

Reforming Medicare's benefit design

February 26, 2013

Statement of

Glenn M. Hackbarth, J.D.

Chairman

Medicare Payment Advisory Commission

Before the

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Chairman Camp, Ranking Member Levin, Subcommittee Chairman Brady, Subcommittee Ranking Member McDermott, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's recommendation to reform Medicare's benefit design.

The Medicare Payment Advisory Commission is a Congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.

Introduction

Over the last several years, the Commission has made a range of recommendations to the Congress regarding traditional fee-for-service (FFS), Medicare Advantage (Part C), and the prescription drug benefit (Part D) designed to improve the coordination and quality of care, to improve the equity of payment, to improve program integrity, and to reduce spending. Most of those efforts have been aimed at providers of care. It was the Commission's judgment that policy changes focused on the provider were the most effective first step to improving the Medicare program. However, there is another actor in the delivery of care—the beneficiary. Here the Commission has also considered policy changes—for example, generating and disseminating quality information, examining shared decision-making protocols, and redesigning the traditional Medicare benefit structure. The Commission has also recommended that Medicare Advantage (MA) and the accountable care organization (ACO) initiative be designed to reward beneficiaries for making cost-conscious choices. In order for Medicare to produce both quality care and lower spending growth, the incentives of providers and beneficiaries need to be aligned to achieve these goals.

The Commission has been considering ways to reform the traditional benefit package with two main objectives: to give beneficiaries better protection against high out-of-pocket (OOP) spending and to create incentives for them to make better decisions about their use of discretionary care. In this testimony, we focus on the Commission's recommended redesign of the FFS benefit package

from our June 2012 report and summarize the Commission's views on key design issues related to restructuring cost sharing under the FFS benefit.

The cost-sharing structure of the traditional FFS benefit has remained basically unchanged since 1965. The current FFS benefit has considerable cost-sharing requirements. For Part A services, it includes a relatively high deductible for inpatient hospital care (\$1,184 in 2013) and daily copayments for long stays at hospitals and skilled nursing facilities. Patients with more than one hospital admission in a year can be liable for more than one hospital deductible for the year. For Part B services, the FFS benefit has a relatively low deductible (\$147 in 2013) but requires beneficiaries to pay 20 percent of allowable charges for most services, except for home health, clinical laboratory, and certain preventive services. Annual changes in the deductibles and copayments under Part A and Part B are linked to average annual increases in Medicare spending for those services.

Under this design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. As a result, a small percentage of Medicare beneficiaries incur very high levels of cost-sharing liability each year (Table 1). For example, among FFS beneficiaries who were enrolled in Part A and Part B for 12 months in 2009, 6 percent had a cost-sharing liability of \$5,000 or more. Without additional coverage, they would be subject to significant financial risk from very high levels of OOP spending.

Table 1. Distribution of Medicare beneficiaries' cost-sharing liability in 2009

Range of cost-sharing liability per beneficiary	Percent of FFS beneficiaries	Average amount of cost sharing liability per beneficiary
\$0	6%	\$0
\$1 to \$135 (2009 Part B deductible)	3%	\$85
\$136 to \$499	34%	\$289
\$500 to \$999	19%	\$713
\$1000 to \$1,999	16%	\$1,456
\$2,000 to \$4,999	16%	\$3,048
\$5,000 to \$9,999	4%	\$6,869
\$10,000 or more	2%	\$15,536

Note: FFS (fee-for-service). Amounts reflect cost sharing under FFS Medicare—not what beneficiaries paid out of pocket. Most beneficiaries have secondary insurance that covers some or all of their Medicare cost sharing. Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year and not enrolled in private Medicare plans.

Source: MedPAC analysis based on data from CMS.

But for most Medicare beneficiaries, what they paid out of pocket is much less than their cost-sharing liability. In part due to the lack of comprehensiveness of the FFS benefit design, almost 90 percent of FFS beneficiaries have supplemental coverage through medigap, employer-sponsored retiree plans, or Medicaid. While this additional coverage addresses beneficiaries' concerns about the uncertainty of OOP spending under the FFS benefit, it also eliminates beneficiary incentives at the point of service and limits Medicare's ability to use cost sharing as a policy tool. As currently structured, many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, regardless of whether there is evidence that the service is effective or ineffective. Moreover, most of the costs of increased utilization are borne by the Medicare program, meaning both the taxpayers and other Medicare beneficiaries pay the premiums.

As mentioned, beneficiaries can have supplemental coverage through medigap, employer-sponsored retiree plans, or Medicaid. For most beneficiaries who purchase Medigap policies, the amount they pay in premiums is often well above the amount they would have incurred in cost sharing in the absence of the supplemental coverage. Yet, beneficiaries continue to buy such

coverage because it has value to them in providing peace of mind. However, even though medigap policies are standardized, it is not easy for beneficiaries to determine the true value of the product they are buying. Medigap policies can have widely varying premiums for the exact same coverage. In learning about policies, most beneficiaries rely on insurance agents, who may not have incentives to help beneficiaries make the optimal choice in deciding whether or not to buy a medigap policy in the first place and, if so, which policy to buy. In addition, outside of the medigap open enrollment period (the 6-month period after turning 65 and enrolling in Part B), switching to a different medigap policy usually would require medical underwriting and higher premiums.

To address the above shortcomings of the current benefit design, the Commission recommended a redesign based on several key principles:

- protect beneficiaries against high OOP spending, thus enhancing the insurance value of the FFS benefit and mitigating the need for beneficiaries to purchase supplemental insurance;
- create clearer incentives for beneficiaries to make better decisions about their use of care;
- hold aggregate beneficiary cost-sharing liability the same as under current law;
- allow for ongoing adjustments and refinements in cost sharing as evidence of the value of services accumulates and evolves; and
- recoup at least some of the additional costs resulting from the higher service use that supplemental insurance imposes on the Medicare program while still allowing risk-averse beneficiaries the choice to buy supplemental coverage if they wish to do so.

In contrast to many recently proposed changes to Medicare benefits that would require beneficiaries to pay more, the Commission's recommendation to hold beneficiary liability neutral reflects our judgment that traditional Medicare's benefit structure is not too rich, especially for the population covered. We believe that the actuarial value of the benefit package should not be reduced while protecting beneficiaries against high OOP spending. At the same time, in recommending an additional charge on supplemental insurance, we maintain that it is reasonable to ask beneficiaries to pay more when their decision to get supplemental coverage imposes additional costs on the program that are not fully reflected in their supplemental

premiums. Those costs are currently paid for by all Medicare beneficiaries through higher Part B premiums and by the taxpayer.

The Commission's June 2012 recommendation to reform benefit design

The Congress should direct the Secretary to develop and implement a fee-for-service benefit design that would replace the current design and would include:

- an out-of-pocket maximum;
- deductible(s) for Part A and Part B services;
- replacing coinsurance with copayments that may vary by type of service and provider;
- secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum;
- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on supplemental insurance.

The Commission's views on the redesign of the Medicare benefit

The recommendation encapsulates the Commission's views on key design issues broadly related to beneficiary cost sharing. The overall structure of cost sharing is defined by: the OOP maximum, above which the beneficiary pays no (or minimal) costs; the deductible, under which the beneficiary pays all costs; and in between, where the beneficiary pays for some portion according to a specified set of rules.

OOP maximum to protect beneficiaries from the financial risk of very high Medicare costs

The Commission maintains that protecting beneficiaries against the economic impact of catastrophic illness is very important. Because the current FFS benefit does not have a limit on the amount of beneficiaries' cost sharing, a small percentage of Medicare beneficiaries incur very high levels of cost sharing each year. Adding an OOP maximum to the FFS benefit would reduce the financial risk for beneficiaries with very high spending and could mitigate the need to purchase supplemental insurance, a significant expense for many beneficiaries.

An OOP maximum is a fundamental feature of an insurance program; it provides financial protection against an unlikely but highly costly event. In general, an OOP maximum is valuable to beneficiaries in two ways. First, those who actually incur catastrophic levels of Medicare costs in a given year would be able to limit their liability at the specified OOP maximum. Therefore, their cost sharing would be lower with the OOP maximum than without it. Moreover, as one considers insurance coverage over a period of several years, a larger percentage of beneficiaries would reach the OOP maximum at some point. For example, the percentage of beneficiaries with annual cost-sharing liability of \$5,000 or more at least once over a four-year period is about double the number for a single year—13 percent compared with 6 percent.

Second, even if beneficiaries did not reach the OOP maximum in a given year, they still were subject to less risk of paying for very high OOP spending. Risk-averse beneficiaries want to be protected from uncertainty and variability in medical spending. Therefore, an OOP maximum that makes very high OOP spending less uncertain and variable has real value, regardless of whether the actual OOP spending for a given beneficiary is high enough to benefit from it. Although beneficiaries may vary in the level of protection they desire and may even have difficulty quantifying how much the value of insurance protection is worth to them, the value of an OOP maximum would be the peace of mind some beneficiaries get from having such protection if they need it.

Deductible(s) for Part A and Part B services that may be combined or separate

A deductible is a fixed dollar amount that a beneficiary pays in a given year before Medicare starts paying for covered services. Its use in benefit design is more pragmatic than intrinsic. If the goal of an OOP maximum is to provide insurance protection against very high medical costs and the goal of cost sharing—copayments and coinsurance—is to provide incentives at the point of service, the role of a deductible is mainly to reduce the cost of other aspects of the benefit package, such as premiums, copayments, and coinsurance. (However, compared with copayments and coinsurance, a deductible can have a different effect on incentives at the point of service.) While beneficiaries might consider a deductible to be financially burdensome, their overall cost might be lower due to a lower premium and cost sharing with a deductible than without it.

The current FFS benefit has separate deductibles for Part A and Part B services: \$1,184 for Part A services and \$147 for Part B services in 2013. This structure of having two distinct parts is mainly historical, reflecting the structure of private insurance as it existed in the 1960s. Since then, the norms in private insurance have changed and a single deductible for all medical services is typical. (Most plans still have a separate deductible for drug benefits.) From a perspective of using cost sharing to create appropriate incentives for beneficiaries, the current structure of deductibles is not ideal: a relatively high deductible for inpatient care, which is usually not discretionary and is less likely to be influenced by cost sharing, coupled with a low deductible for physician and outpatient care, which are more discretionary and more likely to be influenced by cost sharing. A single combined deductible for both types of services might lessen the effects of the current structure on beneficiary incentives somewhat. In addition, it would be easier for beneficiaries to understand and track all Medicare services together, rather than to track them in separate categories.

However, a combined deductible would affect individual beneficiaries' cost sharing differently, depending on their use of services. In general, beneficiaries who use only Part B services—the majority of beneficiaries in a given year—would see an increase in their deductible amount compared with their currently low Part B deductible. In contrast, under a combined deductible (depending on its level), beneficiaries who received inpatient services—roughly 20 percent in a given year—could see a decrease in their deductible amount compared with their currently high Part A deductible. Given these dynamics, beneficiaries' desire for a low combined deductible based on their individual circumstances is certainly understandable. However, their circumstances can change suddenly and unpredictably, and their calculations may turn out very wrong. For example, if individuals who have few health problems get sick unexpectedly, they may be better off under a benefit package with a higher deductible coupled with lower copayments and a lower OOP maximum.

The Commission did not express a definitive position on combined or separate deductibles. However, combining Part A and Part B deductibles presents important challenges for implementation. Under current law, Part A benefits are automatic for individuals who receive benefits from Social Security on the basis of age or disability, whereas Part B enrollment is voluntary. As a result, a small percentage of beneficiaries do not participate in both parts of the

program. About 93 percent of beneficiaries enrolled in Part A also enroll in Part B. For the 7 percent of beneficiaries who participate in Part A or Part B only, issues related to how a combined deductible and OOP maximum would apply need to be resolved.

Copayments, rather than coinsurance, that may vary by type of service and provider

Copayment is a form of cost sharing that specifies a fixed dollar amount paid by the beneficiary at the point of service, whereas coinsurance specifies a fixed percentage of medical expense paid by the beneficiary. The current FFS benefit uses both forms of cost sharing: daily copayments for long stays at hospitals and skilled nursing facilities and 20 percent coinsurance of allowable charges for most Part B services, except for home health, clinical laboratory, and certain preventive services. The Commission prefers the set dollar amounts of copayments because they are more clearly understood by beneficiaries and reduce uncertainty. Especially if the amounts are set to create incentives for beneficiaries to make better decisions about their use of care, copayments are easy to understand, compare, and respond to. Their simplicity makes copayments more effective in influencing people's use of services. Participants in our focus groups echoed these positive qualities of copayments. In contrast, the idea of paying 20 percent of an unknown total bill worried many participants, who considered coinsurance an open-ended liability for which they could not budget in advance. Not having to deal with the hassle of complicated and unpredictable bills was another reason for buying supplemental insurance offering first-dollar coverage.

Compared with the current FFS benefit, any changes in cost sharing—in the form of a deductible or copayments—will bring about changes in beneficiaries' use of services. Ideally, beneficiaries would respond to changes in cost sharing selectively—decreasing the use of nonessential services that are unlikely to improve their health but not changing their use of essential services that are necessary for maintaining good health despite the increase in cost sharing. As discussed in our previous reports, extensive literature about the effects of cost sharing on the use of health care services shows that people generally reduce their use of health care when they have to pay more out of pocket, and vice versa. Their responses tend to vary by type of service—larger responses for discretionary care and smaller responses for urgent care—but not necessarily based on whether the service is appropriate or essential. For example, a Commission-sponsored study

showed that total Medicare spending was 33 percent higher for beneficiaries with medigap than for those with no supplemental coverage, and 17 percent higher for beneficiaries with employer-sponsored coverage.¹ Having secondary insurance was not associated with higher spending for emergency hospitalizations, but it was associated with higher Part B spending that ranged from 30 percent to over 50 percent more. Overall, beneficiaries with private supplemental insurance spent more on elective hospital admissions; preventive care; office-based physician care; medical specialists; and services such as minor procedures, imaging, and endoscopy.

Reduction in the use of both effective and ineffective care raises the question of whether any potential negative effects from reducing essential care could lead to higher rates of hospitalization and ultimately to higher total spending. This issue of “offset effects” may be particularly important if low-income people in poorer health were more likely to forgo needed care, along with nonessential care, as cost sharing increased. (Two recent studies raise concern about such offset effects among Medicare beneficiaries, although the evidence suggests that the size of this offset is unlikely to be large enough to overcome the savings of cost-sharing changes.²) The RAND Health Insurance Experiment (HIE) did not show adverse health effects due to reductions in the use of health care for the average person in the study, but those findings are unlikely to hold true for everyone.³ (The HIE excluded the elderly population from the study.) In fact, although the results were not statistically significant, the HIE found that low-income people with chronic conditions were at greater risk of adverse health outcomes. Because the elderly are more likely to be both low income and have chronic conditions, changes in cost sharing could have an impact on health outcomes among the Medicare population.

1 Hogan, C. 2009. *Exploring the effects of secondary insurance on Medicare spending for the elderly*. A study conducted by staff from Direct Research, LLC, for MedPAC. Washington, DC: MedPAC.

2 Chandra, A., J. Gruber, and R. McKnight. 2010. Patient cost-sharing and hospitalization offsets in the elderly. *American Economic Review* 100, no. 1 (March 1): 193-213. Trivedi, A. N., H. Moloo, and V. Mor. 2010. Increased ambulatory care copayment and hospitalizations among the elderly. *New England Journal of Medicine* 362, no. 4 (January 28): 320-328.

3 Newhouse, J. P. 1993. *Free for all? Lessons from the RAND Health Insurance Experiment*. Cambridge, MA: Harvard University Press.

The Commission recognizes that cost sharing may be too blunt a tool because beneficiaries respond to changes in cost sharing indiscriminately. Ideally, cost sharing would work in conjunction with other management tools for encouraging efficient and appropriate use of health care. However, in the Medicare FFS environment with open-ended service use and provider participation, cost sharing may be one of the few policy tools available.

Secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services

Over the long term, the Medicare program needs to move toward a benefit design that gives individuals incentives to use higher value care and discourage using lower value care.

Policymakers have become more aware that not all health care services have the same value—or the same value for everyone—but identifying which services are of higher or lower value for a given individual is difficult.⁴ These determinations must be evidence based, and several years ago, the Commission recommended that policymakers establish an independent public-private entity that would produce information to compare the clinical effectiveness of a health service with its alternatives. The Congress created the Patient-Centered Outcomes Research Institute to identify national priorities for and sponsor comparative clinical-effectiveness research.

The Commission maintains that the ultimate implementation of changes to the FFS benefit design must not only specify a set of cost-sharing requirements and define services to which those requirements would apply but also allow for flexibility to alter or eliminate cost sharing based on the value of services. To encourage the use of high-value services and discourage the use of low-value services, the Congress should consider giving the Secretary authority to reduce cost sharing on services if evidence indicates that doing so would reduce Medicare spending or lead to better health outcomes without increasing costs, or to raise cost sharing on low-value services. This authority would be exercised through the usual notice and comment rulemaking process. For example, under current law, there are no cost-sharing requirements for many preventive services, and the Secretary has administrative authority to modify or eliminate coverage of preventive

⁴ The term “value based” is used in two ways. Value-based purchasing refers to strategies for paying providers, and value-based insurance design refers to cost-sharing options designed to encourage beneficiaries to use high-value health care services or providers and discourage use of low-value services or providers. Testing these approaches would help policymakers decide which of them could steer beneficiaries more effectively toward the use of high-value services or away from low-value services.

services based on evidence. This flexibility to adjust and refine cost sharing is especially important as evidence evolves. This provision does not diminish congressional authority. If the Congress disagreed with the Secretary's proposed actions, it could act to stop the changes.

No change in beneficiaries' aggregate cost-sharing liability

There are many different ways to combine the three design elements discussed earlier. Within the general structure of cost sharing defined by a deductible, a set of copayments by type of service, and an OOP maximum, there are—in theory—many possibilities consisting of different levels of cost-sharing amounts and definitions of services to which they are applied. In practice, however, a set of feasible design combinations would be constrained by the overall cost of those choices.

The Commission considers it important to allow for different possible combinations of design elements and subsequent adjustments and refinements by the Secretary. However, the Commission does not wish to shift the cost of improving the benefit package to provide better protection against high OOP spending to the beneficiary in the aggregate. Therefore, the Commission has recommended holding the average cost-sharing liability of the beneficiary the same as under current law. In effect, this approach allows the Congress to set the overall value of the Secretary's benefit package and the Secretary is then given discretion within that limit.

An additional charge on supplemental insurance to recoup at least some of the added costs imposed on Medicare

For most Medicare beneficiaries, their actual OOP spending is much smaller than their cost-sharing liability under FFS Medicare because they have additional coverage. In fact, the lack of comprehensive coverage in the FFS benefit design leads many beneficiaries to take up supplemental coverage that fills in some or all of Medicare's cost sharing and protects them from catastrophic financial liability.

At the same time, supplemental coverage can lead to more use of services and spending. In general, there are two possible reasons for the higher spending. First, many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements, regardless of whether there is evidence that a given service is effective or ineffective. Under such minimal exposure to cost sharing, beneficiaries have incentives to receive more care without experiencing additional OOP

costs, and providers have no incentives to manage utilization. Therefore, some portion of the higher spending observed among beneficiaries with supplemental coverage is arguably due to an insurance effect (also called moral hazard). Second, beneficiaries who are sicker and likely to use more services are more likely to buy supplemental coverage. Conversely, beneficiaries who are healthy and do not expect to use many services are more likely to risk potentially high cost sharing without supplemental coverage. It is likely that this selection effect is also partly responsible for the higher spending observed among those with supplemental coverage.

Since the FFS benefit provides indemnity insurance, cost sharing is one of the few means by which the Medicare program can provide incentives affecting beneficiaries' use of medical services. But almost 90 percent of FFS beneficiaries have supplemental coverage that fills in some or all of Medicare's cost sharing, effectively nullifying the program's tool for influencing beneficiary incentives. By effectively eliminating FFS Medicare's price signals at the point of service, supplemental coverage generally masks the financial consequences of beneficiaries' choices about whether to seek care and which types of providers and therapies to use. Therefore, unless supplemental policies were restructured to retain some cost sharing, any changes in cost sharing in the FFS benefit package would have a limited effect on beneficiaries with supplemental coverage.

There are two philosophically different approaches to address the insurance effect of supplemental coverage. One approach is to regulate how supplemental policies can fill in FFS cost-sharing requirements (for example, redefine medigap policies so that they no longer completely fill in FFS cost-sharing requirements). Another approach is to impose an additional charge on supplemental policies. Rather than prohibiting supplemental insurance from filling in all of Medicare's cost sharing, this approach would not change the use of Medicare services among beneficiaries who choose to keep their supplemental coverage. However, it would change the effective price of their coverage. If the regulatory approach can be described as not allowing beneficiaries to add costs to Medicare through supplemental coverage, the additional charge approach can be described as allowing beneficiaries to add costs to Medicare but requiring them to pay for at least some of those additional costs.

In considering policies related to supplemental coverage, the Commission prefers the additional charge approach over the regulatory approach. The additional charge would apply to most sources of supplemental coverage, including medigap and employer-sponsored retiree plans. (However, implementing consistent changes with respect to medigap and employer-sponsored retiree plans would require different legislative changes. The additional charge would not apply to MA plans because they are at risk for benefit designs that increase costs relative to their capitation payments and are able to employ other tools for managing their enrollees' use of services.) The Commission considers it important that risk-averse beneficiaries who wish to buy first-dollar coverage or reduce the uncertainty in their OOP spending through supplemental insurance should be allowed to do so but effectively at a higher price. Regulating supplemental benefits, in contrast, would prevent even those beneficiaries who very much value extra insurance from buying such policies at any price.

Illustrative benefit package

Table 2 presents an illustrative benefit package consistent with the Commission's views on FFS benefit design reform. The package is modeled after the MA-style benefits that include the following copayments: \$20 for each primary care physician visit, \$40 for each specialist physician visit, \$100 for each hospital outpatient visit, \$750 for each inpatient hospital admission, and \$80 for each skilled nursing facility day. We also included a \$150 copayment per episode for home health care. The Commission's recommendation would require a range of copayments for durable medical equipment and Part B drugs. However, for simplicity, we included 20 percent coinsurance for durable medical equipment and Part B drugs. The annual OOP maximum is \$5,000. To keep cost sharing relatively reasonable, the package includes a \$500 combined deductible. We kept the overall beneficiary cost-sharing liability of this package roughly equal to that of the current FFS benefit. We want to emphasize that this package is for illustration only, to analyze the trade-offs between design elements. It does not represent the Commission's recommended benefit package.

Table 2. Illustrative benefit package

FFS benefit package	Illustrative package keeping beneficiary liability neutral
OOP maximum	\$5,000 per year
A & B deductible	\$500 per year
Hospital	\$750 per admission
Physician	\$20 PCP/\$40 specialist visit
	\$100 advanced imaging
Part B drugs	20% coinsurance*
Outpatient	\$100 per visit
SNF	\$80 per day
DME	20% coinsurance*
Hospice	0% coinsurance
Home health	\$150 per episode**

Note: FFS (fee-for-service), OOP (out-of-pocket), PCP (primary care physician), SNF (skilled nursing facility), DME (durable medical equipment).

*For simplicity, we modeled 20 percent coinsurance for durable medical equipment and Part B drugs; copayments in these categories would require a range of copayments.

**We modeled the \$150 copayment per episode considered by the Commission in 2011 as a 5 percent coinsurance on home health services.

In general, the set of copayments in the illustrative benefit package is within the range of typical copayments we see in MA plans. However, MA plans tend to use medical management to complement their use of cost sharing and to mitigate the potentially negative effects from reducing essential care or increasing less essential care. While copayments can make beneficiaries aware of the price of care at the point of service, thus creating incentives to make better decisions about their use of discretionary care, medical management can mitigate the effects of reducing care indiscriminately.

The following analysis of spending and distributional impacts is based on the above illustrative benefit package combined with a 20 percent additional charge on medigap and employer-sponsored retiree plans. (An additional charge would need to be significantly greater than 20 percent to recoup the entire cost of higher service use imposed on the Medicare program by beneficiaries with supplemental coverage.) The scope of the analysis excludes dual-eligible beneficiaries because we assumed current law where Medicaid would fill in any changes under the alternative benefit package and would keep the cost sharing the same for those beneficiaries.

Spending impacts

We modeled the effects of the above illustrative benefit package using Medicare claims data from 2009. (Our June 2012 report includes a detailed discussion of the assumptions underlying our

analysis.) Table 3 shows the relative change in annual Medicare program spending under the illustrative benefit package, combined with a 20 percent additional charge on supplemental insurance. It presents only a one-year snapshot of relative changes. Most importantly, it does not represent a budgetary score, which would take additional factors into account.

Table 3. Budgetary effects of the illustrative benefit package, 2009

Percent keeping supplemental coverage	Percent change in Medicare program spending in 2009	Revenue offset generated by 20% additional charge	Net percent change in Medicare program spending
All	+1.0%	-1.5%	-0.5%
75%	0.0%	-1.0%	-1.0%
50%	-1.5%	-0.5%	-2.0%
None	-4.0%	0.0%	-4.0%

Note: Numbers are rounded to the nearest 0.5 percent. Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We estimated a one-year snapshot of relative changes in Medicare program spending, compared with the actual spending in 2009, if the illustrative benefit package had been in place. Additional charge on supplemental insurance represents revenue to the program and is shown as a decrease in program spending. These estimates do not represent a budgetary score, which would take additional factors into account.

Source: MedPAC analysis based on data from CMS.

Under the illustrative benefit package, which holds average beneficiary cost-sharing liability roughly equal to current law, program spending would increase by about 1 percent if all beneficiaries kept their current levels of supplemental coverage. Given the OOP maximum—which made the illustrative benefit package more generous compared with current law—the same level of cost-sharing liability would correspond to higher total spending under the illustrative benefit package. As a result, program spending would also be higher. However, the 20 percent charge on supplemental insurance would generate about 1.5 percent in revenue offsets. The net budgetary effect would be about 0.5 percent in savings. In contrast, if all beneficiaries dropped their current supplemental coverage, program spending would decrease by about 4 percent because of reduced utilization, and no revenues would be collected from the additional charge on supplemental insurance, with a net budgetary effect of about 4 percent in savings.

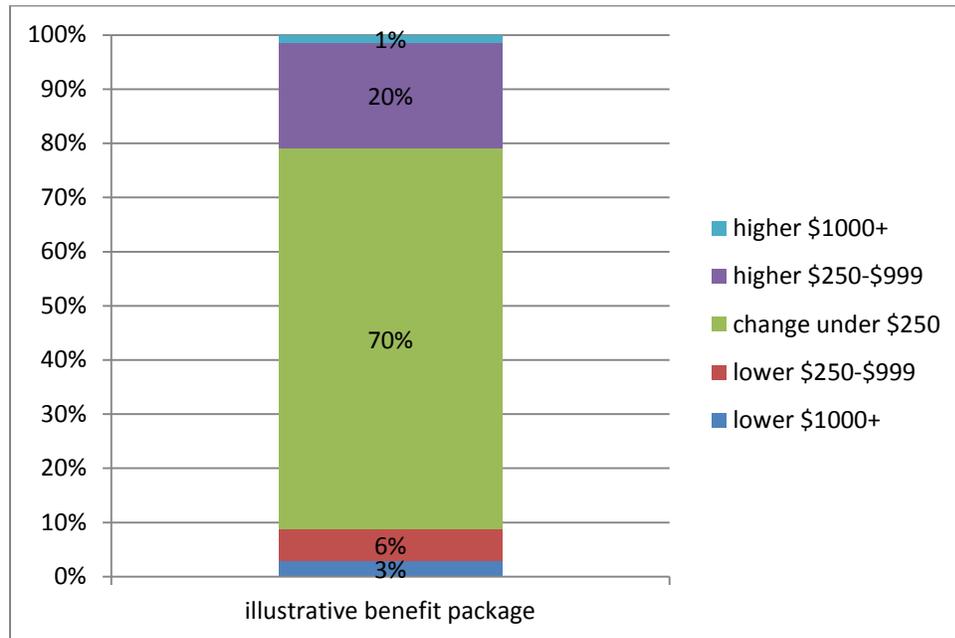
Distributional impacts

Overall, the average beneficiary cost-sharing liability under the illustrative benefit package would be roughly equal to current law by design. However, it would be much less variable because of the

OOP maximum. For example, assuming no change in current supplemental coverage, the standard deviation of cost-sharing liability in 2009 among beneficiaries included in our analysis decreased from \$2,370 under current law to \$1,250 under the illustrative benefit package, around the mean liability of \$1,380.

The effects of the illustrative benefit package (without the 20 percent additional charge) on beneficiaries would vary by their use of services. First, those beneficiaries with cost-sharing liability above the \$5,000 OOP maximum and no supplemental coverage would see their OOP spending go down. In Figure 1, this group would be included in the 9 percent of beneficiaries whose OOP spending decreased by \$250 or more. (Results in Figure 1 assume no change in supplemental coverage among beneficiaries who currently have supplemental coverage.) By contrast, those beneficiaries with no hospitalization and low use of Part B services would see their cost sharing go up, since the revised benefit design would effectively lower the Part A deductible and raise the Part B deductible compared with current law. In Figure 1, this group would be included in the 21 percent of beneficiaries whose OOP spending increased by \$250 or more. In general, beneficiaries with at least one hospital admission would see their cost sharing go down under the illustrative benefit package compared with the current benefit package. For the majority of beneficiaries (70 percent), their OOP spending would not change much because for many of them, their supplemental insurance would dampen the changes in their cost-sharing liability.

Figure 1. Changes in Medicare out-of-pocket spending under the illustrative benefit package, 2009



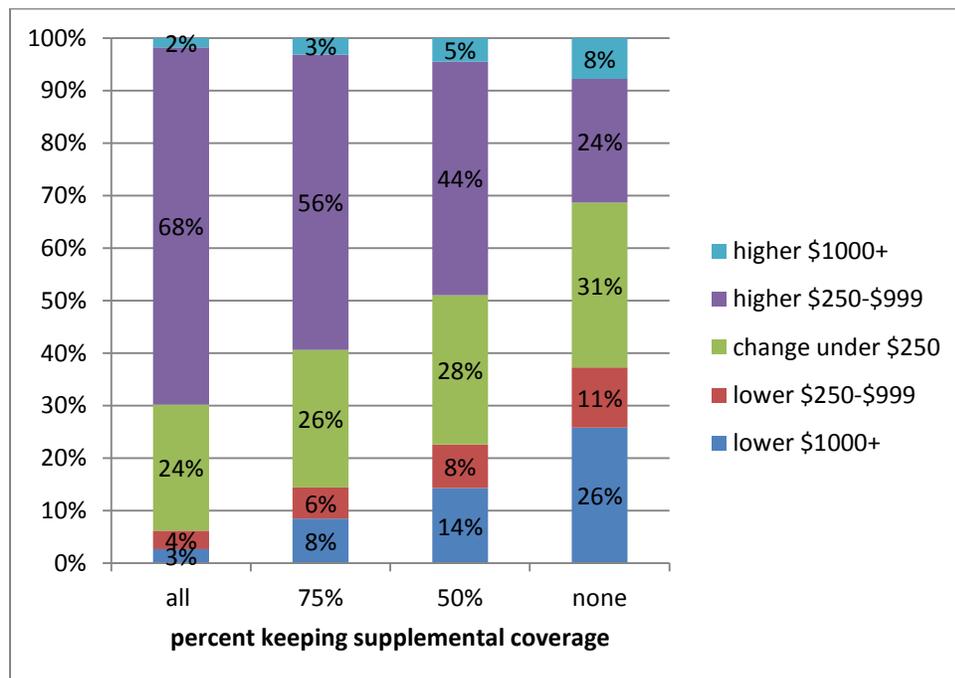
Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We assumed no change in supplemental coverage among beneficiaries who currently have supplemental coverage. Out-of-pocket spending excludes Part B premium.

Source: MedPAC analysis based on data from CMS.

Some beneficiaries who currently have supplemental insurance would drop or reduce their coverage in response to the additional charge and new Medicare benefits. In theory, changes in the FFS benefit and the additional charge on supplemental insurance could alter the individual cost-benefit analysis of having supplemental coverage. First, for some individuals, the benefit of extra protection provided by supplemental insurance would be lower if the FFS benefit were to have an OOP maximum. Without a larger decrease in supplemental premiums to offset the lower value, those beneficiaries would choose to drop supplemental policies. Second, holding the FFS benefit constant, the additional charge on supplemental insurance would increase the effective premiums on those plans and provide an incentive for beneficiaries to switch to medigap policies that required paying more of Medicare’s cost sharing or to drop supplemental coverage altogether. If beneficiaries were to drop supplemental insurance, they could choose to stay in traditional FFS or switch to MA.

Figure 2 shows the estimated distributional impact of changes in total OOP costs—the sum of OOP spending and supplemental premiums—under four scenarios: Among beneficiaries who currently have medigap and employer-sponsored retiree insurance, we assumed that all, three-quarters, half, or none of them keep their current supplemental insurance. Compared with Figure 1, the distributional impacts in Figure 2 are noticeably different. For beneficiaries who keep their supplemental coverage, total OOP costs would be higher because of the 20 percent additional charge on supplemental insurance: At 2009 premium levels, the 20 percent additional charge would translate into a \$420 increase per year (\$35 per month) on medigap plans and a \$200 increase per year on employer-sponsored retiree plans. In contrast, for beneficiaries who drop their supplemental coverage, total OOP costs would be the net effect of higher cost sharing paid OOP and savings on their supplemental premiums (\$2,100 per year on medigap plans and \$500 per year on employer-sponsored retiree plans, assuming a 50 percent employer subsidy rate).

Figure 2. Changes in Medicare out-of-pocket spending and supplemental premium under a 20 percent additional charge on supplemental insurance, 2009



Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We assumed four different levels in take-up rates among beneficiaries who currently have medigap insurance: 100%, 75%, 50%, and 0%. Out-of-pocket spending excludes Part B premium. The change in supplemental premium includes the 20% additional charge on supplemental insurance. Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis based on data from CMS.

If all beneficiaries kept their current supplemental coverage, the 20 percent additional charge on supplemental insurance would increase the total OOP cost significantly. Whereas 70 percent of beneficiaries would have little change in OOP costs under the illustrative benefit package in Figure 1, 70 percent of beneficiaries would have an annual increase of \$250 or more under the illustrative benefit package in Figure 2 because of the 20 percent additional charge on supplemental insurance. The distribution shifts as fewer beneficiaries keep their current supplemental coverage, since the savings from dropping their medigap or employer-sponsored retiree plans decrease their total OOP costs. If all beneficiaries dropped their current supplemental coverage, 32 percent would experience an increase of \$250 or more. Additionally, 31 percent would have little change in their OOP costs 36 percent would see a decrease of \$250 or more.

Improving the Medicare benefit for beneficiaries

Distributional impacts discussed earlier highlight that a small percentage of beneficiaries incur very high cost sharing in a given year and thus would benefit from the OOP maximum under the illustrative benefit package. But a larger percentage of beneficiaries would reach the OOP maximum at some point over a longer period of time. Table 4 compares beneficiaries' hospitalization and spending over one year versus four years. For example, in 2009, 19 percent of full-year FFS beneficiaries had at least one hospitalization, whereas 46 percent did from 2006 to 2009. Similarly, 6 percent of full-year FFS beneficiaries had \$5,000 or more in cost-sharing liability in 2009, whereas 13 percent had at least one year of \$5,000 or more in cost-sharing liability over four years.

Table 4. More beneficiaries would be better off with an out-of-pocket maximum over time

Full-year fee-for-service beneficiaries who had:	2009	2006-2009
1 or more hospitalizations	19%	46%
2 or more hospitalizations	7%	19%
\$5,000 or more in annual cost-sharing liability	6%	13%
\$10,000 or more in annual cost-sharing liability	2%	4%

Note: Includes beneficiaries who were enrolled in fee-for-service Medicare for four full years, from 2006 to 2009. Excludes those who had any months of private Medicare plan enrollment.

Source: MedPAC analysis based on data from CMS.

The overall spending patterns of Medicare beneficiaries show that in a given year, Medicare spending is highly concentrated, with a small number of beneficiaries accounting for a large proportion of the program’s annual expenditures. This pattern is characteristic of insurance programs in general. However, only about half of beneficiaries with high spending one year continue to incur high spending the next year. Although the presence of serious chronic illness can predict high spending, much of very high spending is largely random, due to health costs that are unpredictable. This spending pattern implies that the probability of catastrophic spending over time is higher than the probability in one year would indicate. Even beneficiaries with low spending in a particular year would benefit from the financial protection of insurance as they face greater odds of having a high-spending year over time. Therefore, additional insurance protection that mitigates the risk under Medicare would be valuable to beneficiaries.

One key purpose of insurance is to reduce the financial risk posed by catastrophic medical expenses. Risk-averse individuals want protection from the risk of very high and unpredictable medical expenses. To avoid such risks, they should be willing to pay a premium higher than the average cost of care they might face. The more risk-averse they are, the more willing they are to pay for the insurance. And the more variable potential outcomes are, the more valuable the insurance protection will be. For example, under the illustrative benefit package, the average cost-sharing liability is about the same as under current law, at about \$1,380. However, the distribution of cost-sharing liability is much less variable because of the OOP maximum, as

summarized by the standard deviation of \$1,250 compared with \$2,370 under current law (see Table 5). Although the average cost-sharing liability is about the same, the illustrative benefit package offers much lower financial risk and provides greater insurance protection to beneficiaries.

Table 5. Out-of-pocket maximum reduces the risk of high medical expenses, 2009

	Average cost-sharing liability, 2009	Standard deviation of cost-sharing liability, 2009
Current law	\$1,380	\$2,370
Illustrative benefit package	\$1,380	\$1,250

Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We estimated the cost-sharing liability in 2009 if the illustrative benefit package had been in place, compared with the actual cost-sharing liability in 2009.

Source: MedPAC analysis based on data from CMS.

Although most people are risk averse and are willing to pay to reduce risk, an optimal benefit design does not mean no risk at all. The Commission’s recommendation on the redesign of the FFS benefit package attempts to balance this fundamental trade-off between two opposing forces—risks and incentives—in the context of an unrestricted FFS system where very few policy tools are available for encouraging efficient and appropriate use of health care.