

## Responses from Marilyn Moon to Additional Questions for the Record

### Committee on Energy and Commerce

The Honorable Joseph R. Pitts

**1. Ms. Moon, you have served as a public trustee for the Social Security and Medicare trust funds, and formerly were a senior analyst at the Congressional Budget Office. So I was surprised by the tone of your testimony which not only rejected the idea of using Medicare reforms to help pay for SGR reform, but seemed to reject the budgetary pressures Medicare is creating. You even said “Medicare is not a runaway program in need of reform.” So I have a few *yes or no* questions for you:**

**a. Will you acknowledge that, based on current projections, Medicare’s Trust Fund faces insolvency in the next 10 to 15 years? Yes.**

**b. Is so, would that present a problem for seniors accessing care? No.**

**c. Do you think it is fair that middle class taxpayers should subsidize millionaires on Medicare? No.**

**d. Do you think it is fair that Medicare fails to offer seniors peace of mind by providing a catastrophic cap against financial hardship due to extended illness? No.**

Some of my answers here are difficult to understand without some explanation, however. For example, while I do not think it is fair that middle class taxpayers be asked to subsidize millionaires, that is simply not the way that Medicare works. It is based on a false premise. Second, there are many ways to deal with the issue of trust fund solvency so I believe it is a phony issue to threaten beneficiaries with reduced access to care; the only way I believe that would happen is if poorly conceived policies to “save” Medicare are put in place.

**2. In your testimony, you seemed to only suggest tax hikes as a possible offset for SGR reform. Are there any *Medicare-related bipartisan offsets* you would endorse to help pay for SGR reform?**

As I indicated in my testimony, I believe that there are many promising areas of delivery system reform that can achieve greater efficiency and savings for the program over time. That should be acknowledged as we move forward as a positive change, whether or not it is formally scored as “savings.” Many of the changes in your SGR bill are likely to improve Medicare time, for example. Further, some payment reforms in areas such as home health and skilled nursing care could achieve some additional savings for the program.

In general, however, I do not believe that it is reasonable to ask beneficiaries to pay substantial additional amounts for their care in an effort to “save” Medicare. Even the options that seem less problematic—such as higher contributions by high income individuals—have negative

consequences. That is, there simply are not enough millionaires to yield substantial savings, so those options end up burdening middle class families even more as policy makers try to find further savings. We are already asking high income individuals to pay a lot in taxes and then in income-related premiums. Similarly, options to provide a catastrophic cap, which can be an excellent idea, are often designed to reduce the overall actuarial value of the Medicare benefit, and hence would not be good policy going forward since they would harm many beneficiaries. Finally, it is important to note that in the past, modest increases in Medicare revenues were considered bipartisan and a necessary part of the maintenance of the program.

### **The Honorable Doris Matsui**

**1. Currently, Medicare beneficiaries have separate cost sharing structures when they see doctors versus when they go to the hospital. There may be ways to simplify this and modernize Medicare benefits to look more like health insurance products we see today. However, current proposals to redesign Medicare benefits, such as combining Part A and B deductibles, would redistribute the burden of health care costs to the most vulnerable in the program.**

**a. Can you talk about the potential impact on beneficiaries of a combined Part A and B deductible?**

I fully agree that many of the proposals to redesign benefits end up harming large numbers of beneficiaries. That is, in large part, because the proposals are less than budget neutral. They are often proposed as ways to cut benefits in the guise of improving the program's structure. That said, having two separate cost sharing structures is undesirable for a number of reasons. It is confusing to beneficiaries and results in a number of negative incentives. I would favor a combined A and B deductible if it is not very large, and if low and modest income beneficiaries receive additional protections against this cost sharing increase. Medicare's cost sharing creates an enormous burden on those who have incomes less than 250 percent of poverty, for example. And any changes should be introduced gradually, reducing the Part A deductible while only slowly increasing that for Part B.

**2. Medicare beneficiaries with income above a certain amount already pay higher premiums for doctors and prescription drugs. Can you talk about the potential impact of further income-relating Medicare premiums in Part B and D? What income levels would some of these proposals reach?**

We have already gone a long way toward asking higher income beneficiaries to pay greater premiums. We do not think of individuals with incomes of \$85,000 as wealthy in any other context but in Medicare, the income-related premium treats them as "well off." Lowering the income threshold at which higher premiums begin would be detrimental to many but it is the easiest way to generate higher revenues. Similarly, the share of premiums paid by those with high incomes already rises pretty rapidly. And since we have no cap on the taxes that higher income people pay to support Medicare during their working years, it feels like piling on to go further with this option.

**3. Many Medicare “reform” proposals seek to alter Medigap insurance—supplemental insurance many people buy to help with the costs of Medicare. Such proposals include adding a deductible where there currently is none, imposing cost-sharing amounts, and/or charging an extra tax or surcharge on certain policies. What would the effect of such proposals be on those who purchase such policies?**

The rationale for taxing Medigap and enforcing a deductible is the belief that this program encourages frivolous spending by older Americans. I see no strong evidence that there is a problem. These Medigap changes would not do much to change behavior; they would simply shift costs from Medicare to seniors. Indeed, most health care spending is for services for the very sick and cost sharing is simply bad policy for those individuals who generally are not making “discretionary” decisions. Requiring a modest deductible in these policies is not a terrible idea and most Americans are now accustomed to such insurance structures. But again, the issue is to do this in moderation and not see it as a major revenue source. We should not forget that Medigap is used most by those who do not have access to former employers’ generous retiree health plans. The distributional consequences of these options fall heavily on those with lower middle incomes. The only upside is that a modest deductible requirement should reduce the cost of the policies modestly—unless we also impose a surtax.

**4. The idea of combining the Part A and B deductibles with an out-of-pocket cap sounds good, and may not increase costs for the aggregate beneficiary, but IS likely to increase costs for most beneficiaries in any given year. Can you discuss this further? How does a \$7,500 spending cap play out for a beneficiary with an income of \$23,500 or less (which is the majority of beneficiaries)?**

The difficulty with restructuring proposals is that the number of people with very large expenses is small compared to the numbers who would have modest expenses and be affected by an increase in the deductible. If a proposal is fully budget neutral or attempts to achieve some savings, it is very difficult to design a new deductible plus spending cap that would be viewed positively by a majority of beneficiaries. While more would realize they would be better off with the changes if they looked at this over a number of years—since many older people have one or two years of very high expenses out of a five year span, for example—most of us look at what such a proposal would mean in just one year. A slow phase in and extra protections for those with modest incomes could help to make this work. This may be one area where an income-related benefit makes most sense.

A \$7,500 cap does not provide very good protection to those with incomes below twice the poverty level since it would mean that people would have to spend 32 percent of their incomes on out-of-pocket spending before getting any protection. To this would need to be added the cost of Part B and D premiums and costs of non-covered services that would not count towards the cap. Most seniors would not see this as a very good deal.

It is also important to note that since many beneficiaries have Medigap or employer-sponsored retiree insurance, these supplements would provide some overall averaging of the impact. That is, consider the fact that a Medigap plan is priced with the knowledge that there will be a few

high users of services and many lower users. Since the premium is the same for all enrollees of a given age, it effectively averages the impact of any restructuring proposal. So if the Medicare proposal under discussion would lower average cost sharing, Medigap premiums should also go down. In that way, some beneficiaries would be shielded from the immediate impact of a higher deductible, for example.

**5. 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. Dr. Moon, how would Medicare benefit redesign proposals worsen this problem for seniors and people with disabilities?**

The worst possible proposal would be one which raised deductibles and co-pays on those with incomes below about \$25,000 per year. These individuals and couples have very little flexibility in their budgets and could face substantial increases in out of pocket costs. They would then have to make those tough decisions about what necessities to buy and whether to postpone care. If older and disabled people postpone needed care, the overall costs of health care are likely to rise because they would get more expensive care later—a lose-lose situation for such a policy change because government budgets and individuals would both suffer. Two key elements should be considered in any restructuring proposal: 1) do not try to raise revenues in this way since it would result in pain to a large number of vulnerable beneficiaries, and 2) couple any restructuring change with more generous improvements in low income protections. In the latter case, protections need to extend well above 150 percent of poverty, which is the level above which no protections for Medicare beneficiaries are currently available.

**6. The Medicare Trust Fund is currently estimated to be solvent until the year 2030. That is 13 years longer than was expected before the passage of the ACA.**

**a. Dr. Moon, is Medicare spending out of control? Please also discuss the contribution of population dynamics, namely our aging baby boomer population, to rising costs in comparison to the contribution of so-called “out of control” spending.**

Medicare spending has risen rapidly in recent years, but on a per capita basis it has grown more slowly than the costs of private insurance, for example. Health care costs have simply grown rapidly and that has nothing to do with Medicare being “out of control.” As a society, Americans have opted to spend more and more each year on health care and Medicare has, appropriately, been affected since it endeavors to provide mainstream care to its beneficiaries. The growth in the number of people participating in the program combined with rapid per capita growth yields rates of spending that have caused Medicare to grow faster than most other aspects of either federal spending or any other type of consumer spending. That brings a lot of attention to Medicare and often to calls for reductions on the assumption that somehow it is an unreasonable, out-of-control program. Care needs to be taken to keep the program as efficient as possible, but overall, Medicare covers the most difficult to serve population at rates of growth less than health spending for the rest of us.

**b. Please discuss Medicare spending over the last several years and how the ACA has impacted it.**

Medicare spending growth has slowed substantially over the past 5 years since the passage of the Affordable Care Act. That is not coincidence, but there are a lot of factors likely affecting this slowdown in health care spending. Many observers of health care costs have thought for some time that the very high pace of spending would fall at some point even without any explicit change in policy or identifiable cause. It is just very difficult for any portion of our economy to grow at such a different rate than everything else. In this sense, Medicare and the rest of the health care sector face the same issues. The poor rate of recovery from the Great Recession has also likely had something to do with the general slowing of health care costs, but we would expect that to be more the case for younger individuals whose wages have not been rising and whose employers have cut back on health benefits. But Medicare seems to have been affected by this as well, suggesting that it is very difficult to treat one group of the population differently in the delivery of health care.

The Affordable Care Act has also likely helped to slow growth via the attention paid to finding ways to reform the delivery of care to make it more efficient over time. A large number of demonstrations are underway, some of which are reinforcing approaches that were already being introduced. But as yet we should not expect a great deal of direct impact from the specific demonstrations; rather, providers of care and those who manage health service know that change is coming and have likely begun themselves to think about new ways to adjust their behaviors. They recognize that no one wants to continue to see such rapid rates of growth and it makes sense to try to be proactive in finding efficiencies. We have seen this before when proposals to change care have been made but not yet enacted. For example, controls on payments to hospitals were threatened in the 1970s and hospitals responded by reducing their costs and charges, actually holding off some of the threatened changes in legislation. The great unknown is whether some of these promising new avenues now underway in demonstrations will be able not only to slow growth for some time but will also put us more permanently on a path to lower growth. If that is the case, much of the concern about the solvency of the trust fund will be alleviated.

#### The Honorable Ben Ray Lujan

**1. Dr. Moon, as we have been discussing, last Congress we were able to come to a bipartisan, bicameral compromise that would permanently repeal the flawed SGR payment system. But this package, the SGR Repeal and Medicare Provider Payment Modernization Act, also takes a step further by providing a framework for reforming Medicare's payment system. The bill moves from paying based on volume of services to paying based on quality of care. It incentivizes physicians to switch to alternative payment models like medical homes, case-based payments, or accountable-care payments.**

**a. How would moving away from fee-for-service to alternative payment models help Medicare beneficiaries and the Medicare program?**

One of the greatest needs in improving the delivery of care—both in terms of cost and quality—is to improve its coordination. When care is delivered in siloes—with each separate provider

independently making decisions and ignoring other parts of the system—care is very inefficient. Duplicative tests are administered, care is delivered in the wrong setting (often at too high a level), treatments and drugs may conflict with each other creating adverse outcomes, and mistakes overall are more easily made. The fee-for-service system reinforces the separation and isolation of care. No one is paying for the appropriate coordination or to make sure that when an individual moves from one part of the health care system to another that information is shared or cooperation takes place. The incentive to do as much as possible is very strong in fee for service. If well designed, alternative payment models can both reduce the costs of the program and improve the quality of care that beneficiaries receive. When a course of treatment is paid for as part of a “bundle,” there is suddenly an incentive to make sure that all the different providers communicate with each other and that duplication does not occur. It makes sense to provide care in the most appropriate setting and not hospitalize someone who might be better treated at home, for example. It is not always easy to get these new systems aligned or to encourage providers who are not accustomed to working together to do so, but it will make enormous sense to have that take place.

**b. Would a value-based system like the one we proposed in the SGR Repeal and Medicare Provider Payment Modernization Act also help control costs in the long run?**

The changes proposed in the SGR Repeal and Medicare Provider Payment Modernization Act are very much on target to improve the health care system over time. Let me mention a few of the many provisions that show great promise. Coordination of efforts for those with chronic care needs is particularly important. Our system is perhaps nowhere more fragmented than for these beneficiaries since their needs extend across many different providers and settings. The system is confusing and arbitrary in many ways at present, so better coordination will be a key first step, but also likely to highlight where further changes in Medicare law are needed. For example, the handoffs that occur between home health and outpatient therapy are particularly clumsy and complicated by the outpatient therapy caps and home health rules. More will likely need to be done in that area. Development of guidelines, and better information sharing and transparency are all areas that can have an important impact—if providers take them seriously and use these new tools to modify their practices where appropriate. Providing bonuses to those who participate in patient centered medical homes is also important when that leads to better coordination and improved compensation for primary care physicians who are underpaid in our current health care system.