Written Testimony
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Chairman Brady, Ranking Member McDermott, thank you for this opportunity to discuss strategies to strengthen our nation's health care system and ensure that our Medicare dollars support high quality, cost effective health care.

Background and Overview of Health Care Cost Containment Initiative

Recently, the Bipartisan Policy Center (BPC) concluded a nearly year-long project which examined high and rising health care spending and made recommendations to improve the quality and sustainability of our nation's health care system. I, along with the other three leaders of BPC's Health Care Cost Containment Initiative, former Senate Majority Leaders Tom Daschle (D-SD) and Bill Frist (R-TN) and former Senator Pete Domenici (R-NM), came together around the common belief that our health care system can provide better care to patients at a lower overall cost by prioritizing high value, coordinated care delivery and payment.

We reached consensus on a comprehensive package of reforms that span the entire health care system, with a particular focus on the most powerful federal levers for incenting broad and systemic reforms – the Medicare program and federal health-related tax policy. Our report, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, released last month, describes all of these recommendations in detail. We believe that, if enacted together, these reforms will help improve health care quality for patients and families and lower overall spending growth across the entire health care system.

The work of the Health Care Cost Containment Initiative was informed by substantive, third party analytics and feedback from a broad group of experts and stakeholders. BPC commissioned Acumen, LLC (an organization that provides modeling support for CBO, CMS, MedPAC, and other similar organizations) and MIT economist Jonathan Gruber to estimate the spending and revenue impacts, respectively, of our proposed policies. Over the next 10 years, our proposals would result in approximately $560 billion in deficit reduction. Our Medicare reforms would achieve roughly $300 billion in net savings within that time frame, and over second decade (2024-2033), our proposals would result in another almost $1 trillion in budgetary savings to the Medicare program. These savings estimates are net of the cost of fixing the dysfunctional Sustainable Growth Rate (SGR) physician payment formula. Broadly, we propose the following:

- Preserve the guaranteed health coverage promised in traditional Medicare while adding more choices and protections for beneficiaries.

- Strengthen and modernize the traditional Medicare benefit.
- Reform the tax treatment of health insurance to limit the tax-favored treatment of overly expensive insurance products.
- Empower patients by promoting quality measures that are meaningful to consumers, families and businesses.
- Offer incentives to states to promote policies that will support better organized, value-driven health-care delivery and payment system, such as supporting medical liability reform and strengthening our primary-care workforce.
- Advance the nation's understanding of potential cost savings from prevention programs, through support for research and innovation on effective strategies to address costly chronic conditions.

Senator Domenici and I have long agreed on the urgent need to improve our nation's health care system and to get health care spending under control. Before joining with Senators Daschle and Frist on the Health Care Cost Containment Initiative, Senator Domenici and I co-chaired the BPC Debt Reduction Task Force. The Domenici-Rivlin Debt Reduction Task Force released a broad, balanced package of spending cuts and tax reforms to get our nation's debt on a more sustainable path, which focused heavily on improving our health care system.

The Domenici-Rivlin Task Force Medicare proposals emphasized beneficiary engagement; competition on the basis of quality and value that brings market forces to bear in Medicare; an improved, rationalized traditional Medicare benefit package; and more coordinated systems of health care delivery and payment. All of these elements are reflected in the BPC Health Care Cost Containment Initiative report, which emphasizes improving the quality of care and providing incentives to beneficiaries and providers that will increase coordination and measured effectiveness of care. Some proposals were refined as we acquired more knowledge and recognized the need to prioritize political and economic realities to develop a package around which both sides of the aisle can realistically coalesce.

In today's hearing, I will focus on the Medicare benefit and cost-sharing redesign recommendations Senators Daschle, Domenici, Frist and I released. However, I want to note that our recommendations are structured as an integrated package. We believe that a comprehensive approach, rather than breaking out individual recommendations for implementation, is critical to achieving successful health care system transformation. As was made clear by each of the leaders when the proposal was released, one cannot "cherry pick" a proposal from the report and assume that all leaders would endorse the provision in isolation.

Our Medicare reforms have three key policy foundations:

1. Structural reforms that will preserve traditional Medicare while improving Medicare payment and care delivery by encouraging coordination, competition, and beneficiary choice;
2. Redesign of the traditional Medicare benefit package and cost-sharing; and
3. A series of reforms that can be implemented in the near term that will achieve budgetary savings and support our longer term goals of system-wide health care transformation, such as

expanding competitive bidding for certain goods and services, ensuring that Graduate Medical Education payments support a workforce that can effectively and appropriately deliver care, and encouraging the use of high quality, low cost drugs.

Over the long-term, we envision a health care system where all patients are able to receive high quality, coordinated care. To achieve this goal, the dominant delivery and payment systems must be reformed to encourage providers to form and develop organized systems of care. As the largest payer, Medicare has the opportunity to lead the way. Our proposal calls for the creation of a new, permanent option in traditional Medicare called "Medicare Networks." Medicare Networks would be provider-led and similar to accountable care organizations (ACOs), but with key improvements. Most importantly, Medicare Networks would be enrollment-based, meaning that beneficiaries must make an active, informed choice to join a network—rather than being passively assigned to an ACO without their knowledge, as they are under current law.. Beneficiaries joining a network would receive a discounted monthly premium and lower in-network cost-sharing for participation. We would offer strong financial incentives for both providers to form and beneficiaries to join Medicare Networks, and allow both to share in savings that result from greater quality and efficiency of care. We would repeal the SGR, and physicians practicing within Medicare Networks would receive updated payments based on the Medicare Economic Index (MEI).

Ultimately, beneficiaries would be free to choose between improved fee-for-service Medicare, improved Medicare Advantage, or the new Medicare Networks. In Medicare Advantage, our recommendations would implement a new competitive-bidding structure. Competitively-bid payments to plans would only take effect in regions where such payments are lower than those under current law, therefore guaranteeing savings for the Medicare Trust Funds. Initially, a portion of the savings would be allocated to finance reduced enrollee premiums and cost-sharing. To help beneficiaries navigate plan selection, we propose a user-friendly, up-to-date Medicare Open Enrollment website. Our recommendations also call for continual improvements to Medicare Advantage risk adjustment and a new, budget-neutral reinsurance program to augment the risk adjusters in addressing risk selection issues.

We project these reforms to achieve substantial savings on their own, but we also include a fallback spending limit to take effect no earlier than 2020. This limit would be triggered by spending growth in excess of GDP per beneficiary growth (age-adjusted) + 0.5 percentage points and would apply separately to all three Medicare program options. Acumen's budget estimate includes no savings from this fallback spending limit.

Strengthen and Modernize the Medicare Benefit

Our recommendations improve, simplify and modernize the traditional Medicare benefit package. This redesign provides long overdue protections and preserves the same aggregate cost-sharing that beneficiaries experience today. Again, I would stress that these reforms are part of our integrated package of recommended Medicare reforms, which recognizes that changes in benefits and cost-sharing should protect low-income seniors.

Changing Traditional Medicare Cost-Sharing: Important Considerations

Any reform to the Medicare benefit design should ensure that beneficiary cost sharing provides incentives for appropriate utilization of services without imposing a financial burden on beneficiaries that would keep them from receiving medically necessary services.

Challenges in Traditional Medicare Cost-sharing

In addition to its lack of catastrophic protection, there are several unusual features of Medicare's cost-sharing design that are important to consider when proposing adjustments.

- **Two Deductibles.** Private health insurance typically has one deductible covering all hospital and physician services. Once the deductible is met, it does not apply for the rest of the year. The Medicare program has two deductibles, one for physician and related services ($147 per year in 2013) and one for hospital ($1,184 per episode in 2013). Moreover, the Part A hospital deductible applies to each episode of care. In this respect, the Medicare hospital deductible is more like a copayment, since it may apply multiple times per year.
- **Physician office visits are subject to the deductible.** In most private health insurance, policyholders can see a doctor for only the cost of a copayment, even if the deductible has not been met. This encourages patients to seek care early on, before conditions worsen. In Medicare, beneficiaries who have not met the deductible must pay the full cost of a physician visit.
- **No cost-sharing for some services, very high cost-sharing for others.** A beneficiary with a health condition that requires a very long hospital stay is expected to pay $296 in cost-sharing for days 61 through 90, and even more if more than 90 days are required (remember, Medicare has no out-of-pocket maximum). Clearly, this is not a realistic or affordable amount, and such high amounts are not necessary to provide incentives for appropriate utilization of care. Conversely, some Medicare-covered services, such as home health, laboratory services, and the first 20 days of a Skilled Nursing Facility stay, have no cost-sharing at all. Private health insurance usually includes some kind of cost-sharing for these services. Just as unrealistically high cost-sharing is counterproductive, the total absence of cost-sharing for some services encourages inappropriate utilization and can help fraud remain undetected. If services do not have cost-sharing, there should be a strong justification and the application should be limited. Examples of services that should not have cost-sharing include preventive care (already a strong feature of the Medicare benefit design), hospice care, and very inexpensive services, such as a $3 lab test.
- **Interaction with supplemental insurance.** Even well-designed changes to Medicare cost-sharing will have a limited effect in discouraging inappropriate utilization if supplemental insurance cancels their effect. . Beneficiaries who have and keep supplemental coverage that fills in the entire amount of the deductibles and all coinsurance, are not affected. This is another reason that changes to cost-sharing should be considered in the context of broader reforms.

Medicare Benefit Modernization: The BPC Approach

Currently, the Medicare benefit package provides no limit on annual beneficiary liability. Our proposal would set an annual, beneficiary cost-sharing limit for catastrophic medical costs at $5,315. We would streamline the Medicare Part A and B deductibles into a single, annual deductible of $500 and provide the Department of Health and Human Services (HHS) Secretary with authority to replace coinsurance and establish more predictable copayments for most covered services, similar to those suggested by the Medicare Payment Advisory Commission (MedPAC). Our proposal would also ensure that beneficiaries are able to see their doctor without facing high out-of-pocket costs, by exempting physician office visits from the new, combined deductible; beneficiaries would always be able to see a physician for the cost of a copayment ($20 for a primary care office visit, $40 to see a specialist). Furthermore, we would maintain current policies that eliminate cost-sharing for preventive care and provide for the annual Medicare wellness visit, as well as hospice.

As part of our payment and delivery system reform proposals for traditional Medicare, we seek to encourage organized systems of care that are accountable for quality and cost. One of our recommendations is to dramatically improve the existing ACOs by allowing for greater patient engagement. Traditional Medicare beneficiaries who enroll in our proposed Medicare Networks would receive lower in-network cost-sharing, but would also pay higher cost-sharing if they receive services from Medicare providers that are not part of the network. This would provide stronger incentives for beneficiaries to enroll and access care from high quality, efficient providers.

Reform Medicare Supplemental Insurance

The point of co-payments and deductible to engage patients in ensuring that health care dollars spent on services that actually improve patient health. Therefore, starting at the same time as our benefit redesign proposal, all supplemental coverage would be required to include a deductible of at least $250, an out-of-pocket maximum no lower than $2,500, and cover no more than half of beneficiary copayments and coinsurance. These restrictions would apply to both individually-purchased (medigap) and employer-provided plans, including TRICARE for Life and the Federal Employee Health Benefits Program.

Medigap insurance is expensive. The the market for medigap plans is highly concentrated—two issuers control three-quarters of it—raising concerns about adequacy of competition. [1] Modernizing and strengthening the Medicare benefit package, as we recommend—including a new beneficiary out-of-pocket limit, lower costs for early year physician visits, and other improvements—would make such supplemental policies less necessary and enable beneficiaries to save money by forgoing an expensive product.

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[1] Starc, Amanda. Insurer pricing and consumer welfare: evidence from medigap. Feb. 22 2012. Available at: https://hcmg.wharton.upenn.edu/files/?whdmsaction=public:main.file&fileID=1858.

Increase and Improve Support for Low-Income Medicare Beneficiaries

Low-income beneficiaries cannot afford to pay the same cost-sharing as middle- and upper-income seniors. Currently, most seniors and people with disabilities with incomes below the federal poverty level (FPL) qualify for assistance that covers 100 percent of their non-drug cost-sharing liability—including deductibles, copayments, and coinsurance—but there is no physician or hospital cost-sharing help available for beneficiaries with incomes that are near-poverty. This is a significant gap in the safety-net—one that also complicates efforts to reform Medicare's benefit design and limit first-dollar supplemental coverage due to legitimate concerns about the potential impact on beneficiaries with incomes just above the poverty level who do not currently qualify for any cost-sharing assistance.

In tandem with our Medicare benefit modernization, therefore, we recommend expanding cost-sharing assistance to beneficiaries with incomes up to 150 percent of the poverty level. This proposal would help roughly eight million low-income seniors and people with disabilities, which in conjunction with the rest of our plan, would provide them each, on average, with $1,250 of support.

Under this new, federally funded assistance:

- 50 percent of cost-sharing (including deductibles, copayments, and coinsurance) would be covered for Medicare beneficiaries with incomes between 100 percent and 135 percent of the FPL; and
- 25 percent of cost-sharing would be covered for beneficiaries with incomes between 135 percent and 150 percent of the FPL.

Eligibility would be automatically determined by the Social Security Administration based on an individual's modified adjusted gross income (MAGI). There would be no asset tests for this new assistance, enabling automatic enrollment.

Reduce Subsidies to Higher-Income Medicare Beneficiaries

Importantly, because Parts B and D of Medicare are not pre-funded like Part A or Social Security, the federal government contribution through general tax revenue amounts to a subsidy for medical and prescription drug coverage. We believe that a generous government contribution is appropriate for low- and middle-income seniors and people with disabilities, but providing generous subsidies to high-income beneficiaries who do not need the assistance is unjustified given the perilous fiscal trajectory of the nation.

As part of comprehensive Medicare reform, BPC recommends reducing subsidies to higher-income Medicare beneficiaries. Specifically, the proposal would reduce premium subsidies for Medicare beneficiaries with income starting at $60,000 for single beneficiaries and $90,000 for couples. Because couples are typically more financially secure than single beneficiaries, our proposed thresholds feature a single/couple ratio of 1 to 1.5, as compared to a 1 to 2 ratio for the existing thresholds. The new thresholds would be implemented in 2016 and would be adjusted for inflation after 2018, at which point approximately 17 percent of Medicare beneficiaries would pay income-related premiums. In total, this reform would save taxpayers $66 billion over ten years.

*Proposed Thresholds		
Single	**Couple**	**Premium**
<$60,000	<$90,000	25%
$60,001-$82,000	$90,001-$123,000	35%
$82,001-$135,000	$123,001-$202,500	50%
$135,001-$189,000	$202,501-$283,500	65%
>$189,000	>$283,500	80%

Conclusion

All of these Medicare proposals fit together as an integrated package that seeks to improve quality, reduce waste and inefficiency, and lower costs. Senators Daschle, Domenici, Frist and I all agreed that we needed a sustainable and comprehensive plan for improving our health care system. Our recommendations are intended to support our vision of a more coordinated and efficient health care system that delivers high quality care to all Americans. Due to the inefficiency and waste that plague the current system, delivering better quality and higher value care will naturally lead to lower spending growth. Cost shifting is a short term expedient only, and cannot be sustained over the long term.

Changes to beneficiary cost-sharing should not be solely a budget-driven policy exercise; reform should focus on strengthening the Medicare benefit, blunting the harmful effects of first-dollar supplemental coverage, and expanding protections for low-income beneficiaries. These policies should be pursued in concert with broad, structural reform. Our proposed changes in beneficiary cost-sharing and benefit design were carefully constructed to complement our Medicare delivery system and payment reforms. In our proposal, Medicare beneficiaries share in the responsibility of building a better health care system with the whole spectrum of providers, industry leaders, stakeholders, and payers.

Thank you again for this opportunity to discuss BPC’s approach to creating a higher quality, higher value health care system. I look forward to a continued dialogue with you on this very important topic.