American Hospital Association

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The Honorable Orrin Hatch
United States Senate
104 Hart Senate Office Building
Washington, DC 20510

Dear Senator Hatch:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) welcomes the opportunity to comment on entitlement reform and the potential solutions proposed in the plan you put forth on January 24. The AHA supports several of the key reforms you have proposed for the Medicare program as alternatives to reductions to provider payments.

Medicare is in need of structural reform. Recent history illustrates just why it is important that Congress take a comprehensive view when crafting any plan to modernize Medicare. The annual Medicare physician payment fix is a useful example: in each of the past 10 years, Congress has passed short-term patches to avoid scheduled cuts to physicians' Medicare payments, often by reducing payments to other providers such as hospitals.

We share with you the desire to put patients first. Medicare beneficiaries are at the forefront of our considerations as we strive to modernize and improve care; they are an aging population with unique needs. We continue to embrace quality improvements to bring Medicare beneficiaries, and all patients, the best, most efficient care possible.

Since passage of the *Patient Protection and Affordable Care Act of 2010*, Congress has cut payments for hospital services by $95 billion[i]. Simply ratcheting down provider payments is not real reform. At the same time as these reductions have occurred, hospitals are undertaking a variety of significant reforms ranging from implementation of electronic medical records, to installing value-based payment mechanisms, to establishing Accountable Care Organizations. Your proposal offers additional reforms that can reduce Medicare outlays in the long term.

Those annual cuts create an unstable environment for hospitals, which are already faced with negative Medicare margins. According to data presented at the December meeting of the Medicare Payment Advisory Commission (MedPAC), Medicare margins continue to be negative and fell sharply in 2011. Overall Medicare margins fell from negative 4.7 percent in 2010 to negative 5.8 percent in 2011 – a drop of 1.1 percentage points. This means that, across all service lines, Medicare paid only 94 cents on the dollar of cost to treat Medicare beneficiaries. For outpatient services, Medicare paid 89 cents on the dollar (a margin of negative 11.0 percent), and for inpatient services, Medicare paid only 96 cents on the dollar (a margin of negative 4.0 percent).

MEDICARE ELIGIBILITY AGE

The AHA supports adjusting the eligibility age from the current age of 65 to 67.

In 1965 when Medicare was created, the average life expectancy was 70. Today, life expectancy in the U.S. is, on average, 78 years; and for a person 65 years of age, it is 83 for men and 85 for women.

In the past, raising the Medicare eligibility age was found to be problematic, as it was difficult and expensive to find health insurance at age 65. But starting in 2014, federal law offers guaranteed issue and community rating protections to seniors. This means that a 65 year old cannot be denied coverage by an insurer, and that the coverage offered will be affordable. This makes gradually raising the Medicare eligibility age to 67 more feasible and less onerous for future seniors.

This policy has found broad, bipartisan support from such groups as the Simpson-Bowles National Commission on Fiscal Responsibility and Reform and in proposals made by Vice President Biden and Rep. Eric Cantor and by Sens. Coburn and Lieberman last Congress.

MEDIGAP REFORM

Your proposal would encourage seniors to make more cost-effective health care choices by limiting Medigap plans from providing first-dollar coverage for cost-sharing. The AHA supports modifying Medigap plans to avoid unnecessary utilization.

Almost 30 percent of Medicare beneficiaries have Medigap policies to cover beneficiary payment responsibilities (such as the 20 percent beneficiary cost-sharing responsibility for physician services), or what is commonly referred to as "first-dollar coverage." Nearly 90 percent of beneficiaries have some supplemental insurance coverage to offset their cost-sharing obligations. Studies find that Medigap policyholders use about 25 percent more services than Medicare enrollees without supplemental coverage. MedPAC has gone so far as to recommend an additional charge on the purchase of Medicare supplemental insurance plans. This higher utilization of services directly contributes to higher costs for all seniors in Medicare. Further contributing to higher costs are the advantageous medical loss ratios (65 percent) for Medigap insurers, making first-dollar coverage policies among their most profitable products.

This proposal was supported by the Simpson-Bowles Commission and was included in proposals from Vice President Biden and Rep. Cantor.

SIMPLIFY MEDICARE BENEFIT AND COST-SHARING

Your proposal would create a single combined deductible for Medicare Part A and B services, uniform coinsurance and an annual catastrophic cap. This existing Part A and B distinction for cost-sharing purposes has outlived its usefulness.

This modernization of the program is consistent with health plans Americans have seen throughout their working careers and will likely make more sense to them than the confusing Part A and B cost-sharing

dichotomy that currently exists. MedPAC has also recommended this; their June 2012 analysis also describes the wisdom of an out-of-pocket maximum to protect Medicare beneficiaries from catastrophic costs. This proposal also has significant bipartisan support, from both the Simpson-Bowles Commission as well as the proposal from Senators Lieberman and Coburn last Congress, and the AHA supports this policy.

MEDICAID

The AHA is extremely concerned about any further reductions to Medicaid, a program vital to the health of the most vulnerable: children, the disabled and the elderly. Over the past few years, Medicaid funding has been cut dramatically as states struggle to balance their budgets. Further cuts to Medicaid would threaten the existence of this vital program, which is a lifeline to so many Americans.

Today, hospitals provide nearly $40 billion in uncompensated care per year, and that number will grow if coverage is not expanded to those who cannot afford care. If Medicaid coverage is not expanded and the government does not pay its fair share, hospitals will be forced to "cost-shift," or pass along the difference to the privately insured, exacerbating a "hidden tax" on insured families.

According to a Milliman[ii] study examining 12 years of payment and cost data, hospitals have *negative* 14.7 percent operating margins on Medicaid patients. Medicaid already severely underpays providers, and beneficiaries report difficulty finding physicians who accept Medicaid patients.

In summary, America's hospitals recognize the need to reform Medicare and to move away from continued ratcheting of payments to providers who are already being paid less than the cost of delivery for these services. Moreover, these arbitrary payment reductions do nothing to modernize the Medicare Program. We welcome this broader look at dealing with the financial components of the program.

We appreciate the opportunity to comment, and thank you for your attention to these issues. We look forward to working with you and other stakeholders toward solutions.

Sincerely,

/s/

Rick Pollack
Executive Vice President

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[i] Bad debt and Medicaid DSH cuts included in *Middle Class Tax Relief and Job Creation Act of 2012* and additional DSH cuts for 2022 in the *American Taxpayer Relief Act of 2012*; three-day window cut included in *American Jobs and Closing Tax Loopholes Act of 2010*; estimate of excess CMS MS-DRG coding cut based on hospital analysis and includes additional amounts cut in 2014-2017 in the *American Taxpayer Relief Act of 2012*; sequestration amount estimated from CBO Medicare Baseline. Other provisions of the *American Taxpayer Relief Act* including extension of low volume adjustment, extension of Medicare Dependent Hospital Program and the adjustment to payment for certain radiology services net out to zero and are not shown.

[ii] Milliman: Fox, Will and Pickering, John. (2008). *Hospital and Physician Cost Shift.* http://publications.milliman.com/research/health-rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf