RETHINKING MEDICARE'S BENEFIT DESIGN: OPPORTUNITIES AND CHALLENGES

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"A 21st Century Medicare: Bipartisan Proposals to Redesign the Program's Outdated Benefit Structure"

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Summary Statement
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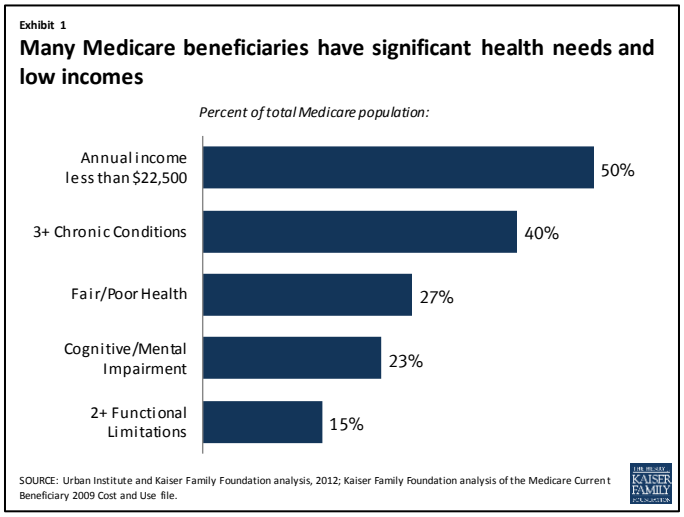
- Medicare is a popular program that serves beneficiaries with significant needs and modest incomes. Roughly one in four is in fair or poor health and about the same share has a cognitive or mental impairment, such as Alzheimer's disease. Half live on incomes below $23,000.
- Traditional Medicare has a complex benefit design, with relatively high cost sharing, and no out-of-pocket spending limit. Most beneficiaries in traditional Medicare have supplemental insurance to ease concerns about unpredictable health expenses.
- Even with Medicare and supplemental coverage, beneficiaries have high out-of-pocket costs, spending three times as much of their household budgets on health expenses as do non-Medicare households. Among beneficiaries with incomes below $20,000, half spend *at least* one-fifth of their income on health care and premiums.
- Proposals to restructure the benefit design have the potential to provide needed catastrophic protection, streamline benefits, coax beneficiaries toward higher-value services, strengthen financial protections for low-income beneficiaries, maintain the average value of benefits, and produce Medicare savings. But, achieving all of these goals simultaneously is a challenge.
- The CBO option analyzed by the Kaiser Family Foundation in 2011 (a unified $550 deductible, a uniform 20% coinsurance, and a $5,500 spending limit) would provide substantial help to a small number of traditional Medicare beneficiaries with high expenses in a given year if fully implemented in 2013. But it would increase costs for most (71%), including beneficiaries without an inpatient stay whose deductible would more than triple from $147 to $550.
- If measured over multiple years, a larger share of beneficiaries would reach a limit on out-of-pocket spending. One-third of traditional Medicare beneficiaries would be expected to have cost-sharing liabilities that reach $5,000 one or more times over a 10-year period, according to recent analysis released by MedPAC and the Kaiser Family Foundation.
- In addition to benefit redesign, some proposals would restrict or impose a premium surcharge on supplemental coverage. Adding Medigap restrictions to the benefit redesign would greatly increase Medicare savings, according to CBO, perhaps because Medigap enrollees would be expected to use fewer services when confronted with higher cost-sharing. A premium surcharge would also increase savings by raising revenues from beneficiaries who choose to pay the surcharge, and by reducing utilization among those who respond to the new fee by dropping their supplemental coverage.
- Benefit redesign proposals could be – and have been – modified to achieve different outcomes. These policy decisions involve tradeoffs for beneficiaries, program spending, and other payers. For example, reducing the out-of-pocket limit would help more people, but reduce Medicare savings. Reducing lowering-sharing obligations for lower-income seniors, perhaps modeled on Part D, could help make benefit redesign more affordable for that group, but may erode savings, unless offsets are found elsewhere. Raising cost sharing for specific services could increase savings, but increase costs for beneficiaries, and risk some foregoing needed care.
- Achieving the multiple goals of benefit redesign proposals presents an opportunity to address long-standing concerns. However, protections for seniors can come with a cost and could be compromised if savings are a priority.

Chairman Pitts, Ranking Member Pallone, and distinguished members of the Subcommittee on Health, I am Tricia Neuman, a Senior Vice President at the Kaiser Family Foundation and Director of the Foundation's Program on Medicare Policy. The Kaiser Family Foundation is an independent, non-profit private operating foundation that is focused on health policy analysis, communications and journalism.

Thank you for the opportunity to testify on the topic of Medicare's benefit design, and the implications of possible changes for beneficiaries, other stakeholders, and program spending. The idea of simplifying Medicare's benefit design has been under discussion since the 1970s. A restructured benefit design could simplify and add predictability to Medicare cost sharing, protect beneficiaries against catastrophic expenses, reduce the need for supplemental insurance, encourage the use of high-value services, and strengthen financial protections for beneficiaries with low-incomes – an important feature of recent proposals given the substantial financial burden many on Medicare currently face. Achieving these multiple goals of benefit redesign proposals, without increasing the financial burden of care for seniors, presents both an opportunity and a challenge, especially if the overall objective is to achieve Medicare savings.

Background

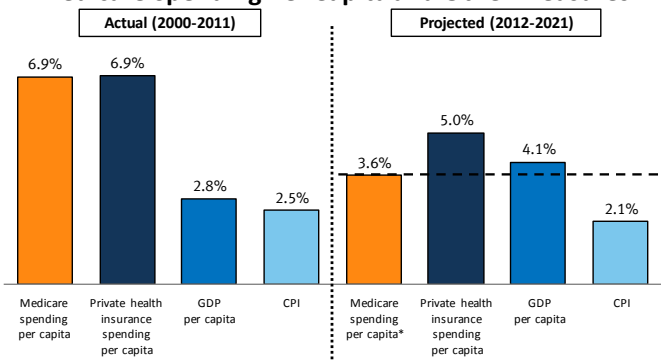
Medicare provides health insurance coverage for nearly one in six Americans, including 43 million seniors and 9 million younger adults with permanent disabilities. Many Medicare beneficiaries have significant medical needs and modest incomes (Exhibit 1). Four in ten beneficiaries live with three or more chronic conditions. About one in four beneficiaries is in fair or poor health and about the same share has a cognitive or mental impairment, such as Alzheimer's disease. More than half live on incomes of $22,500 or less.



Medicare, at 16 percent of the federal budget, has been and continues to be a part of discussions to reduce government spending. Over the long term, the country faces very real challenges, with the retirement of the baby boom generation and rising health care costs (that will affect all payers). In the nearer term, Medicare spending is projected to grow at a substantially lower rate than it did in the past decade, at about the same rate as the economy, and at a slower rate than private insurance on a per person basis (Exhibit 2).

Exhibit 2

Historical and Projected Average Annual Growth Rate in Medicare Spending Per Capita and Other Measures



NOTE: *Assumes no reduction in physician fees under Medicare between 2012 and 2021.
SOURCE: Kaiser Family Foundation analysis of data from Boards of Trustees, Congressional Budget Office, Centers for Medicare & Medicaid Services, U.S. Census Bureau, 2013.

A wide range of proposals have been put forward to further slow the growth in Medicare spending that could potentially affect providers, plans, and beneficiaries, including options to simplify and restructure Medicare's current benefit design.[1]

Benefits, Supplemental Coverage, and Out-of-Pocket Spending

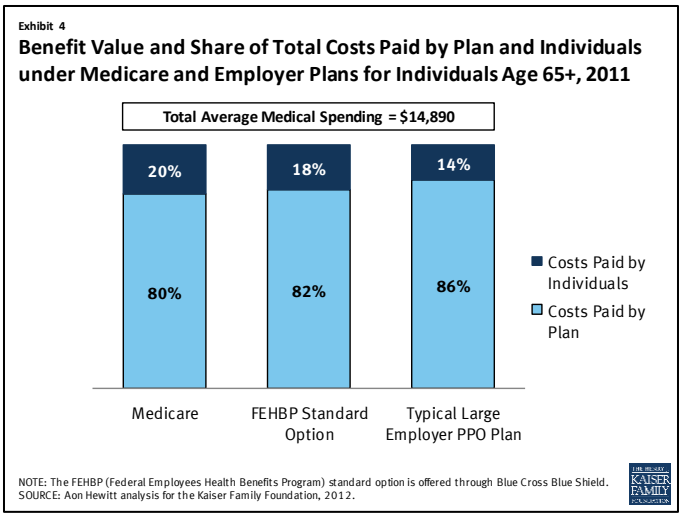
Medicare today has a relatively complicated benefit structure, with Part A (primarily for inpatient hospital and post-acute care), Part B (for physician and other outpatient services) and now Part D (prescription drug coverage). Parts A, B and D each have their own deductibles ($1,184 for Part A; $147 for Part B; and $325 for the standard Part D benefit) and varying levels of coinsurance or copayments, depending on the service (Exhibit 3). Unlike typical large employer plans, Medicare has no limit on out-of-pocket spending for inpatient and outpatient services covered under Parts A and B. Even with the addition of the drug benefit, Medicare remains less generous than the typical large employer preferred provider organization

Exhibit 3

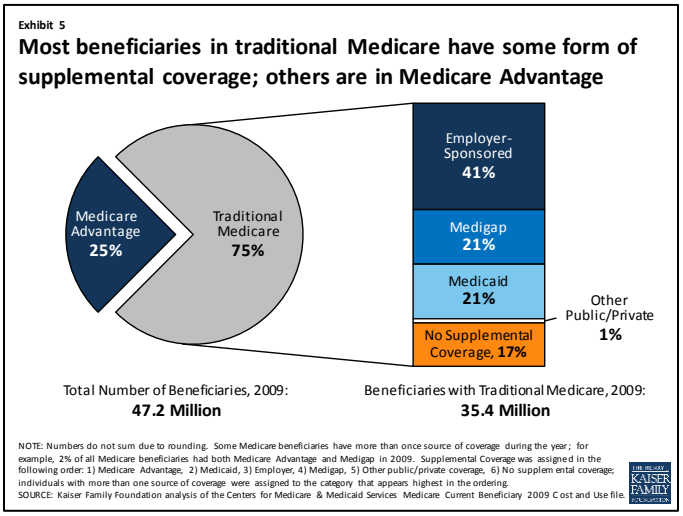
Traditional Medicare has a fairly complicated benefit design and no limit on out-of-pocket spending

Part A	Part B	Part D Standard benefit
Deductible $1,184/spell of illness	**Deductible** $147 in 2013	**Deductible** $325 in 2013
Inpatient hospital No coinsurance, for days 1-60; $296/day, for days 61-90; $592/day, for days 91-150; No coverage after day 150	**Physician and other services** 20% coinsurance	**Initial coverage** 25% coinsurance (up to $2,970 in total drug costs)
Skilled nursing facility No coinsurance, for days 1-20; $148/day for days 21-100;	**Outpatient mental health** 35% coinsurance	**Coverage gap** 47.5% coinsurance for brands, 79% coinsurance for generics between $2,970 and $6,955 in total drug costs
Home health, hospice No coinsurance	**Annual "wellness" visit, clinical laboratory services, home health care** No coinsurance	
	Preventive services No coinsurance for many services, 20% for some	
No limit on cost-sharing for Part A services	**No limit on cost-sharing for Part B services**	**Catastrophic coverage** Minimum of $2.65/generic, $6.60/brand, or 5% coinsurance above $4,750 in out-of-pocket spending

(PPO) plan and the Blue Cross/Blue Shield Standard Option offered through the Federal Employees Health Benefits Program (also a PPO plan) (Exhibit 4).[2]

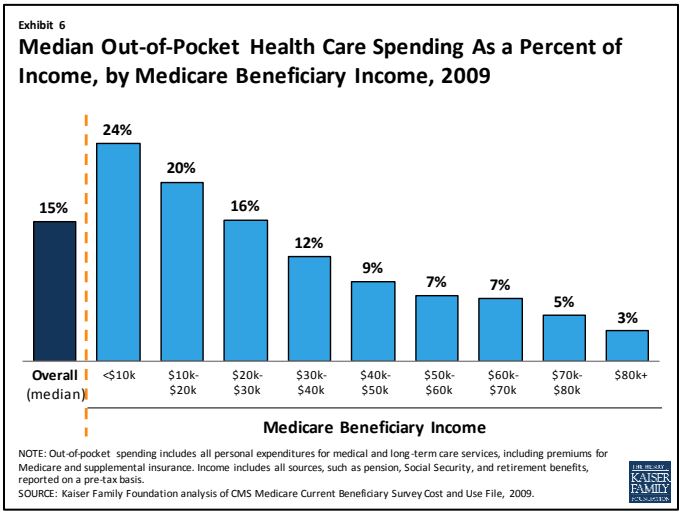


To help cover some or all of Medicare's cost-sharing requirements, and ease concerns about unpredictable medical bills, most beneficiaries in traditional Medicare have supplemental coverage (Exhibit 5). Employer-sponsored plans (mainly for retirees) remain the primary source of supplemental coverage, providing additional coverage to 41 percent of beneficiaries in traditional Medicare in 2009. Another 21 percent of beneficiaries in traditional Medicare are covered by supplemental insurance policies, known as Medigap. Medicaid plays a key role for beneficiaries with low incomes and limited savings – providing wrap around coverage for 21 percent of beneficiaries in traditional Medicare. Another 17 percent of all beneficiaries in the traditional Medicare program (12 percent of the total Medicare population) have no source of supplemental coverage. This includes a disproportionate share of beneficiaries with modest incomes, in fair or poor health, and younger beneficiaries with permanent disabilities.[3] These beneficiaries would be fully exposed to higher deductibles and coinsurance requirements under many of the leading benefit redesign proposals.



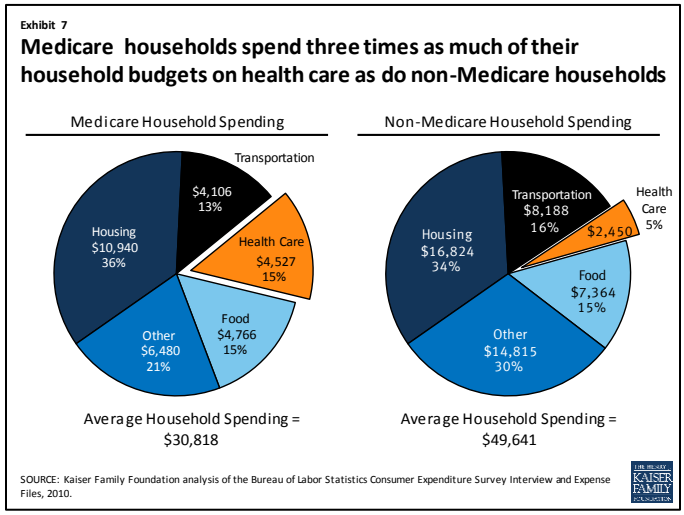
A growing number of Medicare beneficiaries, now 27 percent, are covered by Medicare Advantage plans, rather than traditional Medicare. Medicare Advantage plans provide at least the same set of benefits as traditional Medicare, but do not typically have deductibles for services covered under

Parts A and B and now include limits on enrollees' out-of-pocket spending (not to exceed $6,700 in 2013). Nearly half of all Medicare Advantage enrollees are in plans with limits at or below $3,400.[4]



Out-of-Pocket Spending

But even with Medicare, and supplemental insurance, beneficiaries tend to have relatively high out-of-pocket health costs. In 2009, half of all Medicare beneficiaries spent 15 percent or more of their income on health-related expenses – including premiums, cost sharing for Medicare-covered services, and services not covered by Medicare. Among those with incomes below $20,000, the burden was even higher (Exhibit 6) . Overall, Medicare households spend three times as much of their household budgets on health care as do non-Medicare households (Exhibit 7).



Proposals to Restructure the Medicare Benefit Design

A number of policymakers and other experts have proposed to simplify the Medicare benefit design, generally but not exclusively in the context of broader efforts to reduce Medicare and/or federal spending. Typically, these proposals focus on Medicare Parts A and B, but not Part D. Benefit redesign proposals can be, and have been, structured to strengthen or weaken the coverage provided to beneficiaries under traditional Medicare (or maintain the overall value of the benefit). They can also be designed to increase or decrease federal spending depending on the

benefit parameters, such as the level of the unified deductible and out-of-pocket spending limit, and the extent to which they incorporate financial protections for beneficiaries with low incomes.

In 2010, for example, the National Commission on Fiscal Responsibility and Reform proposed a restructured benefit design as part of a broader effort to reduce the national debt. The proposal would create a combined Part A and B deductible of $550; a single 20 percent coinsurance rate for all Medicare-covered services; a five percent coinsurance rate for costs between $5,550 and $7,500; and an annual out-of-pocket maximum of $7,500.[5] The Congressional Budget Office (CBO) evaluated a similar option, and estimated federal savings of $32 billion from 2012 to 2021.[6]

Some of the more recent proposals to restructure Medicare benefits are designed with the goal of maintaining aggregate cost-sharing requirements for beneficiaries. The Medicare Payment Advisory Commission (MedPAC) adopted this approach in their 2012 recommendation to add an out-of-pocket spending limit to traditional Medicare, replace current coinsurance rates with copayments to simplify payments for beneficiaries, and grant the Secretary of Health and Human Services the authority to make value-based changes to Medicare's benefit design.[7] In 2013, the Bipartisan Policy Center Health Care Cost Containment Initiative (led by Alice Rivlin and former Senators Pete Domenici, Tom Daschle, and Bill Frist), proposed a benefit redesign as part of a broader set of recommendations to reduce health costs, that would also maintain aggregate beneficiary cost-sharing liabilities. In 2013, Erskine Bowles and Alan Simpson – who co-chaired of the 2010 National Commission on Fiscal Responsibility and Reform – made a similar recommendation that benefit redesign not affect average out-of-pocket costs (including premiums).

Some of the recent proposals would also strengthen financial protections for low-income Medicare beneficiaries. For example, the 2013 proposal from Erskine Bowles and Alan Simpson included an income-related out-of-pocket spending limit and a lower deductible for low-income beneficiaries – features that were not included in the recommendations issued by the Fiscal Commission in 2010. The 2013 Bipartisan Policy Proposal also proposed to strengthen

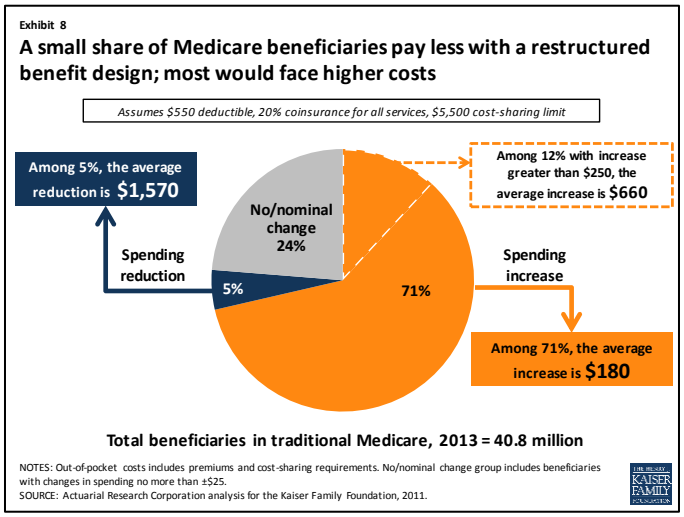
protections for low-income beneficiaries, by providing new federal assistance with Medicare's cost sharing to beneficiaries with incomes between 100 percent and 150 percent of the federal poverty level (with no asset test).

What are the Implications of a Restructured Benefit Design for Beneficiaries?

In November 2011, the Kaiser Family Foundation released a report that analyzed the distributional and cost implications of replacing Medicare's current benefit design with a unified deductible for Parts A and B of $550; a 20 percent coinsurance for most Medicare-covered services; and a $5,500 annual limit on out-of-pocket spending (the CBO Budget Option, which is similar to the 2010 Fiscal Commission recommendation).[8,9] The analysis, conducted with researchers at Actuarial Research Corporation, assumes that the proposal was fully implemented in 2013. Variations on this basic option would produce different results for beneficiaries, other stakeholders, and Medicare expenditures.

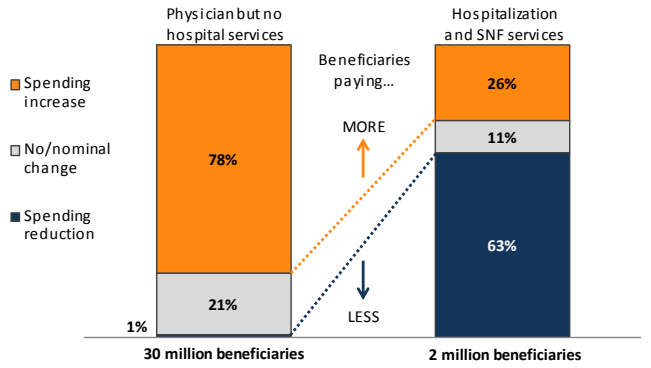
Restructuring Medicare's cost-sharing requirements in such a fashion would be expected to raise costs for the majority of Medicare beneficiaries while reducing spending for some of the sickest. The effects for any given individual would depend on the particular mix of Medicare-covered services they need and their supplemental coverage.

- **Five percent of beneficiaries in the traditional program (about 2 million) would be expected to see savings as a result of the changes, averaging $1,570 in 2013** (Exhibit 8).[10]



- Beneficiaries using inpatient hospital and post-acute care, for example, would be more likely to be helped by the alternative benefit design because they are more likely to incur costs that exceed the limit on out-of-pocket spending (Exhibit 9). In any given year, this group would represent a small share of the total Medicare population.

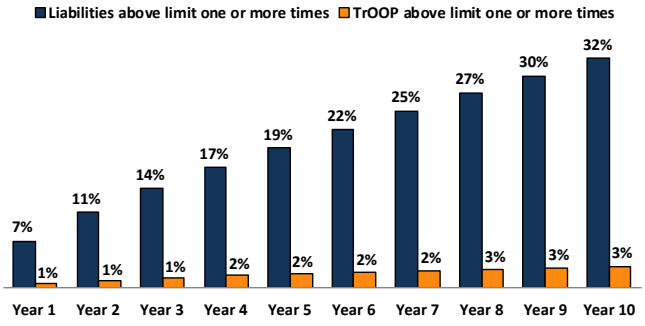
Exhibit 9
Most beneficiaries in relatively poor health could see spending reductions, but they are a small share of the Medicare population



SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation, 2011.

- Over a longer term, a larger percentage of beneficiaries would reach the out-of-pocket limit. MedPAC and the Kaiser Family Foundation recently contracted with the Actuarial Research Corporation to look at the share of Medicare beneficiaries expected to have cost-sharing liabilities above $5,000 one or more times over a ten-year period. While only 6 to 7 percent of traditional Medicare beneficiaries would have cost-sharing liabilities that reach $5,000 in one year, 32 percent would reach this amount at least once over a 10-year period (Exhibit 10).[11]

Exhibit 10
A small share would reach a $5,000 spending limit in any given year, but a larger share would reach the limit over a longer period of time



NOTE: "TrOOP" stands for true-out-of-pocket spending and indicates a beneficiary's cost sharing for Medicare services, excluding payments made on his or her behalf by supplemental insurers. Cohort includes beneficiaries who died during the 10-year period. Analysis assumed current cost-sharing requirements and no changes in supplemental coverage. The $5,000 maximum is expressed in 2009 dollars and indexed for projected growth in average spending per traditional Medicare beneficiary.
SOURCE: Actuarial Research Corporation analysis for MedPAC and the Kaiser Family Foundation, June 2013.

- Not all beneficiaries with intensive service use would see a reduction in spending. Beneficiaries with expenses that do not exceed the out-of-pocket limit could end up paying substantially more for their Medicare-covered services due to the new 20 percent coinsurance for home health services and for relatively short inpatient hospital and skilled nursing facility stays (even with a lower Part A deductible).

- **Overall, 71 percent of beneficiaries in the traditional program (about 29 million beneficiaries) would be expected to see at least some increase in their out-of-pocket costs under the revamped system in a given year.**

    - For example, beneficiaries in relatively good health, who tend to have a few physician visits in a year but no inpatient care would be expected to have higher out-of-pocket costs, principally because they would face a unified deductible ($550) that is more than three times more than their current law deductible ($147 for Part B in 2013).

    - Five million beneficiaries would be expected to face an increase of $250 or more in their out-of-pocket costs, averaging $660 in 2013; more than one third of these beneficiaries have incomes between 100 and 200 percent of the federal poverty level, a group that is not generally eligible for cost-sharing assistance under Medicaid.

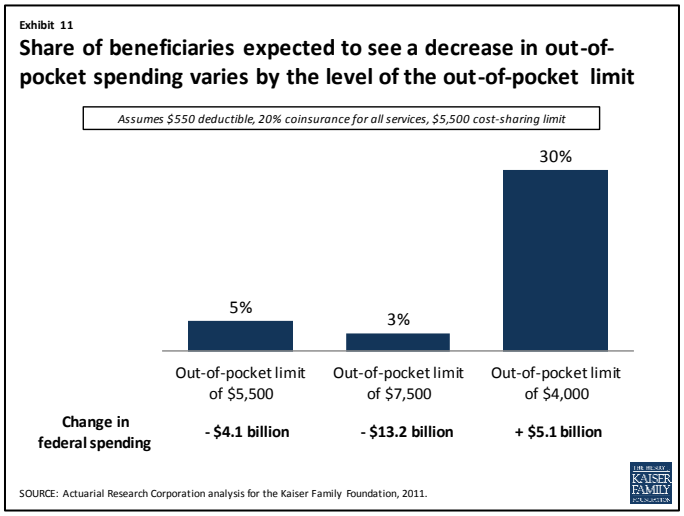
These changes to the benefit design would reduce Medicare spending by an estimated $4.2 billion in 2013, according to our analysis, but aggregate spending among Medicare beneficiaries would rise by $2.3 billion. The proposal would also be expected to result in higher costs for employers ($0.6 billion), TRICARE ($0.2 billion) and other payers ($0.4 billion). Medicaid spending (federal and state combined) would decrease modestly by $0.1 billion in 2013, mainly due to the limit on out-of-pocket spending. Taken together, the changes would result in a net reduction in total health care spending of less than $1 billion in 2013.

Alternative Ways to Restructure the Benefit Design

Proposals to restructure the Medicare benefit design could be, and have been, modified in a number of ways to achieve different policy objectives. Such modifications include the following:

- **Raise or lower the out-of-pocket spending limit.** Proposals vary in the level at which the out-of-pocket limit for traditional Medicare is set. A lower limit would help more beneficiaries but erode Medicare savings, while the opposite is true for a higher limit. For example, if the CBO option were modified to include a lower $4,000 spending limit, 30 percent of traditional

beneficiaries would be expected to see a spending reduction compared to 5 percent under the $5,500 limit, but the benefit design would *increase* federal spending by $5.1 billion compared to savings of $4.1 billion under the $5,500 limit. With a $7,500 spending limit, 39 percent of beneficiaries in traditional Medicare would be expected to see costs increase by at least $250, compared to 12 percent under the $5,500 limit, although this option would also lead to much higher federal savings of $13.2 billion in 2013 (Exhibit 11).



- **Apply the "true out-of-pocket" (TrOOP) concept to the annual spending limit.** If the TrOOP concept were applied, as it is under Part D, cost-sharing payments made by supplemental insurers on behalf of an enrollee would not count towards the beneficiary's spending limit. As a result, fewer beneficiaries would reach the spending limit in a given year. For example, MedPAC and the Kaiser Family Foundation contracted with the Actuarial Research Corporation and found that only three percent of beneficiaries would reach a TrOOP spending limit of $5,000 at least once over a 10-year period – compared to 32 percent if all Medicare cost-sharing liabilities were taken into account – assuming no change in supplemental coverage (Exhibit 10).[12] Of course, beneficiaries may decide not to purchase supplemental coverage if a TrOOP concept were applied given the lower probability of reaching the TrOOP spending limit with such insurance. Applying TrOOP to the spending limit would be expected to increase Medicare savings, in part because fewer beneficiaries would reach the spending limit, but it would also reduce the value of the new Medicare spending limit for beneficiaries.

- **Raise or lower the A/B deductible or exempt physician visits from the deductible.** Proposals also vary in the level of the deductible, entailing another tradeoff between Medicare savings and beneficiaries' cost-sharing obligations. A higher deductible would increase savings and shift costs onto beneficiaries, while a lower deductible would decrease savings but also reduce the share of beneficiaries spending more under a restructured benefit design. Similarly, exempting certain services from the deductible, such as physician visits, would minimize cost increases for relatively healthy beneficiaries, and address the concern that a higher A/B deductible would discourage seniors from seeking care from a physician, when needed. The 2013 proposal from the Bipartisan Policy Center included a $500 deductible, but excluded physician office visits from the deductible.

- **Replace coinsurance rates with copayments.** Some proposals would include copayments (which are fixed amounts) rather than coinsurance (which varies based on the amount of the medical expense) in order to make the cost-sharing requirements easier for beneficiaries to understand. Copayments can also reduce the financial burden on beneficiaries, and can be structured to encourage "higher value" care or care provided in lower-cost settings. This approach was included in the 2012 MedPAC recommendation and in the 2013 Bipartisan Policy Center proposal.

- **Provide additional protections for low-income beneficiaries.** Benefit redesign proposals could also be designed to strengthen protections for low-income beneficiaries, both to address the well-documented financial burdens experienced by this population and to target resources where most needed. One approach for mitigating the effect on low-income beneficiaries would be to federalize cost-sharing assistance for individuals with incomes up to 150 percent of the federal poverty level, using the Part D Low-Income Subsidy (LIS) as a model. The Bipartisan Policy Center would federalize cost-sharing assistance for individuals with incomes between 100 percent to 150 percent of poverty. Adding low-income protections, however could erode expected federal savings or even lead to an increase federal spending, unless these additional costs are offset by other savings or revenue provisions.

An alternative approach would provide greater protections for lower-income beneficiaries (and less for higher-income beneficiaries) by establishing an income-related out-of-pocket spending limit or deductible. Instituting income-related cost-sharing requirements would necessitate a significant administrative effort on the part of Medicare and perhaps other payers, and could raise privacy concerns.

- **Apply the new benefit design prospectively.** Rather than restructure the benefit design in the near future, the redesign could roll out sometime in the future, and apply only to new beneficiaries. This approach would prevent current beneficiaries from seeing any changes in out-of-pocket spending (increases or decreases), but may also reduce Medicare savings in the ten-year budget window. Further, if applied only to new enrollees, this approach would require Medicare to administer two benefit designs: today's design for current beneficiaries and the restructured benefit design for future beneficiaries.

The Effects of Combining the Benefit Redesign with Restrictions on First Dollar Medigap Coverage

In addition to restructuring Medicare's benefit design, several recent proposals attempt to achieve greater federal savings by prohibiting or discouraging beneficiaries from purchasing supplemental coverage generally or "first-dollar" coverage more specifically. In 2011, CBO estimated that restricting Medigap coverage of the first $550 of enrollees' cost-sharing requirements and limiting coverage to 50 percent of the next $4,950 (with the plan paying any cost sharing above that amount) would have saved $54 billion from 2012 to 2021 and that combining this policy with benefit redesign would have saved $93 billion over the same budget window.

The 2010 National Commission on Fiscal Responsibility and Reform proposed a similar policy that would combine benefit redesign with restrictions on Medigap coverage (as well as TRICARE for Life, federal retiree, and private employer-provided retiree coverage).[13] MedPAC also recommended a premium charge on supplemental coverage (including both Medigap and employer-sponsored plans) in conjunction with changes to the benefit design for traditional

Medicare.[14] In his FY2014 Budget, President Obama proposed to increase Part B premiums for new enrollees who purchase "near first-dollar" Medigap coverage beginning in 2017, although he did not propose to fundamentally restructure the Medicare benefit design. [15]

Prohibiting first-dollar Medigap coverage in conjunction with a restructured benefit package would also create winners and losers, according to the 2011 Kaiser Family Foundation analysis, under a policy where Medigap policies are prohibited from covering the first $550 in cost sharing and restricted from covering more than 50 percent of cost sharing above the deductible and up to the new spending limit, assuming full implementation in 2013.[16,17]

- **Half of all beneficiaries in traditional Medicare would be expected to see cost increases with Medigap restrictions and the A/B benefit redesign (less than the 71% with expected cost increases under the benefit redesign alone) and nearly a quarter (24%) would be expected to see costs decline (versus 5% with the benefit redesign alone).** This is a more favorable distribution than the benefit redesign alone because the Medigap restrictions are expected to reduce Medigap premiums (as plans would cover fewer expenses) and reduce Part B premiums because beneficiaries would be expected to use fewer Part B services when faced with higher cost-sharing requirements.

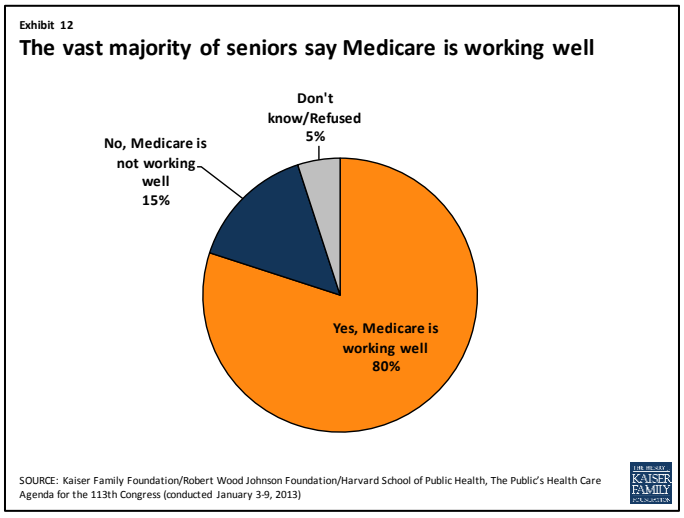
- **The combined benefit redesign and Medigap restrictions would nonetheless increase costs for an estimated six million Medicare beneficiaries by more than $250, with an average increase of $780 in 2013.** More than half of the beneficiaries in this group have incomes below 200 percent of the federal poverty level. Restricting Medigap coverage would require enrollees to pay a greater share of their medical expenses on their own, which would be especially burdensome for enrollees with large medical expenses. For many enrollees with one or more hospitalizations, for example, the increase in cost-sharing requirements would more than offset any reductions in Part B and supplemental premiums.

An alternative approach – a premium surcharge or excise tax on supplemental plans – could raise program revenues and achieve savings by discouraging some beneficiaries from purchasing supplemental coverage. With a surcharge approach, beneficiaries with modest means may be more likely to drop supplemental coverage if they are unable to afford the additional fee. Those who drop coverage would be expected to use fewer services as a result. Higher-income beneficiaries might be more likely to keep their supplemental coverage, in which case their premiums would increase but their use of care would likely be unaffected.

The primary justification for these proposals is the view that supplemental coverage, especially first-dollar coverage, drives up Medicare spending by insulating enrollees from the cost of the services they use.[18] Numerous studies have demonstrated that increases in cost sharing result in decreases in utilization. However, the literature also confirms that people forego both necessary and unnecessary care, the former of which could lead to health complications and additional costs in the long run. Research also suggests that, while cost sharing may affect the decision of whether to seek care, it has a smaller impact on the intensity of care provided, and it may have a smaller impact on the use of certain services.[19]

Conclusion

Medicare today enjoys broad support among the public, and a large majority of seniors say the program is working well (Exhibit 12). Nonetheless, the current benefit design is relatively complicated and, unlike most employer plans, Medicare has no out-of-pocket limit for inpatient and outpatient services. Given Medicare's relatively high cost-sharing requirements, the majority of beneficiaries purchase some form of supplemental coverage.



Several benefit redesign proposals would provide real help to a small share of the Medicare population in a given year, while raising costs for many if not most beneficiaries – many of whom have modest incomes and devote a relatively large share of their incomes and household budgets towards health-related expenses. Some of the more recent proposals would provide additional protections for low-income beneficiaries – an important feature for minimizing the risk of shifting costs onto seniors living on fixed incomes. Finding an approach that will streamline benefits, coax beneficiaries toward high-value providers and services, provide greater protections to those with relatively high cost-sharing expenses and/or low incomes, all without shifting excessive costs onto seniors, is both an opportunity and a challenge, particularly in a deficit reduction context.

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[1] Kaiser Family Foundation, *Medicare and the Federal Budget: Comparison of Medicare Provisions in Recent Federal Debt and Deficit Reduction Proposals*, June 2013, available at: http://www.kff.org/medicare/issue-brief/medicare-and-the-federal-budget-comparison-of-medicare-provisions-in-recent-federal-debt-and-deficit-reduction-proposals/; Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future*, January 2013, available at: http://www.kff.org/medicare/report/policy-options-to-sustain-medicare-for-the-future/.

[2] Kaiser Family Foundation, *How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?: A 2012 Update*, April 2012, available at: http://www.kff.org/health-reform/issue-brief/how-does-the-benefit-value-of-medicare/.

[3] Kaiser Family Foundation, *Examining Sources of Supplemental Insurance and Prescription Drug Coverage Among Medicare Beneficiaries: Findings from the Medicare Current Beneficiary Survey, 2007*, August 2009, available at: http://www.kff.org/medicare/report/examining-sources-of-supplemental-insurance-and-prescription/.

[4] Kaiser Family Foundation, *Medicare Advantage 2013 Spotlight: Enrollment Market Update*, June 2013, available at: http://www.kff.org/medicare/issue-brief/medicare-advantage-2013-spotlight-enrollment-market-update/.

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