructuring Medicare cost sharing is likely to both unfairly redistribute costs to beneficiaries with fixed incomes and limit access to needed health care services. Faced with higher health care costs, many beneficiaries would be forced to self-ration needed care.

While taking a measured look at the program through the lens of improving beneficiary well-being as opposed to securing savings would be a welcome exercise, we believe that the following Medicare 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 reduce health care spending system-wide. We support Medicare savings interventions that eliminate wasteful spending and build on the efficiencies of

³ 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.

⁴ 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>.

the ACA. At a time when Medicare spending is growing at historically low rates, and innovations through the ACA hold 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.⁵

According to DHHS, Medicare cost growth slowed dramatically in recent years to levels “unprecedented in the history of the Medicare program.”⁶ Additional analysis by the S&P Dow Jones Indices illustrates that “...health care costs have decelerated over the past few years, and Medicare costs have decelerated more than other health costs.”⁷

The recent release of the 2013 Medicare Trustees Report affirms an improved fiscal outlook for the Medicare program. The trustees find that the Hospital Insurance Trust Fund is solvent through 2026—two years later than previously predicted.⁸ While some of the health care cost growth slowdown is attributable to the continued effects of the economic downturn, research indicates that much of this change is structural meaning that slowed growth is likely to persist.⁹

Due in part to these recent projections, we believe that there is no justification for policy interventions that would shift added costs to people with Medicare. We reject proposals to redistribute Medicare cost sharing under the guise of securing federal savings. Under the proposed concepts, too many would lose access to affordable coverage, and too many would be discouraged from seeking needed care, threatening the basic health and economic security of our nation’s older adults and people with disabilities.

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 2012, half of all Medicare

⁵ Office of the Assistant Secretary for Planning and Evaluation, “Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows” (DHHS: January 2013), available at: <http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.cfm>; DHHS, “Press release:” Trustees report shows reduced cost growth, longer Medicare solvency” (May 2013), available at: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-05-31.html?DLPage=1&DLSort=0&DLSortDir=descending>.

⁶ Office of the Assistant Secretary for Planning and Evaluation, “Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows” (DHHS: January 2013), available at: <http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.cfm>.

⁷ S&P Dow Jones Indices, “Press Release: Deceleration in Annual Growth Rate for All Nine Indices in June 2012, According to the S&P Healthcare Economic Indices” (January 2012); J. Weisenthal, “Peter Orszag’s Chart Of The Year Could Change Everything You Think About Healthcare And The Federal Budget” (*Business Insider*: December 2012), available at: <http://www.businessinsider.com/peter-orszag-chartshows-medicare-costs-slowng-2012-12>.

⁸ The Board of Trustees, “2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medicare Insurance Trust Fund” (May 2013), available at: <http://downloads.cms.gov/files/TR2013.pdf>.

⁹ A. Ryu, T. Gibson, McKeller, M.R., and M.E. Chernen, “The Slowdown in Health Care Spending in 2009-11 Reflected Factors Other Than the Weak Economy and Thus May Persist” (*Health Affairs*: May 2013); D. Cutler and N.R. Sahni, “If Slow Rate of Health Care Spending Growth Persists, Projections May Be Off \$770 Billion” (*Health Affairs*: May 2013).

beneficiaries had annual incomes below \$22,500. And half of beneficiaries had just \$77,500 or less in personal savings.¹⁰

The cost of living varies considerably for older adults depending on housing status, health status and geographic location. For instance, an older adult in good health who rents a home in Chester County, Pennsylvania requires an annual income of approximately \$26,650 to cover expenses, accounting for only the most basic needs: housing, food, transportation, health care and other essentials, like clothing and toiletries. Yet, the same older renter living in Dallas County, Texas needs an estimated \$28,500 to make ends meet.¹¹

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).

Already faced with high health care costs, many people with Medicare are forced to choose among basic needs, such as buying groceries or seeing the doctor for a persistent cough. Recent analysis on poverty trends among older adults suggests that these harsh choices are commonplace among our nation's retirees. One third of older adults live on incomes below 200% of the traditional measure of poverty; whereas, one half live on incomes below 200% of poverty according to a supplemental measure developed by the U.S. Census Bureau that accounts for out-of-pocket health care costs.¹²

Medicare beneficiaries also tend to have greater health needs than other groups. On the whole, people with Medicare have multiple and significant health needs—40% of beneficiaries have three or more chronic health conditions, and more than one quarter of beneficiaries (27%) report being in fair or poor health. Nearly one in four people with Medicare live with a cognitive or mental impairment, requiring extensive, ongoing care.¹³

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. Three quarters of the Medicare population has coverage through Traditional Medicare. Among this group, most have retiree wrap-around benefits through former

¹⁰ J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicarebeneficiaries-costs-and-service-use-testimony.pdf>.

¹¹ Wider Opportunities for Women, "Economic Security Database: Elder Economic Security Standard™ Index for Chester Country, Pennsylvania" (2013), available at: <http://www.basiceconomicsecurity.org/>; Wider Opportunities for Women, "Economic Security Database: Elder Economic Security Standard™ Index for Dallas County, Texas" (2013), available at: <http://www.basiceconomicsecurity.org/>.

¹² Kaiser Family Foundation, "A State-by-State Snapshot of Poverty Among Seniors: Findings From Analysis of the Supplemental Poverty Measure" (May 2013), available at: <http://kff.org/medicare/issue-brief/a-state-by-state-snapshot-of-poverty-among-seniors/>.

¹³ J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicarebeneficiaries-costs-and-service-use-testimony.pdf>.

employment (41%) and others secure supplemental insurance through Medigap plans (21%). Medicaid provides wrap-around coverage to about one in five (21%), and still a notable share of beneficiaries with Traditional Medicare (17%) lack supplemental coverage altogether. In addition, about one quarter (27%) of beneficiaries are covered through private Medicare Advantage plans as opposed to Traditional Medicare.¹⁴

Many of these supplemental types of insurance, in effect, limit out-of-pocket expenses. As noted by several members of Congress in a “Dear Colleague” letter highlighting the important role played by Medigap plans, “Medicare’s current structure puts beneficiaries who are the poorest and the sickest in a position where, without supplemental coverage, a severe chronic condition or catastrophic event could bankrupt them.”¹⁵ Even with these supplemental coverage options, people with Medicare lack coverage for particular services, including most long-term care services and dental care.

Most Medicare beneficiaries cannot absorb more costs without facing significant hardship. To borrow a crude metaphor, 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.

In its June 2012 Report to Congress, MedPAC made recommendations to alter 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.¹⁶

Various other proposals to restructure the Medicare benefit contain similar elements, including: creating a single, combined deductible for Parts A and B; a uniform 20% coinsurance rate or

¹⁴ Neuman, Patricia, “Rethinking Medicare’s Benefit Design: Opportunities and Challenges” (Kaiser Family Foundation: June 2013), available at: <http://docs.house.gov/meetings/IF/IF14/20130626/101043/HHRG-113-IF14-Wstate-NeumanP-20130626.pdf>.

¹⁵ “Some Facts About Private Medicare Supplemental Insurance” by Reps. Terry, Blackburn and Latham (May 22, 2013), available at: <http://naifa.typepad.com/files/1305terryblackburnlatham-medigapsupport-pdf.pdf>.

¹⁶ MedPAC, “Report to the Congress: Medicare and the Health Care Delivery System” (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

modified copayments for particular services; an out-of-pocket cap on beneficiary expenses; and other piecemeal proposals, such as introducing home health copayments, and/or modified beneficiary out-of-pocket caps and/or cost sharing determined on the basis of income.¹⁷

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 beneficiaries.¹⁸ 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 Redistributing Medicare Cost Sharing

Proposed Changes to Medicare Cost Sharing 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 credible 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."¹⁹ 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.²⁰

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 critical care.

¹⁷ National Commission on Fiscal Responsibility and Reform, *The Moment of Truth* (December 2010), available at: http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf; The Moment of Truth Project, *A Bipartisan Path Forward to Securing America's Future* (April 2013), available at: <http://www.momentoftruthproject.org/publications/bipartisan-path-forward-securing-americas-future>; Berenson, B., Holahan, J. and S. Zuckerman, "Can Medicare Be Preserved While Reducing the Deficit?" (Urban Institute, March 2013), available at: <http://www.urban.org/publications/412759.html>; J. Gruber, Proposal 3: Restructuring Cost Sharing and Supplemental Insurance for Medicare (The Hamilton Project, February 2013), available at: http://www.brookings.edu/~media/research/files/papers/2013/02/thp%20budget%20papers/thp_15waysfedbudget_prop3.pdf; Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment* (April 2013), available at: <http://bipartisanpolicy.org/library/report/health-care-cost-containment>.

¹⁸ Kaiser Family Foundation, "Medigap: Spotlight on Enrollment, Premiums and Recent Trends" (February 2013), available at: <http://www.kff.org/medicare/upload/8412.pdf>.

¹⁹ MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

²⁰ 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>.

The Kaiser Family Foundation issued a 2011 report analyzing the impact of a Medicare redesign plan modeled on one offered by Erskine Bowles and Alan Simpson (Bowles-Simpson), co-chairs of the National Commission on Fiscal Responsibility and Reform.²¹ The study shows that 71% of beneficiaries in Traditional Medicare would have higher out-of-pocket spending—even with a spending cap—and only 5% would have lower out-of-pocket spending.²² Similarly, under MedPAC’s analysis of their 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.²³

A second iteration of the Bowles-Simpson plan made attempts to mitigate the known harms of this significant cost shifting by suggesting a lower deductible for individuals living below 200% of the federal poverty level and introducing an income-related out-of-pocket cap, an approach credited to MIT economist Jonathan Gruber.²⁴ The Bipartisan Policy Center makes similar attempts through the exemption of physician visits from the combined Medicare Part A and Part B deductible and an increase in income eligibility for low-income subsidy programs.²⁵

Yet, it is important to note that these attempts to soften the self-rationing effect of added cost shifting introduce further complexity to the Medicare program and undermine one of the stated goals of proposals that seek to restructure Medicare cost sharing: a more streamlined, simplified benefit. Given our experience counseling people with Medicare, we know that complicated rules and differential treatment creates needless confusion and strain for older adults and people with disabilities.

Income-relating a newly introduced out-of-pocket cap or deductibles would only serve to further complicate the program and is likely to increase administrative expenses. And while well intentioned, elements of these proposals intended to mitigate harm to lower income individuals beg the question: given the well-documented risk of added cost shifting and the complexity required to prevent resulting harms, is this policy approach a worthwhile one?

Stated attempts by the Bipartisan Policy Center and others to strengthen Medicare low-income protections for beneficiaries are worthwhile endeavors. In their current form, such protections do not fully extend to those who cannot afford to pay for necessary health care services. We believe

²¹ The Bowles-Simpson model included 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.

²² 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>.

²³ MedPAC Presentation, “Reforming Medicare’s Benefit Design” (March 2012), slide 10, available at: <http://www.medpac.gov/transcripts/benefit%20design%20mar2012%20public.pdf>.

²⁴ The Moment of Truth Project, A Bipartisan Path Forward to Securing America’s Future (April 2013), available at: <http://www.momentoftruthproject.org/publications/bipartisan-path-forward-securing-americas-future>; J. Gruber, Proposal 3: Restructuring Cost Sharing and Supplemental Insurance for Medicare (The Hamilton Project, February 2013), available at: http://www.brookings.edu/~media/research/files/papers/2013/02/thp%20budget%20papers/thp_15waysfedbudget_prop3.pdf.

²⁵ Bipartisan Policy Center, A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment (April 2013), available at: <http://bipartisanpolicy.org/library/report/health-care-cost-containment>.

that any attempt to restructure Medicare cost sharing must begin with the modernization and broad application of these critical low-income protections.²⁶

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...”²⁷ 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.²⁸ In addition, 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.²⁹

Based on mistaken notions that protection from out-of-pocket costs causes “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 redistribute the burden of Medicare cost sharing, 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 by increasing the cost of owning a Medigap plan. Some proposals would entail applying restrictions and/or increased costs on both current and future beneficiaries 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 when people forego medically necessary services. For example, a major Harvard School of Public

²⁶ For a more detailed explanation of our joint recommendations on strengthening Medicare low-income programs, see: California Health Advocates, Center for Medicare Advocacy, Inc., Medicare Rights Center, “Testimony on Strengthening Medicare for Seniors: Understanding the Challenges of Traditional Medicare’s Benefit Design” (April 2013), available at: <http://www.medicareriights.org/pdf/energy-commerce-testimony-041113.pdf>.

²⁷ Patient Protection and Affordable Care Act, §3210.

²⁸ 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.

²⁹ 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.

Health 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.”³⁰

Due in part to these findings, in a letter to DHHS 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.”³¹

In addition, the NAIC letter 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.” As noted above, in a letter dated May 28, 2013, Secretary Sebelius accepted NAIC’s recommendations.³²

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 frameworks noted above that would redistribute the burden of Medicare cost sharing.

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 Medicare 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 future generations.

Towards this end, we support prudent cost containment designed to solve the true 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—

³⁰ 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.

³¹ 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.

³² Secretary Sebelius’ May 28, 2013 letter to NAIC is available on the NAIC website at: http://www.naic.org/documents/committees_b_senior_issues_related_docs_sebelius_response_letter.pdf.

meaning better quality at a lower price. Proposals our organizations support include: reduction of wasteful spending on drugs, medical equipment and private health plans, and advancing Medicare delivery system reforms made possible by health reform.³³

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 more health care costs to people with Medicare. As such, we ask that you carefully weigh the significant risks posed to Medicare beneficiaries by the proposals discussed above and we urge you to steer clear of these models.

We appreciate this opportunity to submit these comments.



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³³ For a more detailed explanation of our joint-recommendations on cost containment, see: California Health Advocates, Center for Medicare Advocacy, Inc., Medicare Rights Center, “Testimony on Strengthening Medicare for Seniors: Understanding the Challenges of Traditional Medicare’s Benefit Design” (April 2013), available at: <http://www.medicarerights.org/pdf/energy-commerce-testimony-041113.pdf>.

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