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June 26, 2013

My name is Katherine Baicker, and I am a Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health. I would like to thank Chairman Pitts, Ranking Member Pallone, and the Distinguished Members of the Committee for giving me the opportunity to speak today about how we can address the crucial policy challenge of making Medicare work better for beneficiaries and ensuring that it provides the vital protections they need for generations to come. This testimony is derived in large part from recent academic work with my colleague Helen Levy that appeared in the *New England Journal of Medicine*. I summarize that work here.

Medicare is an insurance program. The reason we have health insurance at all is not because health care is expensive, but rather because there is great uncertainty about who will need very expensive and potentially life-saving care and when they will need it. Medicare should give beneficiaries not just access to medical care, but also protection from the risk of catastrophic spending. At the same time, Medicare – like any good insurance – should not cover so much care so generously that beneficiaries end up consuming too much care of questionable value and driving up costs for everyone. This means that beneficiary cost-sharing in Medicare is a balancing act: too little cost-sharing means patients have no incentive to spend Medicare dollars wisely; too much cost-sharing means Medicare fails to perform its insurance function.

How well does Medicare do at this balancing act? Not very. Medicare by itself offers only limited protection against economic ruin. The basic benefit lacks a cap on out-of-pocket spending, so that beneficiaries are exposed to the risk of open-ended cost-sharing. Moreover, the odds of facing a catastrophic expense mount over time. Almost half of beneficiaries are hospitalized at least once in a four year window.[1] Without supplemental insurance, 14.5% of beneficiaries would have faced out-of-pocket expenses of more than $2,500 in 2009, and more than half of beneficiaries would have had at least one year between 2000-2009 where they faced $2,500 or more in out-of-pocket expenses (see Exhibit). 15% would have had at least one year between 2000-2009 where they faced more than $5,000 in out-of-pocket expenses – or more than a third of the average annual Social Security income for a retired worker. And these figures are for hospital, outpatient facility, and physician care only – beneficiaries face additional cost-sharing liability for other categories of care such as prescription drugs, medical equipment, and skilled nursing facilities.

Beneficiaries without any supplemental coverage thus do not have enough insurance and face too much risk. This risk is one reason that 90 percent of beneficiaries obtain some other insurance (retiree health benefits, MediGap, Medicare Advantage, or Medicaid).[1] But beneficiaries with generous supplemental coverage probably have too much insurance. "Too much insurance" may seem like a nonsensical concept, but there is ample evidence that lower copays result in more care, much of it of questionable benefit to health.[2] Beyond the fact that many supplemental plans

are quite expensive for beneficiaries, they substantially raise Medicare program spending.[1-5] The system-wide effects are large, including changes in practice patterns and investment in infrastructure; the spread of insurance is estimated to be responsible for about half of the rise in per capita health spending between 1950 and 1990.[6] Having little or no cost-sharing leads enrollees to consume low-value care and drives up the cost of Medicare for everyone.

As a Medicare solvency crisis approaches slowly but inexorably, pressure to restructure the program in order to reduce spending will only increase. Proposed reforms are typically evaluated on how they impact the bottom line: the HI Trust Fund exhaustion date or the share of GDP devoted to Medicare. They are also evaluated on whether their burden is borne, on average, by providers or by beneficiaries. These metrics are not enough. Reforms must also be evaluated on how they affect the risk of potentially high expenditures to which beneficiaries are exposed – striking a better balance between financial protection on the one hand and preserving incentives to consume care wisely on the other.

Technological innovation raises the stakes. Many new technologies are crucial for extending life and improving well-being, but also add even greater uncertainty about health spending both for individuals and for the health care system overall. Mounting budgetary pressures highlight the fiscal unsustainability and economic costs of the current financing and benefit structure.[7-10] These costs rise as Medicare covers an increasing array of treatments that may not be what most enrollees would choose if they were spending their own money.

Nonpartisan and bipartisan groups have advanced proposals that would address the imbalance in risk facing beneficiaries in the current Medicare program. Although these groups do not propose exactly the same fixes, some of the basic ideas are the same: first, put a cap on the out-of-pocket spending beneficiaries are responsible for – just like most private plans already do – so that beneficiaries without any other coverage are protected from catastrophic costs. Second, restrict "first-dollar coverage" (coverage with no beneficiary cost-sharing) in Medicare supplemental insurance, either by banning it or by imposing a surcharge on plans that provide it. This surcharge would reflect the additional cost to the Medicare program imposed by the extra use of (low-value) care by beneficiaries who face no cost-sharing because of the supplemental plan – since the private premiums charged for those plans do not reflect that additional public cost.

There are of course many challenges in implementing such proposals. Crude cost-sharing that ignores the differences in health benefits produced by different types of care could reduce use of highly effective care as much as it reduces use of low-value care, especially for low-income populations.[11] A more sophisticated value-based approach would be to keep cost sharing lowest for services that are most effective at improving health.[12,13] The value of care delivered would also be improved by promoting coordination across silos – both in insurance and in care delivery. Evidence suggests that insurance features that drive use of one type of care (such as physician visits or medications) may have spillover effects on other kinds of care (such as hospitalizations or emergency department visits) that insurers as well as providers should have incentives to take into account.[14-16]

Striking a better balance between spreading risk and promoting efficiency would make Medicare a better insurance program. Improving the efficiency with which care is delivered to Medicare

beneficiaries also has the potential to improve system-level delivery. The Medicare Advantage program was introduced in that hope that private competition and managed care would result in more efficient care at a lower cost than conventional fee-for-service health insurance.[17] Accountable Care Organizations also aim to improve the value of care delivered through improved coordination. Because the same health care providers generally serve patients with different insurance coverage, changes in care induced by these programs may "spill over" to care delivered to other Medicare enrollees and, indeed, to all patients. Research suggests that these spillovers may be substantial.[18-22]

Medicare was always intended not just to increase access to care but to protect the elderly from financial ruin. As President Johnson said when signing Medicare into law in 1965, "No longer will illness crush and destroy the savings that [older Americans] have so carefully put away over a lifetime so that they might enjoy dignity in their later years."[23] Indeed, the introduction of Medicare reduced out-of-pocket spending among the top quartile of spenders by 40%.[24] Will Medicare continue to fulfill this promise in decades to come? President Reagan highlighted the need for the reform of Medicare's benefit: "All of us have family, friends, or neighbors who have suffered devastating illnesses that threatened their financial security. For too long older Americans, in particular, have faced the possibility of sicknesses that might not only wipe out their own savings but those of their families."[25] Medicare reforms that strike a balance between financial protection and financial incentives will help ensure that the program will be solvent for future generations without undermining the fundamental insurance value of this public insurance program.

EXHIBIT

Medicare Beneficiaries' Annual Cost-Sharing Liability for Hospital, Outpatient, and Physician Use

	Year 2009	Any Year in 2007-9	Any Year in 2005-9	Any Year in 2000-9
Share with Cost-Sharing Liability (Percent):				
Over $1,000	35.6	60.0	72.6	87.2
Over $2,500	14.5	27.9	37.4	53.2
Over $5,000	4.0	7.5	10.1	15.1
Over $10,000	0.9	1.6	2.0	2.4
Average Expenditures ($)				
Medicare	8587	8288	8226	7857
Beneficiary Cost-Sharing	1279	1254	1252	1232

Source: Baicker and Levy, *New England Journal of Medicine.*[26]
Notes: Data from Medicare Claims files for inpatient, outpatient, and carrier (physician) use, expressed in 2009 dollars. The entries show the share of beneficiaries facing cost-sharing liability above the threshold for each row in any single year within the window for each column. For example, while 4.0% of beneficiaries had cost-sharing liability above $5,000 in 2009, 10.1% had annual cost sharing liability above $5,000 in at least one year between 2005 and 2009. These figures exclude other categories of care (such as durable medical equipment) covered by Medicare for which beneficiaries may also incur cost-sharing liability. MedPAC estimates for 2009 that include the cost-sharing liability from all categories covered by Parts A and B (but not prescription drugs) suggest that 6.0% of beneficiaries would face cost-sharing liability of above $5,000, for example.[1] This cost-sharing liability may be paid out-of-pocket or by a third party (such as a Medigap plan).

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