

The Honorable Joseph R. Pitts

- 1. In 2012, MedPAC recommended fee-for-service benefit reforms that would replace the current benefit design and would include reforms similar to some of those you, Senator Lieberman, and the President’s Fiscal Commission recommended. However, MedPAC recommended an additional charge on Medigap insurance, rather than restricting first-dollar coverage. Would you please discuss the policy trade-offs of the different approaches, and which approach you prefer and why?**

An additional charge on first-dollar Medigap insurance would have the advantage of being easy and quick to implement; however, it would probably be much less effective than a broader reform of supplemental coverage design at meeting the goals of the reform. In the Bipartisan Policy Center (BPC) [2013 report](#),¹ we recommended that all supplemental coverage be restricted from covering the first \$250 of a new combined deductible and up to half of additional cost sharing (copayments or coinsurance), as part of a comprehensive benefit modernization that would also establish a combined deductible, the ability to see a physician for only a copayment whether or not the deductible is met, new protection from catastrophic out-of-pocket costs, new cost-sharing assistance for low-income beneficiaries, and reduced premium subsidies for higher-income beneficiaries. Under an additional charge for first-dollar supplemental coverage, there is a concern that many beneficiaries would simply pay more, which is not the intent of the policy. Under a broader reform, which would apply to individually purchased Medigap insurance, employer-sponsored supplemental coverage, and Tricare-For-Life supplemental coverage, beneficiaries, employers, and government would pay less for insurance and would still have reasonable, low out-of-pocket cost sharing compared to commercial health insurance policies available today in the under 65 market. Additionally, limitations on supplemental coverage would help facilitate the success of alternative payment models (APMs), such as Accountable Care Organizations (ACOs). There have been bipartisan proposals to allow ACOs to waive beneficiary cost sharing for some services, such as primary-care office visits. First-dollar supplemental coverage would limit the impact of these reforms and make it more difficult for ACOs to encourage patients to access care from ACO providers, for example. Combining this reform with new cost-sharing assistance for near-poverty Medicare beneficiaries would help assure that changes in supplemental insurance policies do not create barriers to access to care.

- 2. One of the worries that some have in making changes to Medigap is that lower-income seniors could face higher cost-sharing. However, with nearly one in three beneficiaries today enrolled in a Medicare Advantage plan, do you think that the Medicare Advantage plans – which all offer full catastrophic protection – would be a viable alternative to Medigap for many of the impacted beneficiaries?**

In many ways, Medicare Advantage plans are a good example of why Medigap reform is a viable and desirable policy. Medicare beneficiaries who qualify for the Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI) programs – which provide premium, but not cost sharing, assistance to individuals who are just above the federal poverty line (FPL) – are more likely to be

¹ *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*. April 2013. Available at: <http://bipartisanpolicy.org/library/health-care-cost-containment/>

enrolled in Medicare Advantage than the average beneficiary, according to the [MedPAC Data Book](#) from June 2014 (see Chart 9-11).

That being said, more can be done to help lower-income Medicare beneficiaries with cost-sharing. Beneficiaries under 100% of FPL with limited assets are already eligible for help with Medicare's cost-sharing. BPC's [2013 report](#) recommended an expansion of cost-sharing assistance to those beneficiaries just above the poverty line, while also proposing advanced payment and delivery models for traditional Medicare to give Medicare beneficiaries a choice in delivery systems with accountability for both quality and cost, as well as strong incentives for providers and beneficiaries to participate in those systems.²

- 3. In your testimony you said, "SGR reform must not add to future deficits. Cost growth in health care has slowed in recent years, which makes projected health care spending appear less daunting than it has in the past.....Fixing the SGR must be paid for – that's just good budgeting." Would you please explain why it's good policy to offset the SGR bill and why that's important for the budget and for beneficiaries?**

While deficits have declined in recent years, thankfully as a result of a recovering economy, the long-term fiscal outlook for the nation is still very challenging. The Congressional Budget Office said it very well in their 2015 Budget and Economic Outlook (**emphasis mine**):

When CBO last issued long-term budget projections (in July 2014), it projected that, under current law, debt would exceed 100 percent of GDP 25 years from now and would continue on an upward trajectory thereafter—a trend that could not be sustained. (The 10-year projections presented here do not materially change that outlook.) **Such large and growing federal debt would have serious negative consequences, including increasing federal spending for interest payments; restraining economic growth in the long term; giving policymakers less flexibility to respond to unexpected challenges; and eventually heightening the risk of a fiscal crisis.**

At the very least, we shouldn't make this problem worse. And, there are many reasonable approaches to paying for a permanent SGR fix that would also improve the operation and efficiency of the program for both taxpayers and beneficiaries. It is important to remember that beneficiaries pay, either directly or indirectly through supplemental insurance, 20 percent of the cost of many services. Therefore, cost-reductions in the Medicare program benefit both help reduce the deficit and help reduce beneficiary out-of-pocket expenses.

- 4. According to the Congressional Budget Office, Medicare's spending will continue to climb over the coming decade – totaling more than \$1 trillion in 2024. One of my worries is that as Medicare consumes more general revenue dollars, it will crowd out other domestic policy discretionary priorities. What Medicare reforms do you think could be adopted with the SGR that would help put downward pressure on Medicare spending the most?**

I agree with your concern that long-term growth in Medicare spending could put pressure on many important discretionary spending priorities, such as education and research. I think the most effective reforms to put downward pressure on Medicare spending would be more aggressive efforts to encourage providers and beneficiaries to engage with alternative payment models, in which providers assume some risk for both the cost of services delivered and quality outcomes. For example, BPC

² *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*. April 2013. Available at: <http://bipartisanpolicy.org/library/health-care-cost-containment/>

recently published a [variety of recommendations](#) to improve accountable care organizations and other APMs, including establishing higher updates for all providers (not only physician-fee-schedule providers) for participating in APMs and lower updates for all providers who do not participate in APMs beginning in 2018.³ Next month, BPC will release recommendations to encourage the adoption of a core set of meaningful quality measures, and to make the information available to consumers in a format that assists them in their health care decision-making.

- 5. I am sure you are familiar with some research by the Urban Institute which finds that, each Medicare beneficiary will, on the average, take almost three times more out in Medicare benefits than they put in to the system in payroll taxes and premiums. One of the facts that demonstrates this is that individual's payroll taxes do not "pay for" the full cost of their benefits. Please explain why that mathematical reality itself necessitates changes to Medicare over time?**

I would define the problem differently. Medicare has never been an entirely pre-funded system; parts B and D have always relied upon general funds and beneficiary premiums. The most substantial potential fiscal problem is if Medicare costs resume growth that is faster than the broader economy for an extended period of time. While the recent slowdown in Medicare costs specifically and healthcare costs in general is welcome and encouraging, the most likely way to make it last is to continue to aggressively move away from fee-for-service payment toward alternative payment models that reward more coordinated, higher-value care.

- 6. It has been suggested that the only thing Congress needs to do to fix Medicare's funding shortfall is to raise general taxes. You mentioned you're in favor of more revenue *in the context of tax reform* that broadens the base and lowers rates. Can you talk about any concerns you have from a policy perspective regarding just increasing taxes to pay for SGR? For example, would it fix the problems of seniors not having catastrophic protections or millionaire still having their premiums paid for by taxpayers? Based on your years of experience working with Congress to examine Medicare and federal programs, do you think the general public would accept a large tax hike to pay for Medicare changes?**

Additional revenue could be part of a balanced, compromise agreement to pay for a permanent SGR fix, so I would hope that nothing would be taken off the table to begin. But a balanced package could also make improvements to and modernize the Medicare benefit design, reduce subsidies to higher income Medicare beneficiaries, and aggressively encourage adoption of APMs. I think the general public is most likely to accept a balanced package that could include a variety of these elements.

- 7. It can be said that SGR reform is Medicare reform rather than a "physician payment bill," because the threat of not fixing it falls squarely on the shoulders of seniors who might have access to their doctor interrupted if we fail to reform. Do you agree with that perspective and, if so, can you provide a few thoughts on how SGR reform is Medicare reform?**

I do believe that efforts to advance APMs, such as those in the tri-committee SGR reform act, would constitute important reforms to and improvements of the Medicare program, beyond just fixing the

³ *Transitioning to Organized Systems of Care: Near-Term Recommendations to Improve Accountable Care Organizations in Medicare*. January 2015. Available at: <http://bipartisanpolicy.org/library/transitioning-to-organized-systems-of-care-near-term-recommendations-to-improve-accountable-care-organizations-in-medicare/>

physician payment formula. And I think that many of the potential additional policies that could be part of an offset package, such as modernizing Medicare's beneficiary cost sharing and supplemental coverage reform, would qualify as meaningful Medicare reform that would benefit taxpayers and beneficiaries as well. At the same time, Medicare beneficiaries should have access to information, including quality information, in a format that is accessible to consumers.

- 8. The SGR reform act is authored by Dr. Burgess and supported by many members of both sides of the aisle – including the chairman and ranking members of the Energy and Commerce, Ways and Means, and Senate Finance Committees. This bill puts forward a new vision for how physicians might deliver services and be paid under the Medicare program. Your testimony includes some thoughts on the policy, but I am curious as to whether you think the**
- 9. to control their provisions in the bill have the potential to help increase the quality and delivery of care to seniors in need?**

I believe that APMs, such as payment bundles, patient-centered medical homes, and accountable care organizations, have great potential to increase the quality and coordination of care delivered to Medicare beneficiaries, and that the tri-committee legislation would do so as well by encouraging adoption of APMs. At the same time, as mentioned above, Medicare beneficiaries need meaningful quality information to assist them in their health care choices and accessing high quality providers and services.

- 10. There has been a lot of discussion in recent years about the slowdown in the annual growth rate of Medicare spending. You have probably been following the literature and CBO's analysis pretty closely, but my question is pretty simple: in your opinion, is the slow-down in Medicare spending a reason not to offset SGR reform? And, based on your historical perspective, do you think it is likely to rebound in coming years closer to historical averages?**

The slowdown in the growth in Medicare spending is certainly welcome, but no one knows if it will persist. I certainly wouldn't count on it. It's not a good reason to avoid paying for SGR reform. The best way to make it more likely that the slowdown in growth of healthcare costs persists is to aggressively move away from fee-for-service toward alternative payment models. The tri-committee SGR legislation takes important steps in that direction, and another good step would be to extend differential updates (higher fee-schedule updates for providers that participate in APMs, lower updates for others) to all Medicare providers, not only physician-fee-schedule providers.

- 11. As a former director of the Congressional Budget Office, you understand well the way that the current SGR formula creates uncertainty in the federal budget. Please discuss why, from a CBO perspective, it could actually cost more to do annual short-term patches, rather than adopting a long-term SGR reform proposal? And is it accurate to say that CBO's estimate of the cost of SGR repeal is "on sale" now compared to historical averages? Do you expect the cost of SGR repeal to increase in the future?**

I think the biggest downside to continual short-term patches is delaying or missing the opportunity to implement thoughtful changes to the program to discourage fee-for-service payment, encourage provider accountability for both cost of services delivered and quality outcomes, and improve the patient experience. Our best chance to permanently reduce the growth rate of Medicare spending is through payment and delivery system reform and improving and consolidating meaningful quality measures, which cannot be achieved in six month and one year patches. Since no one can be sure what

will happen with healthcare cost growth in the next few years, the fact that the cost estimate from CBO for a permanent SGR reform is significantly lower than in past years seems like an excellent reason to make a deal and get this important work done this year.

The Honorable Larry Bucshon, M.D.

- 1. In your testimony you support MedPAC’s recommendation to increase branded medication co-pays and decreasing generic medication co-pays for the Part D LIS population. During questioning at the hearing you also stated that this policy would not have a negative effect on Part D LIS beneficiaries. We have 200,275 Part D LIS beneficiaries in Indiana who take a mix of doctor prescribed branded and generic medications multiple conditions. I have seen data (highlighted below) that challenges your assertion and I would like your feedback. Faced with greater cost-sharing, low-income individuals may attempt to switch to less costly but less effective or tolerable therapies or may entirely forego, delay, or decrease use of recommended medications. For example, research has shown that responsiveness to price increases for prescription drugs is significantly greater than for emergency room (ER) and hospital visits among low-income populations. Comprehensive drug coverage improves medication adherence, and reduces racial disparities in outcomes and costs. A recent Health Affairs study found that when cost-sharing for cardiovascular drugs was eliminated following a heart attack, total healthcare spending for nonwhite patients decreased by 70%, and rates of cardiovascular events decreased by 35%. Financial disincentives to use brand medicines may unintentionally create barriers to prescription drug adherence among low-income populations, potentially costing Medicare and Medicaid more in unnecessary hospitalization and otherwise avoidable medical care. CBO acknowledged that policies that decrease the use of prescription medicines would cause Medicare spending to rise; citing a substantial body of evidence that indicates that “people respond to changes in cost sharing by changing their consumption of prescription drugs,” including reductions in number of prescriptions filled in response to price increases. Other researchers found that even small copay increases for low-income cancer patients in Medicaid reduced their use of unnecessary medicines while significantly increasing the probability of having an ER visit and raising their health care costs.**
 - a. If you could please provide your thoughts on this data, I would greatly appreciate it.**

Those are very interesting results. To clarify, the proposal in BPC’s [2013 report](#) would have reduced the copayment for generic and preferred brand drugs to zero for all LIS beneficiaries (down from about \$1.00 or \$2.50 depending on income) and would have increased copayments for non-preferred brand drugs from \$3.50 to \$4.00 (for the lowest-income LIS beneficiaries) or \$6.50 to no more than \$8.00 (for those in the higher-income LIS tier.⁴ I suspect that eliminating cost-sharing for low-cost generics and preferred brand drugs would have a positive effect on drug adherence and may, at least partially, if not wholly, outweigh any negative effects from a \$0.50 to \$1.50 increase in non-preferred brand copayments. But to know for sure, the change would need to be tested empirically. Clearly, patient choice is very important, and we included a provision in our proposal to ensure that patients would continue to have access to non-preferred brand drugs if the doctor writes “dispense as written” on the script.

⁴ *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*. April 2013. Available at: <http://bipartisanpolicy.org/library/health-care-cost-containment/>

Additionally, there are many factors that affect drug adherence. Patient education and care coordination, which could be facilitated by alternative payment models, such as patient-centered medical homes and accountable care organizations, also have the potential to improve drug adherence, and would be promoted by the bipartisan tri-committee SGR legislation.