



AMERICAN ACADEMY *of* ACTUARIES

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

**Hearing on
Examining Traditional Medicare's Benefit Design**

February 26, 2013

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The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

On behalf of the American Academy of Actuaries' Health Practice Council, I appreciate the opportunity to submit the following written testimony to the House Ways and Means Health Subcommittee for the record related to its hearing on changes to the Medicare fee-for-service (FFS) benefit design.¹

Improving the quality and cost-effectiveness of care under the Medicare program is a key health policy challenge. Many Medicare reform proposals in recent years have focused on realigning financial incentives in Medicare's provider payment and delivery system. However, a comprehensive package of reforms to improve Medicare sustainability also should consider better aligning incentives on the beneficiary side. To accomplish this, there have been calls to update the program's traditional fee-for-service (FFS) benefit design (i.e., its cost-sharing features) and to address other issues related to beneficiary incentives. Such changes could deal with some of the shortcomings of the current benefit structure, including its lack of a cost-sharing maximum, and could help encourage Medicare beneficiaries to seek more cost-effective care.

Current Medicare Fee-For-Service Benefit Design

Like most other health insurance plans, Medicare uses patient cost-sharing requirements, such as deductibles, copayments, and coinsurance, to help balance the cost of the program with the comprehensiveness of the benefits provided (see below). Patient cost sharing directly lowers Medicare spending by shifting a share of medical costs to the beneficiary. In addition, cost sharing can lower spending overall by reducing health care utilization.

Selected Part A and Part B Cost-Sharing Requirements	
Part A	
Hospital stay:	\$1,184 deductible for days 1–60 per benefit period \$296/day copayment for days 61–90 \$592/day copayment for days 91–150
Skilled nursing facility stay:	\$0 for the first 20 days each benefit period \$148 per day for days 21–100 each benefit period All costs for each day after 100 each benefit period
Part B	
Annual deductible:	\$147
Physician services:	20 percent coinsurance
Outpatient hospital Services:	20 percent coinsurance (up to hospital deductible of \$1,184)
Note: See www.medicare.gov for cost-sharing requirements for additional Medicare covered services.	

¹ This testimony is based on two Academy issue briefs, *Revising Medicare's Fee-For-Service Benefit Structure* (March 2012) and *An Actuarial Perspective on Proposals to Improve Medicare's Financial Condition* (May 2011).

While Medicare's patient cost-sharing requirements perform the same basic functions as similar requirements in other health insurance programs, their structures vary greatly. Medicare's hybrid nature—which combines a mandatory hospital insurance program with voluntary coverage for physician and outpatient services as well as voluntary prescription drug coverage—is directly reflected in the structure of the Medicare fee-for-service benefits. Whereas private health insurance programs typically have integrated benefit structures that are designed to manage hospital and non-hospital expenses in a coordinated fashion, the Medicare Part A (inpatient hospital) and Part B (physician and outpatient hospital) benefits are structured very differently from each other—and the patient cost-sharing provisions are not coordinated between the two. This lack of coordination in the design of Medicare's FFS benefits has important consequences for both beneficiaries and taxpayers.

In an ideal situation, patient cost-sharing requirements align beneficiary incentives with program goals to provide high-quality and cost-effective care. Medicare's current FFS cost-sharing requirements, however, are not well structured to meet these goals and have other drawbacks. In particular:

- Medicare does not place an annual limit on beneficiary cost-sharing liability. The lack of an annual limit on cost sharing under the FFS option leaves beneficiaries unprotected against catastrophic health costs.
- Most Medicare beneficiaries have supplemental policies. Because there is no cost-sharing limit, supplemental coverage is a necessity for beneficiaries who desire protection against the costs associated with catastrophic illness. Most Medicare beneficiaries have supplemental coverage that also fills in the FFS cost-sharing requirements for non-catastrophic illnesses, which reduces the incentives for beneficiaries to seek cost-effective care.
- The FFS deductibles are higher for inpatient care. Cost-sharing requirements aim, in part, to influence consumer behavior. Medicare's cost-sharing provisions, however, are not structured in an ideal way to do this. Part A inpatient stays, which are less likely to be influenced by cost-sharing requirements, require fairly high deductibles—\$1,184 in 2013 and additional copayments for hospital stays lasting beyond 60 days. In contrast, Part B physician and outpatient services, which are more likely to be influenced by cost-sharing requirements, require a fairly low annual deductible of \$147 in 2013. Thereafter, a 20 percent coinsurance is required on most Part B services.

In contrast to traditional Medicare FFS plans, Medicare Advantage plans have some flexibility on how to structure cost-sharing requirements—and very few use the FFS cost-sharing structure. In addition, all Medicare Advantage plans now are required to provide an annual cost-sharing limit, which in 2013 can be no more than \$6,700.

Restructuring the Fee-For-Service Benefit Design

To address the problems with the current FFS benefit design, proposals have been developed that would combine a new cost-sharing limit² with a unified Part A and Part B deductible. The copayment and coinsurance requirements also could be restructured. These changes would result in more coordinated Part A and B cost-sharing requirements and would bring the FFS benefit design more in line with the structure of private health insurance programs.

Unifying the Part A and B deductibles has the potential to better align beneficiary incentives designed to reduce unnecessary care and promote more cost-effective care. But, as discussed in more detail below, the majority of Medicare beneficiaries have supplemental coverage that can limit the effectiveness of the incentives in Medicare's cost-sharing requirements. In addition, beneficiaries need more access to price and quality information to better facilitate more cost-effective beneficiary behavior. And perhaps most important, provider incentives need to be consistent with beneficiary incentives and more information regarding treatment effectiveness is needed.

Adding an annual cost-sharing limit could be a significant benefit enhancement that would, absent other changes, increase the cost of the program. When combined with the introduction of a unified Part A and B deductible, however, such a restructuring could be achieved in a budget neutral way. In other words, the out-of-pocket limit and combined deductible could be chosen so that costs to the Medicare program would be the same under the new structure as they are projected currently. As an alternative, this restructuring can be done in a way that reduces (or increases) Medicare costs. An annual out-of-pocket limit would reduce cost-sharing for those beneficiaries with the highest health care spending. In any year, however, even if the plan design changes are made to be budget neutral, the majority of beneficiaries who have lower health care spending would face higher cost-sharing amounts.³

Beneficiary Cost-Sharing Liability vs. Out-of-Pocket Costs

Medicare beneficiaries who receive medical services are responsible for meeting any applicable cost-sharing requirements. These beneficiary cost-sharing liabilities, however, may not reflect what a beneficiary actually pays out of pocket to meet those requirements. For instance, beneficiaries with supplemental coverage (e.g., Medigap, employer-sponsored retiree health coverage) have all or a portion of their cost-sharing liabilities covered. A full accounting of how a change in the Medicare FFS plan design would affect beneficiary out-of-pocket costs (including premiums for supplemental coverage) therefore would need to incorporate not only the specific changes to the benefit design, but also whether and how changes in Medicare supplemental coverage are required and whether and how beneficiaries change their supplemental coverage purchases and health care utilization in response to the changes.

² Even with a cost-sharing limit, beneficiaries would remain responsible for all costs associated with benefits that are not covered by Medicare.

³ Setting the unified deductible below the "budget neutral" level would reduce the number of beneficiaries who would face higher cost-sharing requirements, but would increase the cost of the Medicare program unless offset by other spending reductions or revenue increases.

A report from the Medicare Payment Advisory Commission (MedPAC) provides insights on the effects of adding a catastrophic limit on cost sharing and combining the Part A and B deductibles, assuming other cost-sharing requirements remain unchanged (Table 1). Under current law, which does not include a cap on cost sharing, a combined deductible of \$595 would have been required in 2011 to remain budget neutral compared with the separate plan deductibles. Under this approach, 6 percent of Medicare beneficiaries would have experienced a reduction in out-of-pocket spending of \$50 or more and 28 percent would have experienced an increase in spending of \$50 or more. About two-thirds of beneficiaries would have experienced no change or a change of \$50 or less.

Implementing a cap on cost sharing would require higher combined deductibles to remain budget neutral. The lower the cost-sharing cap, the higher the combined deductible and the more likely it is that beneficiaries would experience an increase in out-of-pocket costs. For instance, a \$3,000 cap on cost-sharing would have required a \$1,635 combined deductible and 36 percent of beneficiaries would have faced increased out-of-pocket costs of \$50 or more. Nevertheless, the increased catastrophic protection would result in large savings for many of those exceeding the cap.

Table 1. Level of combined FFS deductible required to hold constant Medicare program spending in 2011

Catastrophic limit on cost sharing	Combined deductible required to break even	How FFS beneficiaries' out-of-pocket spending would differ from baseline			
		Nonspenders	Change of \$50 or less	Spending increase of \$50 or more	Spending decrease of \$50 or more
None—current law	\$595	5%	61%	28%	6%
\$7,000	960	5	56	33	6
\$5,000	1,170	5	54	34	7
\$4,000	1,328	5	53	35	6
\$3,000	1,635	5	52	36	7

Notes: Out-of-pocket spending includes only cost-sharing amounts paid by the beneficiary. It excludes spending paid by supplemental coverage as well as premiums for Medicare and supplemental coverage. Changes in out-of-pocket spending incorporate changes in utilization due to the revised cost-sharing requirements, but not any changes in supplemental coverage. Categories may not sum to 100 percent due to rounding.

Source: Actuarial Research Corporation (as published by MedPAC in *Report to the Congress: Medicare and the Health care Delivery System*, June 2011, Chapter 3).

With a combined deductible and a cap on cost sharing, beneficiaries who are more likely to face increased cost sharing include those with no hospitalizations and high Part B spending, but not enough to exceed the catastrophic cap, since the combined deductible exceeds the current Part B deductible. Beneficiaries who are more likely to face a reduction in cost sharing are those with hospitalizations and spending exceeding the cap.

Note that this analysis reflects the change in cost-sharing liability over a one-year period only. Over a longer time period, it is likely that beneficiaries would have some years during which they are hospitalized and would incur a lower cost-sharing liability under a combined deductible

and cost-sharing cap, and some years during which they would have a lower cost-sharing liability under the current FFS plan design. In other words, using a one-year basis to estimate the change in cost sharing understates the value to beneficiaries of adding a cost-sharing cap on a budget neutral basis.

When adding a cost-sharing limit along with a unified deductible, other cost-sharing requirements could remain unchanged. As an alternative, service-specific copayment and coinsurance requirements could be replaced with a uniform coinsurance rate for all services. Or, flat copayments, which are more typical among Medicare Advantage plans, could be used. Moving toward flat copayments in FFS Medicare could have the advantage of being more understandable and predictable to beneficiaries than coinsurance, in which cost sharing varies depending on the cost of the service. Depending on the copayment levels set, however, moving toward copayments rather than coinsurance could require higher unified deductibles to stay budget neutral. Although not the focus of this issue brief, the costs of adding a cost-sharing limit could be offset in ways other than increasing other cost-sharing requirements, such as through premium increases.⁴

An issue that would need to be addressed if Part A and B deductibles are combined is how to treat beneficiaries who sign up for Part A coverage but not Part B coverage (or vice versa). Applying the combined deductible would allow Part A-only beneficiaries to meet a lower deductible, but they would not be subject to potentially higher cost sharing under Part B. Moreover, allowing Part A-only beneficiaries to benefit from the addition of a cost-sharing limit could create equity concerns. An alternative would be to maintain the current higher Part A deductibles for beneficiaries choosing to enroll only in Part A and not allow them to benefit from the cost-sharing limit.

Impact on Medicare Trust Funds and Part B Premiums

A redesign of the Medicare FFS benefit package that is budget neutral still could have important implications for the funding of the Medicare program. This would occur, for instance, if a combined deductible and cost-sharing cap shifts costs between Parts A and B. In turn, this could affect not only the trust fund finances, but also Part B premiums.

For instance, a combined deductible that is less than the Part A deductible and greater than the Part B deductible could mean that Medicare spending (net of cost sharing) would shift from Part B to Part A. How costs shift between the two parts is complicated by the cost-sharing cap, which could change the distribution of net costs between Part A and Part B.

In addition, issues arise regarding the timing of claims during a year. If a beneficiary has physician care early in the year and inpatient care later in the year, the deductible first would apply to the physician care, with any remaining deductible applicable to the inpatient care. This would result in different net spending in the Part A and Part B programs than if inpatient care was received earlier in the year with the deductible first applying to that care. With hospital stays early in the year, which are usually accompanied by physician services, it may be difficult to determine how to split the deductible between Part A and Part B. Which services are received after the cost-sharing cap is reached, rather than before, similarly could affect the distribution

⁴ In addition, cost-sharing requirements could be increased without moving to a unified deductible.

between Part A and Part B spending. It may be appropriate for CMS to perform a retrospective adjustment at the end of the year to redistribute spending between Parts A and B to better reflect the true split between Part A and B spending, rather than the timing of claims.

If the implementation of a combined deductible and a cost-sharing cap results in a net shift in Medicare spending from Part B to Part A, then Part B premiums, which are set at a percentage of Part B costs, would be lower than they are under current law. If a plan design change were to shift costs from Part A to Part B, however, Part B premiums would be higher. The Part A trust fund exhaustion date also could be affected.

An increase in Part B premiums could result in a decrease in Part B enrollment. Part B is a voluntary program, and, although the vast majority of Medicare Part A enrollees also enroll in Part B, participation rates have been declining somewhat over the years. The Medicare trustees project that participation rates will continue to fall due to the higher premiums that apply to higher-income beneficiaries as well as the younger aged who are still working and have coverage from an employer.⁵ Nevertheless, Part B participation rates are projected to exceed 90 percent throughout the current 75-year projection period.

If Part B participation rates decline more substantially, Part B premiums could increase even further, assuming that those enrolling would have higher health care needs than those who forgo coverage. At some point, it might be appropriate to consider additional measures to increase participation. Such measures could include increasing the penalty for those forgoing coverage, mandating Part B coverage, or allowing individuals to choose higher cost-sharing requirements in return for lower premiums. The latter approach, which also could allow individuals to choose lower cost-sharing requirements in return for higher premiums, in effect could combine FFS plan design changes with a premium support approach.

Aside from any potential shifts in costs between the Medicare Part A and Part B programs associated with changing the FFS cost-sharing requirements, it is also important to consider any interactions between Medicare and Medicaid. Although changing the Medicare cost-sharing requirements likely would have little or no direct effects on beneficiaries dually eligible for Medicare and Medicaid, there is a potential shift in costs between the two programs.

Medicare Supplemental Insurance

Because Medicare imposes significant cost-sharing requirements, most beneficiaries have some type of supplemental coverage to fill in the gaps. According to data compiled by MedPAC, 89 percent of FFS beneficiaries in 2007 had supplemental coverage: 43 percent had employer-sponsored coverage; 29 percent had individually purchased Medigap coverage; 16 percent had Medicaid, and 1 percent had other public coverage.⁶

Supplemental coverage can remove the financial incentives for beneficiaries to control their health spending, and some research suggests that filling in Medicare's cost-sharing gaps results

⁵ See Table V.B3 of the 2012 Medicare Trustees Report.

⁶ Percentages calculated from Figure 3-1 in MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2011.

in higher Medicare spending than would have been incurred otherwise.⁷ As a result, there have been calls to limit the extent to which Medigap plans are allowed to cover Medicare's cost-sharing requirements. Other proposals would levy a surcharge on Medigap plans or Part B premiums for beneficiaries with Medigap plans with low cost-sharing requirements. Such a surcharge would be a way for Medicare to recoup some of the costs of higher utilization among beneficiaries with Medigap plans and would encourage beneficiaries to choose plans that fill in less of Medicare's cost-sharing requirements. If changes to the FFS plan design are implemented, insurance products that coordinate with Medicare may need to be modified so that they do not limit the desired impact of any FFS restructuring. For instance, Medigap plans could be prohibited from covering the higher deductibles. Or, the cost-sharing caps could be implemented on a true out-of-pocket basis, meaning that beneficiary cost sharing covered through supplemental coverage would not count toward the cost-sharing limit.

Reducing the richness of Medigap plans available to beneficiaries, either directly through legislative/regulatory changes or indirectly through levying a Medigap or Part B premium surcharge, could result in an increased understanding among beneficiaries of their benefit choices, lower insurance premiums (due to reduced plan generosity and increased administrative and marketing efficiencies), and a reduction of unnecessary utilization. Reducing the share of costs that Medigap plans can cover would shift costs at the point of service to beneficiaries, increasing the incentives to seek more cost-effective care and avoid unnecessary care. This has the potential to lower both Medicare and beneficiary costs, but the extent to which costs would decline is unclear. Changes in the rules governing Medigap plans should be structured carefully to avoid unintended consequences. Research suggests that broad increases in cost sharing, rather than targeted increases, reduce not only unnecessary care, but also necessary care, especially among the low income and chronically ill.⁸ Preventive care could be exempted from any new cost-sharing requirements, and additional protection for low-income and/or chronically ill beneficiaries who are not eligible for Medicaid should be considered.

Other issues that should be addressed when considering changes to Medigap plan requirements include:

- Policymakers would need to decide whether required changes in Medigap plans would apply to new coverage purchases only or to all existing policies as well. Medigap benefits are contractually guaranteed and cannot be cancelled for reasons other than premium non-

⁷ Although much research agrees that Medicare spending is higher among beneficiaries with supplemental coverage, there is less agreement regarding whether this difference is due to cost-sharing differences or other factors, such as the tendency of beneficiaries with higher health care needs to obtain supplemental coverage. For a review of the literature, see MedPAC *Report to the Congress: Aligning Incentives in Medicare* (Chapter 2, June 2010).

⁸ The RAND Health Insurance Experiment found that although the reduction in services resulting from higher cost sharing did not lead to poorer health outcomes for the average person, low-income individuals in poor health were more likely to suffer poorer health outcomes. See Joseph P. Newhouse and the Health Insurance Experiment Group. *Free for all? Lessons from the RAND Health Insurance Experiment*. Cambridge, Mass: Harvard University Press (1993). More recently, Amitabh Chandra et al found evidence that the savings associated with raising cost sharing for physician visits and prescription drugs is offset modestly by increased hospital utilization. The offsets are more substantial, however, for the chronically ill. See "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," *American Economic Review* 100(1): 193-213 (2010).

payment. Besides the potential legal issues that may arise due to a violation of the contractual agreement, customer and insurer issues arise from changes to existing policies. A consumer's premiums collected to date might have reflected prefunding for future services. Accordingly, insurers have accounted for this prefunding in the form of reserves. If changes are made to policies already in force, a clear transition plan to maintain fairness to insureds and reserve adequacy for insurers would need to be developed.

- Many Medicare beneficiaries may be enrolling in Medigap plans to make their cost sharing more predictable and to avoid the inconveniences and complexities associated with paying providers directly. Any changes to Medigap plans, and to Medicare cost-sharing requirements more broadly, should incorporate ways to minimize beneficiary inconvenience or confusion as well as additional administrative burdens on providers for payment collections.
- Medigap plans are only one source of private supplemental coverage. Even more beneficiaries are covered by employer-sponsored supplemental policies. While employer-sponsored plans typically do not provide first dollar coverage, it still may be appropriate to consider the role of employer-sponsored plans in supplementing Medicare and whether changes are needed.⁹ Note that employer-sponsored supplemental plans often include drug coverage and take the place of Part D as well as supplementing Parts A and B.
- The addition of a cost-sharing limit for the traditional FFS program in itself could reduce the demand for supplemental coverage. Reducing the ability of supplemental plans to provide first dollar coverage further could reduce enrollment in these plans. Lower enrollment in supplementary coverage would mean that more beneficiaries would face the financial incentives inherent in the FFS benefit design, without those incentives being limited by supplemental coverage that fills in cost-sharing requirements.

Value-Based Insurance Design

Redesigning the FFS benefit structure could be a step in the direction of better aligning beneficiary incentives to seek cost-effective care. As discussed earlier, broad changes in cost sharing, however, will not necessarily target reductions in unnecessary or ineffective care. In the longer-term, moving to a value-based insurance design (VBID) could structure beneficiary financial incentives more effectively. A VBID approach would lower the cost sharing for high-value services and increase the cost sharing for low-value services. The ACA moved Medicare in this direction by covering certain preventive services with no cost sharing.

Adjusting cost sharing to align incentives with effective use of services has shown promise in reducing spending in the non-Medicare market—most often for prescription drugs.¹⁰

Comparative effectiveness research can provide more guidance to help distinguish low-value and

⁹ In the same manner, it may be appropriate to consider the role of Medicare when it is the secondary payer to other coverage, such as employer coverage for active workers aged 65 and older. In these instances, Medicare coverage in effect supplements other coverage. There are limits, however, as to how much Medicare will pay, and therefore, the extent to which Medicare fills in cost-sharing requirements. For instance, if the primary plan already pays more for a service than Medicare does, then Medicare would pay nothing more.

¹⁰ See for instance, "Evidence That Value-Based Insurance Can Be Effective," Michael E. Chernew, et al. *Health Affairs* 29(3): 530-536, March 2010.

high-value services. Although lowering cost sharing for high-value services could gain widespread acceptance, it likely would be more difficult to implement higher cost-sharing requirements for treatments deemed of lower value. One potential way to increase cost sharing for lower-value services is to use reference pricing. Under reference pricing, Medicare would pay the costs of the lowest-price option when multiple treatment options achieve similar results. Beneficiaries choosing a higher-cost option would pay the difference.

Conclusion

The current Medicare FFS benefit design has several drawbacks. It lacks a cap on cost sharing, making supplemental coverage a necessity if beneficiaries are to be protected against the costs associated with catastrophic illnesses. Since most beneficiaries have supplemental policies to cover their FFS cost-sharing requirements, their incentives to seek cost-effective care are reduced. In addition, the Medicare FFS cost-sharing requirements are skewed toward less discretionary services. Restructuring the FFS benefit design by unifying the Part A and B deductibles and adding a cost-sharing limit would provide protection against catastrophic health costs and has the potential to encourage beneficiaries to seek cost-effective care.

Restructuring the FFS benefit design could be done in a budget neutral manner, or it could be done in a way that reduces Medicare spending overall. For Medicare to achieve savings beyond the amounts shifted to beneficiaries, the plan design changes would need to encourage beneficiaries to take a more active role in their health care, seek care when necessary, and learn more about the cost and expected outcomes of their care. Restructuring, however, will affect only the few beneficiaries who do not have supplemental coverage, unless insurance products that coordinate with Medicare are modified so that they do not limit the desired effects of any FFS restructuring. In addition, provider incentives need to be consistent with beneficiary incentives and more information regarding costs, quality, and treatment effectiveness is needed.

Redesigning the FFS plan design is more of a short-term solution, with transitioning to a VBID a longer-term approach. Even under a VBID approach, however, a more comprehensive restructuring of not just the benefit design but also the payment and delivery systems is needed to move Medicare toward a more integrated, coordinated, and cost-effective system.