ALLIANCE FOR HEALTH REFORM

Streamlining Cost Sharing in Medicare

Alliance for Health Reform
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ED HOWARD: So, welcome. My name is Ed Howard. I'm with the Alliance for Health Reform, and I am demonstrating to those in the room that the acoustics are not so great, so I am taking this occasion to tell our speakers to speak slowly and distinctly so that people can actually hear what you have to say. I want to welcome you to this program on the basics of Medicare cost sharing and the fee for service part of the program, and I extend that welcome on behalf of Senator Blunt, Senator Rockefeller, our board of directors.

You know, Medicare is an important, an expensive and a complicated program even compared with other health insurance. How many Americans know all the parts of it, their ABCs if you will, not to mention part D for prescription drugs? So when you hear policy experts warn that Medicare spending is a threat to the long-term stability of the federal budget, they're talking about the levels of government spending, but beneficiary spending is substantial, too, and it's getting more burdensome year after year.

Then there's the confusion, premiums, coinsurance, deductibles, not to mention the coverage that most beneficiaries have to fill the holes in Medicare. That benefit package is full of it, I mean full of holes. [Laughter.] Hence our discussion today about streamlining beneficiary

spending. Cost sharing is the term of art. There are a lot of proposals floating around with a lot of common elements, and we're going to take a closer look at some of the major ones today. We'll also look at how the provisions to simplify the design of Medicare benefits and the cost sharing that goes along with those might affect those least able to cope with big changes, that is the beneficiaries, especially low income beneficiaries.

Our partner in today's program is the Kaiser Family Foundation, which is a font of thoughtful analysis of the Medicare program, some of which you can find in your materials in the packets, and some of which were written or overseen by our co-moderator today, Tricia Neuman, who directs the foundation's program on Medicare policy. Tricia?

TRICIA NEUMAN: Thank you, Ed, and I want to thank the staff of the Alliance for putting together what promises to be a really interesting program on policy options to restructure benefit design around traditional Medicare. I also want to thank this fabulous panel of experts who have come together to offer their insights on this topic.

Now, the idea of restructuring Medicare benefits may seem like a new idea because it has gotten quite a bit of attention of late, but actually this is an idea that has been kicked around not for years but for decades. It actually has

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gotten more attention in recent years because it could be a mechanism for achieving deficit reduction, and so you will see proposals to restructure Medicare in several of the debt and deficit reduction options that have been put on the table.

I think we all know and Ed has said that Medicare provides highly valued services for people in their program. It is a very popular program. It enjoys broad public support, and it's important to this population because many have chronic conditions. Many live in fair or poor health, and many live on modest incomes. In fact, half of all people in Medicare live on an income of $23,000 or less, but from the outset Medicare has been complicated. You can see in this chart that Medicare for people who are in parts A, B, and D has three deductibles. It has different co-pays and coinsurance, depending on the services that people use. It, unlike most large employer plans, has no limit on out-of-pocket spending, so a concern over the years has been the lack of catastrophic protection, and many of the proposals that you'll hear about aim to address that concern.

Now, when people talk about restructuring Medicare, they talk about hoping to achieve different goals, and what you can see in this next slide is the many goals that people have talked about. So they've talked about streamlining benefits. More recently they talk about using Medicare benefit redesign

to achieve Medicare savings and federal savings. They also talk about protecting individuals against catastrophic expenses, reducing the need for supplemental insurance, encouraging use of high value services, and some of the proposals talk about this being a vehicle to strengthen protections for the lowest income people on Medicare.

The challenge is, I think you will hear, is achieving all of these lofty goals at the same time, and I think our panelists may have something to say about that. So without further ado, Ed, I think this promises to be a really great session, and I look forward to hearing what everyone has to say. Thanks.

ED HOWARD: Great. Thanks very much, Tricia. A couple of logistical items before we get to our program, as I said in your packets you're going to find a lot of background information, including speaker bios, more generous than we're going to have time to give them now, and the PowerPoint presentations for those who have them. If you're watching on C-SPAN, that same information and more is available on our website, allhealth.org.

Some of you may be watching a couple of days from now, and the webcast that is arranged with the support of the Kaiser Family Foundation you can find that webcast and a podcast in the next day or two at kff.org, and those same presentations

along with digital copies of the background materials in the kits and more will remain at allhealth.org for your convenience.

Those of you in the room, there are green question cards that you can use at the appropriate time to ask a question. There are also microphones on both corners of the room that you can use to ask your question directly and a blue evaluation form that we hope you will fill out before you leave so that we can improve these programs even more for your benefit.

As Tricia mentioned, we have a terrific panel, and we're going to get right to them because this is a complicated subject, and it's great to have as many expert analysts arrayed about us to help explain the questions. We're going to lead off with Juliette Cubanski, if we get her the clicker.

TRICIA NEUMAN: She's got it.

ED HOWARD: Alright. Juliette's the associate director of the foundation's program on Medicare policy. She's the author of a major study of the impact of restructuring Medicare's benefit design. It seemed sort of relevant among other Medicare related analysis that she's undertaken, and today we've asked her to explain in some greater detail the current structure of the benefits and cost sharing and how some

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of the prominent proposals for changing that structure would affect beneficiaries. Juliette?

JULIETTE CUBANSKI: Thank you, Ed. Thank you and good afternoon to all of you. So I'm just going to jump right in because time is short, and I have a lot of material to cover. I'm going to jump in where Ed left off and talk to you about some of the recent proposals that have been introduced lately to restructure Medicare cost sharing and make changes to supplemental coverage for people on Medicare.

Proposals introduced in the last few years have taken three main approaches to changing Medicare cost sharing. One is to modify the cost sharing features of traditional Medicare by simplifying and unifying the deductibles and the cost sharing amounts across the different parts of Medicare and adding an out-of-pocket spending maximum that traditional Medicare currently lacks.

The second approach is restricting or discouraging supplemental coverage that's available through Medigap supplemental policies and retiree plans offered by employers. Most beneficiaries today have some form of supplemental insurance coverage to help pay their Medicare cost sharing requirements, which some research has suggested leads to higher utilization and higher Medicare spending, especially the so-

called first dollar Medigap plans that cover all of part A and part B deductibles and coinsurance.

Proposed changes to supplemental coverage include requiring those with supplemental coverage to pay more of the upfront and ongoing Medicare cost sharing liabilities or imposing a surcharge on their supplemental insurance premiums, and the third approach is simply a combination of the first two, some form of restructuring Medicare cost sharing and some form of prohibition or restriction on supplemental coverage.

Focusing in on the restructured cost sharing piece, we've seen a number of different proposals from different groups, but I'm going to focus on the options that have been analyzed by the Congressional Budget Office and the Medicare Payment Advisory Commission. Under the CBO model, there would be one $550 deductible for part A and B services, a uniform coinsurance rate of 20-percent for all Medicare covered services, and a $5,500 out-of-pocket spending maximum.

The key difference under the MedPAC approach from CBO is that rather than impose a uniform coinsurance rate, MedPAC suggested varying copayments for Medicare covered services such as $750 per hospital admission, $20 for a primary care doctor visit, or $40 for a specialist visit. Both proposals would achieve savings for Medicare and would also, of course, affect how much beneficiaries pay for Medicare covered services.

Analysis of the CBO option prepared by Actuarial Research Corporation for Kaiser shows that the CBO design would actually increase spending by most beneficiaries while reducing spending for a small share. Seven in ten beneficiaries would face modestly higher costs. This reflects the fact that the majority of people on Medicare don't actually use very expensive services in any given year. Only about 20-percent are admitted to a hospital, for example, but about 80-percent of all beneficiaries use doctor visits or other types of part B services. So most people would have to pay a higher deductible than they currently pay for part B, but they wouldn't spend enough to reach the out-of-pocket spending limit.

Conversely, a small share of beneficiaries, the 5-percent in the pie you see here, would have substantially lower spending under the new cost sharing design. This is a relatively sicker group of people with higher utilization and spending that would exceed the new annual out-of-pocket limit. But while only a small share would see savings from the CBO design in any given year, a much larger share stands to benefit over a longer period of time because while one might not have spending high enough to reach the annual out-of-pocket limit in year one or year two, over multiple years the likelihood of having a year of high expenditures increases from less than 10-percent of beneficiaries in year one, having spending above a

$5,000 out-of-pocket maximum in the chart you see here, to more than 30-percent over a ten-year period.

In terms of how the CBO design would affect Medicare spending, analysis suggests that program spending would decrease because many beneficiaries would face higher costs overall, as I just showed you, and that would in turn lead to a reduction in the use of Medicare covered services.

So turning now to supplemental coverage there are a couple of basic approaches to prohibiting or discouraging supplemental coverage that I want to walk through. One approach described by CBO would be to prohibit first dollar Medigap coverage, whereby enrollees would pay more of the upfront costs and more of their ongoing Medicare cost sharing liabilities up to the new out-of-pocket spending maximum.

Under MedPAC's approach, rather than restricting the generosity of plan coverage itself, a surcharge would be added to the premium. This would allow people to buy as much coverage as they desire, but it would require them to pay more to compensate, as it were, for the added costs that they purportedly impose on the Medicare program, and MedPAC also would impose the same surcharge on an employer sponsored retiree plans.

President Obama's 2014 budget proposal took a similar approach, but there, the surcharge would be added to the part B

premium of new enrollees who purchase Medigap policies with particularly low cost sharing requirements. I'm quoting the budget proposal there, and, again, you can achieve savings to Medicare through these types of restrictions on supplemental coverage through higher beneficiary costs that lead to reduced utilization and therefore lower Medicare spending.

Looking at the distributional implications of the CBO option to prohibit first dollar Medigap coverage Kaiser analysis shows that nearly eight in ten beneficiaries with Medigap policies would actually be expected to pay less overall because although their average out-of-pocket spending for Medicare covered services would increase, the fact that the Medigap policy itself provides less generous coverage and the reduced utilization from higher cost sharing would reduce the Medigap premium, and for many the Medigap premium decrease would more than offset the higher cost sharing that they would pay for Medicare covered services, but one in five Medigap policy holders would see their costs increase, including a disproportionate share of Medigap enrollees in relatively poor health, those who require impatient hospital care and those with lower incomes. These groups are more likely to face overall higher costs above and beyond the reduction in their Medigap premiums.

Restrictions on Medigap coverage would have different implications on Medicare beneficiaries in different parts of the country because the share of beneficiaries with Medigap varies widely across states, as you can see here on this map from a recent Kaiser report where you see the share of beneficiaries with Medigap ranges from less than 15-percent in six states and D.C. to a high of close to 50-percent in five Midwestern states, North Dakota, South Dakota, Nebraska, Kansas, and Iowa.

And imposing restrictions on the generosity of coverage offered by both Medigap and employer sponsored retiree plans or imposing some type of premium surcharge on these policies could affect fully six out of ten beneficiaries enrolled in traditional Medicare.

So as I mentioned, most proposals in this area combine both restructured cost sharing and changes to supplemental coverage, but lately we've seen some new features added to this basic framework, including suggestions to incorporate, quote unquote, value based cost sharing in the new benefit design, which is charging higher costs for lower value services and lower costs for higher value services.

We've also seen proposals to vary the cost sharing amounts and the spending limit depending on a beneficiary's income, for example, increasing the out-of-pocket maximum level

for higher income beneficiaries. And finally there's been increased attention to the burden that these proposals might place on low to modest income beneficiaries, and so some recent proponents of these types of changes have suggested the need to incorporate some type of additional protections for people with low incomes, which could take the form of lower cost sharing amounts for lower income people but also the option to expand or enhance the existing programs that help low income people on Medicare pay their Medicare premiums and cost sharing amounts.

Looking quickly at the distributional impact of putting these two pieces together, the restructured cost sharing and supplemental coverage restrictions, as the CBO design suggested, about a quarter of beneficiaries here would pay less, a much greater percentage than under the restructured benefit design alone, and this is largely because of the drop in Medigap and part B premiums, as a result of the higher cost sharing and reduced utilization.

So I just want to leave you with some quick takeaways from my quick overview. First and most obvious, not all of the proposals to restructure Medicare cost sharing and make changes to supplemental coverage for people on Medicare are alike, and therefore the implications for people on Medicare in terms of their costs, whether they would be higher or lower, and their

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choices with respect to supplemental coverage would vary depending on the details of the approach.

As it has been mentioned there are certainly savings to be had in these proposals, but there are also winners and losers among people on Medicare. Unifying the deductible and charging a uniform coinsurance rate would lead to modestly higher costs for many, but the out-of-pocket limit would be very helpful to a small share of people on Medicare in any given year but a larger share of people over a longer period of time. While restricting the supplemental coverage that's available to people on Medicare would achieve savings through higher cost sharing and reduced utilization, but a major concern here is that when you increase beneficiary costs and there's an attendant reduction in utilization, this could actually lead to higher costs in the long run and worse health outcomes potentially if beneficiaries are cutting back on needed services, not just what's unnecessary and not just what's optional. And finally in considering these proposals, if shifting more costs onto beneficiaries appears to be unavoidable, then careful attention should be paid to protecting those who are least able to absorb these higher costs through enhanced financial protections.

Thank you all, and I look forward to your questions.

ED HOWARD: Thanks, Juliette. We're going to turn now to someone who is absolutely not a stranger to the senate hallways. I'm talking about Sheila Burke. She was Bob Dole's chief of staff as majority and minority leader of the senate. She's held a bunch of other important senate posts. She's been executive dean of the Kennedy School at Harvard. She's been the chief operating officer of the Smithsonian, and she is one of the country's most respected health policy analysts. Recently she helped shape the proposal by the Bipartisan Policy Center to restructure Medicare's benefits, and we've asked her to tell us a little bit about that plan, which was issued jointly with the endorsement of Alice Rivlin, Pete Domenici, Bill Frist, and Tom Daschle. Did I get it right?

SHEILA BURKE: You got it right.

ED HOWARD: Okay. Sheila, thanks for being with us.

SHEILA BURKE: Thank you. I was afraid Ed was going to say I was there when they wrote Medicare. He was sort of going down there. Not quite that old, and we have a special connection, just in case there's announcement out of London. We want to be the first ones to let you know. [Laughter]. I have, as Ed pointed out and I want to thank again the Alliance and the Kaiser Family Foundation for once again scheduling a briefing on a critical issue and discussion at a very important time, and also give them extraordinary credit for the materials

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that are in your packet, which are really a terrific array of the proposals and descriptions that I think will be tremendously useful to you in taking on this remarkably complicated issue.

I should note at the beginning that the proposal that I am going to describe for the Bipartisan Policy Center is one that is really only one element of a much broader initiative, and the four sponsors feel very strongly about pointing this out, that this is really part of a much broader conversation about reforming our health care system and really moving towards the future in terms of driving value based purchasing, maintaining choice, and encouraging innovation in the Medicare program and in the health care system generally.

As Ed pointed out, the project is, in fact, the work of our four leaders of our health and economic team at the Bipartisan Policy Center, and that is, in fact, Senator Pete Domenici, Dr. Alice Rivlin, Senator Tom Daschle, and Senator Bill Frist. It is the second of initiatives of the BPC. The original initiative was led by Senators Daschle and Dole and Baker and Mitchell. So this is an ongoing conversation by leaders that care very deeply about these issues and are deeply immersed.

Chris Jennings, Steve Lieberman, Paul Ginsburg and I were privileged to staff the effort, along with Bill Hoagland,

Katherine Hayes, Brian Collins, and Loren Adler of the Bipartisan Policy Center, and Brian is here and is the wizard behind much of the work that we did. So if anything gets tough, I'm looking at Brian.

With regard to our proposal, really Tricia did a terrific job of, I think, explaining what the goals are of any of these initiatives, certainly to modernize and simplify the benefit to promote predictability in terms of what beneficiaries can expect, and to increase support for low income beneficiaries who might well be exposed and discouraged from seeking out appropriate care.

So our goal was to address all of those issues. I will walk through, sort of, the key elements of that proposal, and I would also note that one element, which is meant to help finance the cost of this, is a reduction in the subsidies to higher income beneficiaries.

As Tricia pointed out and as you've seen in the materials that you have in your packet and is evidenced here and described in the Health Affairs piece in your packet, with the expectation of the addition of part D in 2006 Medicare's benefit design has really not changed substantively since its inception in 1965. The deductibles and the cost sharing are, of course, in addition to the part B premium and the part D premium. They vary depending on the service. It is

complicated and at the end of the day does not provide protection against catastrophic costs. In order to deal with the uncertainty and that unpredictability, 90 plus percentage of the Medicare population have some form of supplemental coverage, either that they purchase themselves, they get through their employers, provided by Medicaid, but essentially it is protect against what you see here in terms of the multiplicity of exposure and the complexity of navigating that system.

Our goal was essentially to revise that outdated system by providing the kind of financial protection from the cost by essentially creating a cap, ultimately a cap on catastrophic costs. It replaces the current system, we believe, with one that is far less complicated than the one today. The copayments are designed to encourage higher value services. We exempt physician office visits from the deductible, we hope minimizing the cost increases that are likely to be borne by relatively health beneficiaries. As Juliette points out, there's a very small percentage of Medicare beneficiaries who utilize hospital services on an annual basis, but a great many, in fact, that use part B services. So by exempting physicians' offices so that people can, in fact, visit a physician without having to incur the deductible we hope we'll reduce the opportunity or the risk of their incurring higher costs, and

perhaps most importantly in this benefit change, we cap the cost sharing required by beneficiaries so that they are, in fact, protected against these catastrophic costs that do occur, although in a relatively low number of individuals on an annual basis, but, again, as Juliette pointed out, over time that number would certainly increase.

This very complicated but nicely colored chart is really an illustrative example of how the cost sharing changes might, in fact, take place in the way we structure the benefit going forward. We recognize and acknowledge that it will, in fact, benefit some, primarily those who, in fact, use inpatient services and will result in some increased cost, as Juliette points out, for those who use primarily B services, but we believe, again, that exempting physician's office visits would, in fact, be helpful, and in these examples you sort of see an explanation of what might occur in a traditional case in terms of someone who's using part B services, in the case of an institutionalized patient, and then in the last case where you see an increase, again, depending on the services that are used.

The reasoning behind our proposal with respect to supplemental coverage, and we are, in fact, as Juliette suggested, one of those proposals that both restructures as well as places limits on supplemental coverage, but the

reasoning is, in fact, the belief that supplemental coverage, particularly first dollar coverage, does, in fact, drive up utilization. Again, I would note that we've exempted physician services, at least the office visits, from these deductible, but nonetheless recognizing that, in fact, these might well as encourage, we place a limit essentially on the construction of those proposals, prohibiting all supplemental plans, including those offered by TRICARE and the federal employees' plan from covering first dollar beneficiary cost sharing.

Again, we would require that they include a deductible of at least $250 and include an out-of-pocket maximum no lower than $2500 and cover no more than half of the beneficiaries copayments, coinsurance, once the deductible is met and would ask that the National Association of Insurance Commissioners essentially be asked to develop a standard Medigap plan that would meet these requirements. Now recognizing, in fact, that there would be low income individuals, this was pointed out, who might well be exposed to additional costs. We also provide additional protection to lower income beneficiaries by essentially absorbing at the federal level a higher percentage of cost sharing for those between a hundred and 135-percent of the poverty line and then up to 150-percent of the poverty line. So, again, additional support for those individuals and new protection for those between a hundred and 150-percent of

the poverty line, and then lastly, again, we ask higher income beneficiaries to bear some of the additional cost by reducing the federal subsidy to singles earning $60,000 or more and couples with incomes of $90,000 or more. This proposed change, we acknowledge, would probably impact about 17-percent of beneficiaries, but, again, we believe coupled with the greater protection for low income beneficiaries and the broader simplicity of the program, we think would have a broad impact that is a positive one on the program as a whole, and I will stop there.

ED HOWARD: Great. Thanks very much, Sheila. We will now hear from Joe Baker. He, for the last four years or so, has headed the Medicare Rights Center, a nonprofit organization that works to improve health care for beneficiaries through counseling and advocacy, among other functions. He's a lawyer by profession, law school professor, in fact, at NYU. He has a lot of years of service in public and nonprofit activities, and today, surprise, he has some words of caution about the plans to restructure the benefits in Medicare and how beneficiaries, particularly low income and vulnerable beneficiaries, would fair under these proposal. Joe, thanks very much for being with us.

JOE BAKER: Ed, thank you for inviting me. Whoop, let me turn on my mic. Ed, thank you for inviting me. Tricia,

thank you for inviting me as well, and I'm glad to be here and see you all here on this important topic. We've heard quite a good description, I think, of the number of the proposals that are out there, and there are even more variations on these themes, so I wanted to talk generally, and then dive down into some specifics about what these proposals' impact would be on Medicare beneficiary. You've heard some of that.

I think we start, for our purposes at least, in our work in representing beneficiaries, and many of you are doing that work as well, really with a couple large points. One is we should not be looking at this as a way to shift cost to beneficiaries. If you see CBO scores, if you see scores on various, you know, Bowles and Simpson, et cetera, basically what you are seeing there is savings to the federal government because costs that have been borne by the federal government or the risks of those costs are being shifted either to consumers directly, to employers who will be picking up a tab, or to other insurance products down the line and off of the states, for example, for the Medicaid program.

We really do not think that that shifting should be occurring. If it is occurring, that's what we should be calling it. Language is important, as we all know. When we're talking about streamlining the Medicare benefit or redesigning the Medicare benefit, we look underneath that. Is that really

shifting costs out of the federal government ledger onto somebody else's ledger, and particularly we're concerned about shifting costs to consumers.

We've really got to be conscious of the winners and losers here. It's hard to do this, and we're not saying let's not simplify the Medicare program, let's not restructure it in some way that will make it better for beneficiaries, better for providers, better for us all, but we've got to be conscious of the winners and losers, and a lot of discussion up here about that in Kaiser has done a great job of kind of parsing that with the different proposals, but the other thing I think we really need to consider is what the context that we're dealing with here, and that context is really widespread economic insecurity amongst people with Medicare, both the disabled and 65 and older, and I wanted to spend some time on that, and this is very familiar to Juliette and Tricia because their work here has been key, I think, in teaching us about who people with Medicare are.

Half of people with Medicare live on incomes of less than $22,500 a year. That's always a good cocktail moment when you mention that. People's eyebrows raise quite frequently. They also have less than $77,500 in the bank in savings, and to some that sounds like a nice little nest egg. It doesn't sound like a nice little nest egg when you realize they have to pay

full freight for dental coverage, long-term care, the roof needs fixing, et cetera. As we all know things that hit us hit older people, and they have less elasticity in income and savings.

Medicare households are already spending an average of 15-percent of their income on health care costs, and actually a lot of that is premiums. They're already paying premiums for their health care. About 46-percent of their premiums are involved in that, and it's only five-percent for us non Medicare folks, and premiums are rising. 26-percent of the average social security benefit is now spent on premiums as opposed to about seven-percent in 1980. So when you hear people with Medicare need more skin in the game, they've got a lot of skin in there already, and I'm worried that the next piece of skin might be the scalp. So we've got to be very, very careful when we're looking about these redesign, streamlining, or other proposals.

The common proposals we've kind of run through in various forms, and they have these components to it, doing a consolidated deductible, taking that thousand plus deductible for part A and the $147 deductible for part B and aligning it around the 550 mark. Well, as we've heard, because most people only use doctor services in a year, that is effectively an increase in the deductible for most folks.

Uniform coinsurance, once again, and this is where winners and losers come in. If you provide uniform coinsurance across the board, you're going to have some folks that need services and are vulnerable and particular poor, lower income folks, lower middle income folks that are going to have, in effect, an increase in their health care costs that may prevent them from accessing that care.

Varying coinsurance and copayments, and this could be value based care, once again, taking a look at can we provide incentives for folks both informational, which I would say is just as important, but also economic incentives to drive them towards high value either care or providers. I mean, that is something that can be experimented with.

Adding a catastrophic cap, 5,000, 5,300 in that range, 5,500 is bandied about a lot, talk a little bit about Commonwealth's part E proposal or Medicare extra proposal, which would actually set that out-of-pocket deductible about $3,000, which seems, from a beneficiary perspective, to be about the right place. That's the balance there. It doesn't necessarily save money for the federal government, but it helps a higher proportion of people with Medicare.

Income relating premiums, deductibles or caps, once again, it's a slippery slope. We already do it. We do it, as you know, for part B and part D already. So now we're moving

that line, and some of the proposals would bring that income at which you're paying a higher premium into the 40, 45, $50,000 range over time. Once again, maybe that's what we want to do, but how does that not inch its way down, and also administratively, are we creating a lot of administrative headaches for ourselves in doing that, and is it really worth the savings as it were?

The first dollar supplemental coverage and prohibiting that or surcharging that, people buy it because they want it. The most important thing that we hear time and time again on our helpline for seniors is I need to know what I'm going to spend in a year on my health care when I buy that Medigap plan C or I buy that Medicare plan F. I hate paying those premiums, but I know what my health care bill is going to be for this year. That level of security is something that seniors value very much.

I think the bottom line is in all of these proposals where you're seeing savings, you're seeing shifts to consumers, and I would think the underlying piece of it is this is important because a lot of these proposals not only do you say, for example, get a higher deductible so people are paying out-of-pocket. You're also reducing utilization as Sheila and others were saying, and certainly we need to be concerned about utilization, but the real driver in our health care system

overall of our spiraling costs are those costs, are prices, and anything that doesn't get at delivery system reform or cost or price reform but simply twiddles with the design to push costs onto consumer without at the same time – and bipartisan does have Medicare networks and kind of expansion of ACOs. That might be something to do at the same time. Once again, if you're just pushing costs onto consumers and you're expecting them to self-ration care, they're in the least able position to do that, and that's really this reduces both needed and unneeded care. Guess what? Increasing costs to consumers works. They will self-ration. The problem is they don't know what they're not getting is needed or unneeded. They rely on their doctor on that, and once they're with a doctor, once they're in the medical system, once they're being treated by a physician, it's usually that provider that's driving utilization, not them. They're going to do whatever that doctor says, no matter how much they've got to spend. If they've got to mortgage the house, they'll do it.

I just want to talk really quickly about, I think, the Bipartisan Policy Center has some great ideas about increasing protections for low income individuals. Yeah, give a shout out there. [Laughter.] I think we really do need to talk in any of these proposals about what we're going to do for lower income beneficiaries and not only just make a program but make

sure people get in it. Woefully inadequate enrollment and extra help in our QMB, SLMB Medicare savings programs, and finally, part E, this Medicare essential, Medicare extra where we're combining in a public program A, B, and D, financed through beneficiary premiums, preserves beneficiary choice. You get all that simplification without once again shifting costs to consumers. They are paying a higher premium for that, but they don't need a Medigap plan.

I think these are the ways that we can talk about simplifying without shifting costs. That is our main goal in this discussion. It's unfortunate it happens in a deficit reduction environment, and that's what we need to really be careful as we talk about these proposals. Thank you.

ED HOWARD: Great. Thanks very much, Joe. Leave that slide up there for a second. For those of you who are watching on C-SPAN, if you are a low income beneficiary and enrolled in Medicare, take note of that first item in the first bullet. That is the Medicare savings programs and extra help that Joe was talking about. Find out if it applies to you. You might be able to get some help, not only with paying your part B premium but also with paying the deductible, paying the 20-percent part B copayment as well, or you might know somebody who could benefit from that, and there are a lot of folks who are eligible, as Joe pointed out, who are not enrolled in those

programs. So take advantage of what's already there while we're talking about what might be coming down the road.

Let me then turn to our final speaker, Frank McArdle, who I guess if you were writing a commercial you would say he knows benefits. [Laughter.] Before he hung out his own shingle, if you will, Frank held senior positions at Aon Hewitt, one of the country's most renowned benefits firms, at the Employee Benefit Research Institute, at the Senate Aging Committee not far from these hallowed halls, and the Social Security Administration, and we've asked him to share his insight today into how these proposals for Medicare would affect both retirees with health benefits and the firms that provide them.

So, Frank, thanks very much for being with us.

FRANK MCARDLE: Thank you, Ed, and good afternoon, everyone. As you heard each of the other speakers mention, supplemental coverage is a key ingredient in all of the proposals that are being talked about today and around Washington because retiree health plans are a very important source of supplemental coverage for about 30-percent of Medicare beneficiaries, but I have to tell you that these programs are at a fragile juncture after more than two decades of relentless cost pressures and design changes in response to that, and now even more change is on the horizon. I think it's

fair to say that when policy changes are made, the employers will tell you, who sponsor retiree health benefits, nine out of ten of them will tell you that it's very important for them to understand the potential changes that are being discussed today and generally around Washington.

By way of background, we've also heard the supplemental coverage kind of lumped together, employer coverage and Medigap, but, in fact, the two are very different. Just two differences, one, Medigap, as you know, is standardized. Retiree health plans are far from standardized, so it's harder to know what any particular policy change, how it's going to impact the many variations of policies that are out there.

The second thing, and this affects the idea of a surcharge, is that retiree health plans typically do not provide first dollar coverage. Decades ago they did, but over the past two decades that has largely disappeared, though not completely. So when you're talking about a surcharge in relationship to an assumed increase in Medicare utilization, I would argue that the two programs are very different.

Juliette did a great job of indicating some of the cost repercussions, and I want to just hit on a couple of her points, but in general if the employer plan, the retiree health plan, or the union plan is continuing to cover Medicare covered services the way it did before and now Medicare is going to pay

a smaller share of those services, the plan is going to pick up the costs. Now, Juliette gave one example where the cost increase in 2013 would be about 1.2 billion. That's total costs increases for employers and retirees combined, but if you set the spending limit at 7500 instead of 5500, their analysis shows the cost would be three times higher at 3.8 billion, or if you set it lower at $4,000, employer plans could theoretically save about a billion dollars, although I would say that the law could be engineered to keep that from happening by the way you regulate what counts toward the Medicare spending limit.

So you have these cost repercussions, and how are they going to be felt? Well, it's going to vary a lot depending on the design of the plan, what the Medicare proposal is and the level and form of the employer contribution. So I'm going to give you three different examples. In one, let's assume it is an older, more generous plan where the employer is paying for most of the cost or the union plan is paying for most of the cost. That increase would be fully and immediately borne by the employer and the union in this example.

The company or the public employer, if that's the sponsor, would immediately have to account on their financial statements for the Medicare law change. Immediately they have to account for that increase. What's the incentive there? For

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the employer, it's to look at raising premiums, cutting back the benefit design or maybe even eliminating the plan, that is if they have the legal flexibility to do those things. Most private sector plans have that flexibility but not all do. There are collectively bargained plans where there is not that flexibility, and there may be public plans where the benefits are protected by the state constitution, for example.

Let's take a second example, a non-collectively bargained plan, but here, as is common, the employer has a cap on the amount the employer will contribute toward the retiree health plan. So now the change, let's assume the CBO change that Juliette outlined comes along, and you have that cost increase. Well, the employer's cost increase is going to be limited by the amount of the cap, and so gradually over time the retiree is going to bear more and more of that increased cost in the form of higher premiums.

Finally I want to give you a third example, and this is a common example, which I'll call an access-only plan where the plan is made available to retirees, but the retirees pay 100-percent of the cost. Again, assume a change like the CBO option. There the retirees immediately feel the impact of that premium increase. So what would they do? Well, if I were one of them and I had an alternative coverage option to pursue, I would do that, adding adverse selection to what is already a

high cost option because of adverse selection that's been going on. So you could predict these access-only plans would be unraveling as these changes come about, and then finally I mentioned a minute ago just in passing and I can elaborate in the Q and A that you could engineer a lower spending limit and still not save employers money if you don't count toward the beneficiary's spending limit under Medicare the amounts that the employer or the union plan pays. So if you do that and I'm a retiree, I may ask myself, well, gee, why should I continue paying a premium? Before I only had an out-of-pocket limit under the employer plan, but now I can get it under Medicare. Why do I need to keep paying that premium, or if I'm the employer I say, you know, this is one more reason why maybe it doesn't make sense for me to offer retiree health plans. We now have good drug coverage. We have good other coverage under Medicare. They now have a new spending limit. I could save a lot of money if I eliminate this plan. I could save a lot of money even if I give a portion of that savings to the retirees to use for their Medicare premiums or for some other purpose.

So I think adding the spending limit diminishes the value of the employer plan. I think employers probably would only be more inclined to keep it if the spending limit under Medicare was so high that they felt that their retiree population was not protected by it. So there's potentially a

lot of disruption in the wake of a very well intended set of cost sharing changes. I think some of that could be mitigated. Obviously if the changes were applied to future retirees and you grandfather or protect existing retirees, but there's a tradeoff.

If you want to avoid disruption, you're not going to realize the same level of savings in the budget window, and if the changes are instead applied to all current retirees, then I think it would be important for lawmakers to consider ways, at least a transition benefit or a transition arrangement where you guarantee access without underwriting so that, if a retiree, for example, has to switch from an access-only employer plan, to an individual Medigap plan, that they have that option without being penalized for their health status, and finally I just want to come back to some things that Joe said because this concept of having skin in the game, which was one of the reasons given for changes in cost sharing, which was not on Tricia's slide, but that concept of skin in the game actually developed in the private sector in the 1990s, and it developed with respect to active employees, and we all know that that design and concept has expanded, but I think it's very different when you're trying to apply that to a retiree population because of the volatility that they face for their health care spending, not only direct health care spending but

also other health related support services that are not covered by Medicare or by supplemental coverage, and even with Medicare covered services there are estimates that a couple at age 65 would need to have squirreled away around $200,000 in order to pay for their lifetime retiree health costs just for Medicare covered services.

I think we also need to remember that there's volatility for retirees on the income side, and it's a downward volatility. Obviously a lot of retirees may be spending down their assets, but increasingly a lot of retirees are getting their benefits, not maybe the federal employees but in the private sector, getting their benefits from defined contribution plans where the account balance, the money that they have available to them varies with the market, with the asset allocation, and so those kinds of fluctuations in income compound the concern about volatility that Joe was talking about and the need to have some more security.

So I guess I would close by saying if supplemental coverage and particularly retiree health benefits are to be changed directly or indirectly for the purpose of Medicare cost sharing, the preferred approach in my opinion would be to try and find ways that would not add further volatility to what is already a kind of risky business for retirees and their health care. Thank you.

ED HOWARD: Great. Thank you, Frank. Thanks very much. Thank you to all the panelists, and now we get to the segment of the program where you get a chance to join the conversation. As I've mentioned there are green question cards that you can use to query one or all of the panelists, and there are microphones at either side of the room. The one on my right is way on the other side of the room, so you'll have to strike out early to get to it, and I'm pleased to recognize as our first question or commenter someone I need to identify not only as the president of the National Coalition on Health Care but also a member of the board of directors of the Alliance for Health Reform, and I'm talking about John Rother, who is also no stranger to these senate hallways. John?

JOHN ROTHER: Thank you, Ed. I want to start by thanking the Alliance and Kaiser for an excellent, excellent discussion. This is a tough area. This is not a simple area, and I personally have a lot of sympathy for the effort to deal with the fragmentation of Medicare. It does not make sense. No one would design that program today. However, I'm going to make two kinds of comments. One is on messages from focus groups that I've reviewed over the past two years trying to test out some of these ideas with seniors, and I think it's fair to say that the idea of a deductible that comes every January after you've just spent Christmas with your grandkids

is a non-starter. There's simply no way to sell that to retirees.

Now, I do think that retirees understand that maybe there should be some cost sharing at the point of service, but the deductible is just an impossible sell is what I can report. Now, I'm not saying it's bad policy. I'm just saying that a flat, across the board approach is a very difficult one to convince seniors that works, so I'm much more interested in the kind of variable benefit that Sheila reported on from the Bipartisan Policy Center, particularly something that's keyed to the value of the benefit design, and I applaud the idea of exempting physician office visits, but here again from the focus groups most seniors don't decide to go to the hospital. That's not a voluntary decision for most people, and so they don't really get why they should be charged for something that's somebody else's decision not theirs.

So I think this becomes quite difficult, and particularly when we obviously need to save money in the program, so I have an alternative approach to suggest, which is I think not just seniors but all of us need to be more engaged in decisions around the care we receive, and people need the tools to become engaged, and particularly seniors because they're the most active utilizers. Most seniors have no idea how to compare one procedure with another, one doctor with

another, one hospital with another, and we all know that prices and quality vary, sometimes quite substantially, so we need transparency in the system so that people can understand that there are consequences to these decisions and that they have choices that have a real impact, and, secondly, much of the effort to change behavior by seniors I think should not be so much economic as guidance.

People need guidance, and the best place I think would be the patient centered medical home where there's a care team that knows the whole situation and can counsel people as to how to appropriately utilize the system. So I'm just arguing for a broader approach. We do need to simplify Medicare. We do need to think about what the proper role is of cost sharing, but that's not the only tool we have, and, in fact, I think seniors would be much more open if we provided some additional tools to help them be better patients. Thank you.

ED HOWARD: Thank you, John. Anyone want to chime in on any part of that?

JOE BAKER: I will.

ED HOWARD: Joe?

JOE BAKER: I think certainly our work with seniors and people with disabilities on Medicare bears out that they do need more information, and they want more transparency in the health system and that the complexity that they see in the

health system isn't always or frequently isn't the actual Medicare benefit or benefit structure but rather the structure of the health care delivery system. So I think the idea of the patient centered medical home, the ACO structure, some of these yet to be proved, but on their way and certainly scaling up. I think they are the kinds of things and the kind of experiments that we need to be doing in the Medicare program in order to give seniors and people with disabilities in Medicare that kind of place, that home base, and that information agent because I think a lot of consumers now are looking to their providers for this kind of information.

What I think will be interesting over the course of the next few years, doctors and providers have been typically seen as kind of white hats. It's like the insurers versus the providers. You've got a coming together of insurers and providers and a mix of payer and provider now, so maybe the hats are getting a little grayer. I don't know, but consumers need to know that, and they need to see that, and that instruction needs to be transparent, and they may need other assistance in navigating that, but certainly, I think, that can help with the utilization issues that we've discussed and also in making sure that folks are getting the highest value and highest quality care, but we've got a long way to go, and there are always going to be, I think, a large proportion of seniors,

particularly folks over 80, over 85 that are going to need a lot of assistance in navigating whatever system we come up with. They're not going to be their own information agents in many instances.

ED HOWARD: Okay. Yes, go ahead.

BARBARA KORNBLAU: Barbara Kornblau, the Coalition for Disability Healthy Equity, and the Fibromyalgia and Chronic Pain Association. I'm concerned because you are talking about disabilities and seniors in the same breath, but people with disabilities who retire on disability are not eligible for Medigap insurance, and there are people who are dual eligible with a $500 deductible a month before Medicare picks up, sometimes higher than that. So in doing these studies, is anyone taking that into consideration because most of these people are very low income but not low enough to be covered for everything and don't have the options. They're paying dollar one and dollar two because they're no Medigap. So are the studies taking that into consideration?

ED HOWARD: Sheila?

SHEILA BURKE: I'll defer to Tricia and Juliette in terms of the work that they've done, but I think you raise an extraordinarily important point, and that is that we often confuse or at least fail to recognize that there are real differences in that population who are serviced by the Medicare

program. A full array of issues in terms of impairments, those that present because of age, those that present because of disability, and the attention both to the mix of services as well as the financing of those services is one that has not gotten the kind of discussion or attention that it should have.

The issues with respect to the very low income, people that are duals, people that come in because they're QMBs or SLMBs, even the complexity of that program and the method by which you qualify and the benefits that are available to you depending upon the basis of your qualification complicate a complicated question, and so your point is right. We haven't paid close enough attention to it, and as we look at restructuring and look at what the protections might be, that is clearly a population we need to spend more time on, but I'll turn to Juliette in terms of the kind of work that form the basis of some of their research as well.

JULIETTE CUBANSKI: Well, I think Sheila answered your question perfectly. Our studies don't actually address beneficiaries with disabilities separate from the traditional population overall. I think you raise an important question aside from these proposals to restructure Medicare cost sharing and change the rules of supplemental coverage specifically with regard to Medigap. Looking more specifically at how the Medigap rules are different for people with disabilities than

they are for people age 65 and over on Medicare is an issue that our studies don't address but is certainly an issue that's worthy of policymakers' attention.

BARBARA KORNBLAU: It's kind of like if you want to find out what's going to happen to seniors if you change Medigap, you can just look at the disability population since they don't have Medigap. Thank you.

SHEILA BURKE: Joe actually raises an additional point that I would raise, and that is I think there's increasing interest in looking at how the states are dealing with some of these issues because of the unique nature of some of the state programs, whether it's New York and others, and so in looking at sort of these solutions and looking at those unique populations I think we would benefit from understanding whether states have stepped in and tried to address some of these issues.

JOE BAKER: Some states do have open enrollment in their Medigap plans for people with disabilities.

SHEILA BURKE: Right.

JOE BAKER: So that's a piece, and there is, you're right, no federal open enrollment. I think the second thing is we're hoping with the coming of the ACA exchanges and certainly in Medicare Rights Center and we've worked with a lot of other groups nationally to try to make sure as Medicaid programs are

streamlined both eligibility and enrollment processes that the programs like QMB, SLMB, other programs that help low income folks are also part of that streamlining inserted into that exchange, which is hopefully the brand spanking new computer system, you know, New York and other states are revising and updating these systems that have been around since welfare, and so hopefully it's a new front door for a lot of these programs, but you're absolutely right. It's not consistent nationwide, and it's not going to be any time soon, so when we're looking at these federal proposals to really streamline or improve Medicare, we've got to make sure that it's there for people that are disabled and under 65 as well.

TRICIA NEUMAN: Now, this is one for Frank. Frank, you talked about the effects of benefit design of different employer plans, but you also mentioned a surcharge. Can you talk a little bit about how employers might respond to a surcharge or what that might mean for retirees, and are there differences between employer plans and Medigap because some of the proposals would have a surcharge on both?

FRANK MCARDLE: Yeah, I think that's a great question, and one thing about it is the surcharge as a concept sounds really easy, doesn't it? We'll just add a fee, and then we'll have this effect, but then when you start to get beneath that idea, it gets really messy in my opinion. For example, what

triggers the surcharge? Is it any kind of supplemental plan? Well, that wouldn't make a lot of sense because you could have high deductible supplemental plans that don't have big Medicare utilization effects, but would it be only first dollar plans? Well, how do you define what a first dollar plan is? So just the regulatory mechanism to try and differentiate among different kinds of supplemental plans for purposes of a surcharge I think is scary, but beyond that I think if you try and have a uniform surcharge on all plans, you really don't have a policy justification for that if the idea is Medicare utilization.

The other question is on whom is this surcharge going to fall? There's one idea which is you put an excise tax on the plan, but there's already an excise tax on high cost plans that's built in to the Affordable Care Act that takes effect in 2018, and it will start. Employers are already looking at how they will change their retiree health designs to live within that cap. So now we're going to have two excise taxes, and I don't know how they would correlate. If it falls on the employer, well, you can imagine what the effect would be. The employer's not looking for an added cost increase, so the reaction I think would be pretty significant, and then if it's sort of something where you add on to the retiree's Medicare premium, their part B premium, to me that's another level of

complexity that makes my head spin because now you have somehow the employer or somebody has got to give a value of what that retiree health coverage is, I would guess, and we know that employers are not happy about having to report these values. They're quite burdensome, and then you can have life changing events that would affect the determination of what that surcharge would be, or would it be a tax on the retiree and subject to the income tax rules?

So I think, as I said at the beginning, once you get beyond the idea of, gee, a surcharge is easy, and we just impose a fee, it becomes so complicated that I think that from the standpoint of retiree health plans I just see a lot of problems with it. There's kind of a backdoor way of avoiding a surcharge, and I think maybe it's embedded in some of the proposals you've heard discussed here, which is to say, okay, we won't have a surcharge, but we're going to stipulate what the design would be of the retiree health plan, and if you do that and certainly Congress could do that, but it would be a very significant departure from all the history that we've had where these are voluntary benefits negotiated by labor and management or just offered by the employer, and these designs have evolved, and they're very different for different sectors of the economy, and suddenly if you're going to have a federal definition of what those plans have to look like, you could do

it, but in terms of the impact, it would be a very big, big difference from what we're used to.

ED HOWARD: We've got a related question, Frank, and I don't know whether you're the person who wants to take this on or some of our other panelists. The questioner writes both the first and second presenters actually stated the first dollar Medigap coverage drives up utilization. Please describe what, if any, research has examined the competing hypothesis that high user beneficiaries, i.e. sick people, self select into first dollar coverage, and that's what causes the utilization rates for Medigap policies to be higher, or are those the same thing?

JULIETTE CUBANSKI: No, I think those are sort of the two competing arguments. I think the questioner sort of answered his or her own question. There is research that suggests, MedPAC has summarized this in a report, that there is higher Medicare spending, higher utilization among people with Medigap policies, but then on the other hand there is this belief, and I think there is some research to suggest that people who are sicker are purchasing Medigap policies because it does provide them with sort of a piece of mind and the protection from the Medicare cost sharing requirements that would otherwise be relatively burdensome if you have relatively high medical needs. So I think there is then this question of

well, if you impose these restrictions on Medigap supplemental coverage, are you penalizing people just because they're sick? Are you penalizing them? Are you making it harder for them to get assistance with the Medicare cost sharing that they would otherwise be unable to afford but they're willing to pay the Medigap premium in order to get the financial protection, and most people with Medigap policies have the relatively more generous first dollar policies as opposed to some of the other Medigap plan designs that we've seen lately that don't pick up as much of the Medicare cost sharing liabilities.

So I think this is the tension that we face, and it's certainly one that would need to be reconciled with if policymakers were to move forward with this type of option.

TRICIA NEUMAN: This is a related question. Do any of the proposals that have protections that cost sharing increases wouldn't result in people not getting necessary care? In other words are there safeguards that are included in these proposals that would make sure that the cost sharing works to prevent unnecessary care but doesn't impede somebody from getting necessary care?

SHEILA BURKE: You know, I think the proposals are confronted with the same issues that we're confronting in the current program, which is there have always been concerns as to whether or not even with the existing cost structure there are

people who delay or avoid care because of the costs that are going to be incurred. I mean, a lot of the support programs QMBs, SLMBs, and others were developed, in fact, to address the concern that particularly those with low incomes didn't have the capacity to essentially finance that first step.

I think in the construct of the Bipartisan Policy Center proposal we at least acknowledged that in the context of having the physician visit excluded from the deductible so that you don't have to essentially meet the deductible of 500 plus dollars when you walk in the door you have essentially a fixed co-pay for your visit to the doctor, again recognizing that the majority of Medicare beneficiaries, in fact, utilize part B service. A relatively small percentage utilize part A, but, again, there was attention to that question and also the addition of protection for those between a hundred and 150-percent of the poverty line, who currently don't benefit from a federal support in terms of cost sharing exposure.

So, again, I think this is a problem that we've always confronted. It's a question of whether or not any kind of requirement essentially delays or prevents someone from securing care. Commonwealth and others have done work on this question. It comes down to the fundamental question as to the presence of insurance, what difference does that make and the acknowledgement and in the absence of insurance, in fact,

people delay. The same issue has arisen with respect to cost sharing.

I think it's a problem we confront now with the existing program, and it will be a problem we confront going forward in terms of how we restructure what that benefit looks like. I mean, to John Rother's point earlier, people now face this absurd part A cost on an episode basis, which is this bizarre construct of a 60-day. You know, you essentially pay it if you're hospitalized, and then you don't pay it if you're within that 60 days, but then you pay it again in another 60 days. So, I mean, people are confronting cost sharing problems today. Many of them have protection, financial security in the purchase of coverage, or it's available because of their union or because of their retirement plan, or because of Medicaid, but, again, this is not a problem that's new to us. It's a problem we continue to struggle with, which is what the balance is.

JOE BAKER: I think that's right. I mean, I think some of them don't try to mediate between that at all. They're just simply shifting costs right on to consumers, and there's a nice savings number at the end of them. I think the Commonwealth part E proposal probably gets the closest and friendliest from the beneficiary's perspective with a lot of the elements that Sheila has talked about, and I think also as we know from the

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Commonwealth work many other countries with national health systems have first dollar coverage and use other mechanisms to calibrate or provide disincentives for unnecessary care, mostly through provider payments or in control and provider budgets and provider directives. You know, it's a much more directive health system in that regard.

TRICIA NEUMAN: Joe, there are two cards I can coordinate at the same time because you've mentioned part E, and I think a lot of people in the room have not heard of part E, so can you describe what is part E? How does it differ from Medicare Advantage?

JOE BAKER: Sure.

TRICIA NEUMAN: What's Medicare essential? You mentioned that earlier?

JOE BAKER: Well, part E and Medicare essential, and unfortunately I'm not the expert on this. I really do refer you to the Commonwealth slides and report on this, and there's a bit of a change in the proposal recently, but basically what it is, is taking parts A, B, and D and combining them in a public government run program. So you would say that sounds like Medicare Advantage. That sounds like Medicare HMO, and yes, but those are run as we know by private insurance companies under contract with the federal government. This would actually be a federal program. The piece here of course

would be that for the first time you would have a public part D plan. Right now, as you know, part D, prescription drug coverage, is supplied only through private health insurance companies.

So it would be bringing those three things together. A lot of folks are in the Medicare Advantage program. One of the reasons they're in the Medicare Advantage program with these private plans is because they like the simplicity of having all of those benefits kind of merge together. A lot of the streamlining that we're talking about that would occur in the government program occurs in Medicare Advantage plans. They like that. They don't like the limited network of doctors, or they don't like some of the care management or medical management that occurs in Medicare Advantage. They don't like some of the geographic limitations, but they like that simplification, if you will, and the kind of one stop shop. You don't need a Medigap plan.

So this would basically, part E or Medicare essential, would combine parts A, part B, part D, and you would not need a Medigap plan. There would be higher premiums. So it wouldn't be the same premium structure for all of that because you would be getting supplemental coverage. I think one of the components, for example, there would continue to be coinsurance for part B, I think ten-percent coinsurance. So we didn't go

through it in detail in our slides. It's not talked about a lot on the hill as like a viable proposal because even though it has a significant savings associated with it for a variety of components, about 183 billion I think over ten years, it's seen as we're going to put all this under the government, including part D, and a lot of folks like the part D program over here on the private side, but it is a way of getting to this simplification, this streamlining, and saving money at the same time, given the components there.

ED HOWARD: And just a small commercial, a few weeks ago we actually did a briefing. Some of you were there, I believe, featured a presentation by the former CEO of the Commonwealth Fund, Karen Davis, about proposals like Medicare essential that would revamp the benefit structure as well. So you find a lot of both complimentary and critical information about and related to that plan at that briefing on our website.

JOE BAKER: Yeah, I recommend that highly as well, and I also say that in Medicare essential, at least, there is a lot of delivery system reform as well. So the patients that are in medical home, ACO, that model is relied upon as well to achieve some of the savings. So I think again it's looking at redesign of the benefit but also redesign of the health care delivery system because that is essential to kind of get at the underlying problems.

ED HOWARD: Yes, go right ahead.

KAREN DOMINO: Hi, I had a question for the panel about the unintended consequences of the income related premiums. Particularly if you increase the level of value going down in terms of where these premiums would actually affect people, and what would be the effect if you see people not taking Medicare? I mean, people, for instance, going out and attempting to buy insurance in a wider scale and through the exchanges possibly, perhaps in the state of New York where the costs have come down, and what kind of things would this do to the Medicare program and the other beneficiaries who are poorer?

ED HOWARD: Did I ask you to identify yourself?

KAREN DOMINO: I'm Karen Domino. I'm a Robert Wood Johnson Health Policy fellow.

SHEILA BURKE: Karen, I don't think we know the answer to your question for a number of reasons. The presumption has always been and our experience has always been that Medicare has been positively viewed as compared to private insurance for this population as much more accessible, much more affordable. Part A is required. I mean, it occurs. Part B is voluntary, and of course, D is as well, and so our experience has been that when one looks towards turning 65 or one is disabled that Medicare is an inevitability and viewed as a positive one because historically people weren't able to purchase in the

market anything nearly as fulsome for the price that essentially they pay for the Medicare program because it's trust fund financed under A and a combination of general revenues and supplemental trust fund on B.

Compared to what you'd buy in the private market, it was always viewed as a value. Now, what will occur in the new world order in terms of what might be available in an exchange structure? One might imagine that given the role of the private sector largely in the individual small group and large group market that is employment based or an individual market as compared to sort of the financing of the elderly as a population, which hasn't occurred since 65, again, you'd have to look at are the benefits comparable? Is there security there? What does the benefit structure look like in terms of what the premiums going to be? I don't think we know the answer.

In terms of the changes on the income side, which was something that was introduced obviously after 65 as relatively recent, again, it's relatively higher income to the point that was made earlier. The large majority of these beneficiaries are at 22,000 or less. The income targets that are viewed at least in the BPC proposal are at 60,000 for an individual, down from 85, and then a hundred plus for a couple. So, again, it's not targeted at very low income individuals who make up the

bulk of the Medicare program or people who are very low income who are duals, the eight or nine million people who are in the duals, because of their income or their status.

So, again, I don't think we know the answer. I mean, it's a reasonable question to ask, but I think there are a whole host of reasons why Medicare, not the least of which is the structure of the trust funds, would continue to be a benefit and viewed more positively and what the benefit structure looks like, but, again, it's a question that will come up. We're looking at a whole host of proposals on restructuring the way we think about Medicare, whether it's ACOs, medical homes, you know, looking across the full continuum of care, which we've not done a very good job of. We tend to focus on the acute side, but there is this post acute side, which are beginning to focus on as well. I think it's an interesting question but certainly not one that I know the answer to.

JOE BAKER: I think that you're right. The crystal ball is kind of cloudy on what the coming exchanges will do and whether wealthier individuals will keep that coverage post 65, which they could do. The subsidies run out at age 65. You can't get subsidies for coverage after 65, but wealthier people, you know, above 400-percent, would not qualify for those anyway. I think the second piece is my problem with

income relating premiums is this slippery slope idea. So some do go down to 40,000, and three years from now when we haven't controlled cost through other delivery system reforms, are we – you're 26.5. You're a wealthier Medicare beneficiary. You're going to pay more, and then it does strike me as we're setting the limit for wealthy or higher income at 60,000 or whatever, even 87, or now 85,000 when on our tax structure we're setting it at 250 or 400. No one is saying, hey, yeah. Let's raise taxes on those rich $65,000 folks, you know?

So why we're looking to people with Medicare as wealthy and higher income at 60 plus in income, that strikes me as a bit ironic to say the least, but my main problem with it, it doesn't really solve. It gets you money. It doesn't really get you a lot of money, but it gets you some money, but at the end of the day it doesn't solve the underlying problem, which is health care costs, and there's a lot of other proposals that get there that I think we should be doing before we just kind of up the bill for people with 60 or more thousand dollars a year.

FRANK MCARDLE: Can I? Yeah, I just wanted to add that I think people don't realize that when the Medicare premium is related to income that it's based on modified adjusted gross income and not your taxable income, and that can be a very big difference. For example, a retiree, when they turn age 70 and

a half, the following year they have to start taking distributions from their retirement plans. A lot of retirees don't get that rule quite right and end up taking two years worth of distributions from their plans, and so suddenly their income is juiced up a lot, but it's not taking into account, well, what if I have a spouse who needs in-home care that I have to pay for 24/7? There's no correlation between those two because it's not looking at taxable income, and same thing as if a retiree sells their house and then suddenly they have a bump up in income, and now they have to pay a higher Medicare premium because they saved all their lives, paid down their mortgage, and now they sell their house.

I mean, I think there can be a lot of inequities in applying that, and it's not just getting higher income people. It's people who fall into income situations with a certain degree of variability.

ED HOWARD: We have a bunch of questions related to income, I guess related to income relatedness. One of them is very quickly responded to if I can ask some of our panelists to respond. For the analyses that have been cited, the 50-percent and Sheila just mentioned this again, 50-percent of Medicare beneficiaries have incomes of 22,500 or less. Do the income figures include social security benefits and pensions?

TRICIA NEUMAN: Yes.

ED HOWARD: There you go. I knew that was easy.

TRICIA NEUMAN: Next?

ED HOWARD: Okay, very efficient.

TRICIA NEUMAN: I have a question on this income related issue. Some of the proposals have an income related out-of-pocket limit, and the idea there is let's give greater protection for lower income people but not so much for higher income people as a way of conserving federal dollars and resources. This would be really new for Medicare in income relating a benefit, not just for those with low incomes. I have questions about how this works for employers. I have questions. I don't know if, Sheila, you've thought about how Medicare would administer something like this? What's it mean for beneficiaries? Does anybody on the panel want to speak to what it might mean to have an income related limit because I know it sounds appealing to people who are trying to provide greater protections to those with modest incomes.

So anybody want to jump in on that one?

ED HOWARD: Good question.

JULIETTE CUBANSKI: Well, I guess so there is this question about income relating the out-of-pocket spending limit. There are also proposals that have suggested income relating other features such as the deductible, modifying the cost sharing amounts depending on a beneficiary's income. I

think there are several questions from an administrative standpoint in terms of, well, just sort of backing up a little bit, you know, we've referenced the income related premium. So there are already aspects of Medicare that are income related. So people with incomes above $85,000 a year as an individual, people with incomes above $170,000 a year as a married couple pay higher monthly premiums for part B and for part D plans if they're enrolled.

So there is a mechanism in place currently for Medicare to know a beneficiary's income, and that's administered through SSA. They know how much Medicare beneficiaries are making if they're paying these higher income premiums, but it's very different when it comes down to income relating lots of other features of the benefit in terms of does your deductible drop from 500 to 400 or 300 depending on which income bucket you fall in, and how do you report that to Medicare? Is it based on MAGI? Is it based on your taxable income? What if Medicare thinks you have more income than you actually do? Is there a process for you to appeal so that you get placed into a lower cost sharing category? There are, I think, a host of questions, and then it raises a set of privacy concerns for some people who may be worried that if they are paying a lower copayment, they're benefitting from this income related provision, but then the doctor might know how much their income

is or at least what income category they fall into, and I think that raises real privacy concerns for some people.

So I think this proposal, again, it looks good on paper, and it seems like a great idea, and it certainly is a way of making it less painful, less onerous, less burdensome for some lower income people than the average Medicare beneficiary, but I think it also raises concerns that haven't yet been fully thought through in terms of the administrative complexities of making it work.

FRANK MCARDLE: Well, from a retiree health plan perspective there's no way that the employer is going to know what the retiree's income is going to be. So basically the administration of this would all have to occur outside of the employer plan, and some administrative entity would then have to communicate it, but in addition typically the organizations that sponsor retiree health plans are large corporations which often offer, you know, defined benefit or defined contribution retirement plans as well. So they would be higher income on average than the average beneficiary, or it may be state government employees who have good benefits and good pensions that go along with it, so they might be more likely to be impacted, and in a way the retiree plan, if you think about this, is in a sort of passive situation, which is Social Security will determine. I presume it would be Social

Security, although they are very overburdened now with administrative duties with the growing baby boom generation. So Social Security would be administering this, and it would be sort of an unknown, and so functionally for everybody who's higher income and the out-of-pocket limit is higher, it's like that example in Juliette's study and Tricia's study where the spending limit goes up to 7500, so in effect it's increasing the cost of the plan for everybody who has got that additional income out-of-pocket boost.

So I think that would be hard for employers to know. I think they want more certainty about their costs and what their costs are going to look like. So I could see that adding another complication, and then finally there is the same thoughts I expressed about income variability with respect to the premium I think would also be applicable here to the out-of-pocket limit with sudden changes in income suddenly putting the out-of-pocket limit up when there may be other reasons that wouldn't necessarily justify that from a tax equity standpoint.

JOE BAKER: I think everybody has said the plusses and minuses of this. I think it comes back to, once again, you're trying to simplify the benefit, and you're making it more complicated at the same time, and the motivation is certainly good when we're looking at more vulnerable, poorer folks, but then you step back and say the real treasure of the Medicare

program in a sense is its uniformity across all classes. It brings Americans like social security together in a big social insurance program, and so as you kind of chip away at that, I think you start to have some problems. I also go back to saying a lot of people say Medicare is unsustainable. No one seems to say the Defense Department is unsustainable.

If we need more money in the Medicare program and the health care system or we need to enhance benefits for lower income folks, you know, we can use the tax system to do that, and I would say our history of getting these kinds of better benefits to poor Medicare beneficiaries isn't that great. Once again, QMB and SLMB, which are wonderful programs, extra help, very low enrollment rates. That's why Ed had the commercial at the beginning for learning about those and telling your friends and family about those.

It's the right motivation, but I think at the end of the day it overcomplicates, and it's administratively very burdensome.

ED HOWARD: And I'm sorry we need to get you to a microphone if you're going to ask a question. Let me just take a ten-second break here. We're coming toward the end of our time, and I want to make sure you have a chance to pull out that blue evaluation form and fill it out as we go through these last few questions, and I think from what Joe has said

that we know how you would answer this next question. What do you think of the Macaskill Coburn Bill, which would lower the income threshold for income related premiums from $85,000 to $50,000?

JOE BAKER: Well, at the risk of repeating myself, once again, that's a good example of the slippery slope. [Laughter.] We just keep going down the slope until we get to a number where we're raising enough money, and once again I would say we've got a tax code. We have a very robust debate about changing that tax code every time we decide to change it and where that money should be spent, and I really think that's where we should be focusing on income and what folks should be paying for, the whole array of services that our government provides to us as opposed to focusing in very narrowly on Medicare premiums for folks that are either at some level of income that's considered wealth or not. These numbers move, whether it's 50,000 or 60,000 or 87,000. It's really to raise money, and it seems like the tax system is the best place to do that, not Medicare premiums.

ED HOWARD: I'll take that for a don't like.

JOE BAKER: I don't like it.

SHEILA BURKE: Obviously it's not dissimilar from the approach that he Bipartisan Policy Center took. It's lower, but I think I would go back to my earliest comment, which is

the BPC proposal is one that is part of a much broader set of recommendations that include reforms to the program broadly and to essentially move towards making it a much more cost effective program and is not dependent upon this as the only method of essentially rethinking the way we organize and finance services. So it is an element. It is not, I would say, the most important element by any stretch. I think there are far greater elements that are important to consider, including the simplification of the benefit and the structural changes in terms of maintaining choice but moving towards more coordinated systems of care.

So again I think the value here is in looking across a wide array of things rather than one specific thing. I don't imagine that any of our principles would support that as an independent element. That is simply to change the premium. I think they would only consider it as part of a much broader strategy that would also result in reduced program costs and would hopefully benefit everyone in terms of reducing those costs.

ED HOWARD: Yes, ma'am, now that we've made you walk to the back of the room?

MARIA SCHIFF: Thank you.

ED HOWARD: You want to identify yourself?

MARIA SCHIFF: Sure, Maria Schiff with Pew Charitable Trusts. I have two related questions about individuals who buy first dollar Medigap coverage. One is do we know what their income profile is, whether they're part of the 22,000 income group, but a related one is if we know that people who buy first dollar coverage tend to use more services, but we don't know if it's a sort of a chicken and egg kind of thing. It would seem to me that if they are using more services, we could see if those are presumably in the nondiscretionary like more hospitalizations where you don't think that that's particularly discretionary, or at least it's discretionary at the part of the physician and the hospital admitting department, but not the type that you think of as discretionary services in general?

TRICIA NEUMAN: Let me answer the straightforward question first, which has to do with income. So people who purchase Medigap are not the poorest on Medicare generally because they have Medicaid, and they don't tend to be the highest income groups on Medicaid because they tend to have employer coverage if they were affiliated with an employer. So you're really talking about a middle income population without as many people in either tales.

MARIA SCHIFF: Uh-huh.

TRICIA NEUMAN: In terms of service utilization, the studies that I have seen have not teased apart what types of services people use more when they have full cost sharing or what services forego when they are confronted with cost sharing, and I don't know. Maybe anybody else in the panel might be able to help and whether anybody has really looked at it in a more refined sense? I mean, Rand obviously did some work years ago.

MARIA SCHIFF: Yeah.

TRICIA NEUMAN: There's been a lot of work done on the effects of brand versus generic cost sharing and how that has driven people to encourage people to use lower cost drugs. So there's some research related to cost sharing and utilization, but I don't know of any research that answers your question directly.

MARIA SCHIFF: Yeah, it seems if there's serious discussion about limiting or prohibiting first dollar coverage, that it's knowable to know what kind of services those individuals are using, and if it's largely hospitalizations, then you think of them as sicker as opposed to just morally hazard.

JOE BAKER: Yeah. Well, I think your own statistic is 46-percent of people with Medigap have incomes under 30,000.

So it's not that 22. I'm quoting from a Kaiser brief on that, so I do my Kaiser homework. [Laughter.].

TRICIA NEUMAN: I'm sure he's right.

JOE BAKER: I wrote it down, and I think once again going back, I think there should be more information available about what this effect is of first dollar coverage. Once again, time and again, and this is anecdotal based upon our helpline. We help about 15,000 people with Medicare a year, and what we see is they're very confused about what's needed or unneeded, and we don't provide health advice to them or health information. We coverage only, but what we find, and I think studies bear this out, is that once they're in the health system, their utilization is not necessarily driven by themselves. It's driven by a provider and provider's recommendation. I mean, that's why you go to the doctor, right, to find out what you need to do.

What we're concerned about, as I said earlier, is that initial visit you don't know if it's unnecessary, necessary. I think much of the literature around this is looking at imaging as a new driver of cost, and that's certainly something that you don't toddle off directly to the imaging center. Maybe somebody does. I don't know. Maybe I should be doing that. [Laughter.] You know, you go to a doctor first, and that doctor says x-ray, MRI, CAT, whatever it is. So that to my

mind is before we jump on this, like, get rid of first dollar coverage bandwagon, I think we need a lot more information, and we also need to understand that there it's quite clear. The statistics show it. It works. It prevents people from going for that first visit or walking through the door because they're going to have to pay money upfront. That's why preventive care is a zero co-pay, to encourage people to go get it.

I think that is the concern. A lot of the value based designs, you know, that's what value based is, zero dollar for preventive care, or less for generic drugs and et cetera, and we're not, I don't think, at a place where – certainly Mark Fendrick and others, Mike Chernew, have done a lot of work on value based, and the private insurance market has experimented a lot with it, and we need to continue to do that, but as we all know, getting a bunch of doctors to agree on, okay, this is high value and this is not so high value, it's tough, and it's going to take time. So I think we do need to have some time.

Fortunately we do have some time. Even though we're all concerned about Medicare's financial future, it's in some of the best shape it's been in, in decades, and that does give us a window of opportunity to allow some of these things to be experimented with before we go off and cut off the first dollar coverage just because, hey, we need to save some money in 2013.

ED HOWARD: Anything else? One question that kind of has come up inferentially throughout this discussion and it's because I wrote it down that I can repeat it, that is isn't it likely that any of the proposals that we're talking about, with or without safeguards for low income people, are only getting consideration and will only get serious consideration in the context of trying to generate savings in the Medicare program while we discuss deficit reduction and Medicare being in an unsustainable situation?

TRICIA NEUMAN: I mean, maybe yes. Maybe no. I mean, these proposals have been talked about in the context of deficit and debt reduction. It would be conceivable that they would be talked about in the context of the SGR, the physician payment reform fix, where there's a question about how to finance the payment reforms for physicians under Medicare. So I don't necessarily think it's a debt reduction frame that would drive these policies.

JOE BAKER: I think I did articulate earlier that my concern is that we are talking about these in the context of debt reduction, and you certainly see numbers in Bowles Simpson and CBO and others where there are significant savings, and those savings are primarily driven by significant cost shifts to consumers. I think there are other more moderate and I think more long looking, if you will, proposals, like at the

Bipartisan Policy Center, you know, that would still shift costs. There's always going to be winners and losers, you know, in any of these redesign. There's always going to be an adjustment period as it were, and I would say as a consumer organization I've been crying wolf a lot and maybe been very negative. I think there are proposals that are out there that would generate some short term savings to pay for SGR, like drug rebates be back on for low income Medicare beneficiaries, which would save a significant amount of money, about 140 billion over ten years. It's in the president's budget.

Whether they're politically feasible or not is another matter, but I think they're there, and they're worth the debate. While we have time to look at these proposals in a more, and I hesitate to say dispassionate because we'll all get passionate about it, but not looking at them to drive savings because I don't think we're ever going to calibrate it so that everybody's a winner. There's going to be some level of adjustment where someone will pay more in a certain circumstance, but I see these proposals, many of them, as taking this opportunity of deficit reduction to do some good things, but at the end of the day they're saving money, and a lot of it is because of shifting costs to consumers or to other insurance programs.

SHEILA BURKE: I would agree with Tricia that it's not entirely clear to me that the only reason to drive this discussion is, in fact, a budget discussion, although it could well occur in that context, but I think any of us who have spent the bulk of our professional lives thinking about, worrying about, and studying the Medicare program recognize that we are in a period of time where there clearly is the need for and the desire to relook at the program. Certainly all of the work that's taking place in terms of restructuring the financing, restructuring the delivery system, the relationship between providers and payers, the relationship between beneficiaries and provider and structure, the development of ACOs, medical homes, all suggest to you that there is a growing awareness of the fact that the program that was developed in 1965 is not a program that is suitable for today.

No one would today create it, and it is certainly not related to or similar to any other kind of system in place. It has enormous benefits but also has exposure as well to beneficiaries, and so I would hope that the conversations would occur with a mind towards improving it for those of us who are boomers who are not long from qualifying to maintain it for a very long period of time.

I mean, the program has done a great deal over the years, but it needs our attention in terms of moving it

forward, and on that point if I could take a point of privilege because I know he is a C-SPAN watcher. Today is Bob Dole's 90th birthday.

TRICIA NEUMAN: Happy birthday.

SHEILA BURKE: So I want to wish you a happy birthday.

ED HOWARD: Happy birthday, Senator Dole. [Applause.] Alright. Well, that's a perfect endnote if I could take that opportunity. Following up on this discussion I should give a shout out to the National Health Policy Forum, which has a program devoted to this issue specifically as it connects to low income beneficiaries. I think it's August 2, so you can pick up the thread of the discussion in that context as well.

Let me just take a moment to thank you for your very thoughtful questions and your attendance here this afternoon. Thank our colleagues, Tricia and Juliette, and their colleagues at the Kaiser Family Foundation for making this program so rich in its background and in its content ask you to join me in thanking our panel for a really good discussion. [Applause.] Nicely done.

[END RECORDING]