

FOR IMMEDIATE RELEASE:
November 20, 2012

CONTACT:
Allyson Funk
202-434-2560 or media@aarpp.org

AARP Opposes Cost-Shifting to Seniors in Medicare and Medicaid
WASHINGTON, D.C. – Yesterday, AARP sent a letter to members of Congress and the President opposing proposed changes to Medicare and Medicaid that simply shift costs to seniors, including raising the eligibility age for Medicare. The full text of the letter to members of the House of Representatives, the Senate and the President is below:

November 19, 2012

Dear Senator:

On behalf of our more than 37 million members and all Americans age 50 and older, AARP is writing to express our views on proposed changes to Medicare and Medicaid. As you know, AARP has worked tirelessly to protect and preserve the Medicare and Medicaid programs for decades, and we continue to welcome open dialogue and discussion on how to best keep our nation's commitment to the health security of current and future older Americans.

AARP has a long history of supporting efforts to strengthen Medicare and Medicaid and to ensure they are available for generations to come. Towards that end, we have worked with both sides of the aisle to support key pieces of legislation, such as the Balanced Budget Act of 1997, the Medicare Drug Improvement and Modernization Act, and most recently, the Affordable Care Act.

For the last nine months, AARP has engaged in a national conversation, You've Earned A Say, with millions of our members and all Americans about the future of Medicare and Social Security. Through our publications, website and more than 4,000 events across the country, we provided information about the long-term financial challenges facing these programs as well as balanced information – both pros and cons – about the different proposals on the table in Washington. More importantly, we listened to their views about how to strengthen Medicare for older Americans, their children, and their grandchildren.

Older Americans recognize the need to address the nation's fiscal deficit and they acknowledge the daunting task we face to put our nation's finances on a more secure path. But older Americans, across party and regional lines, also have serious concerns about efforts to make major changes to the health care and retirement benefits they have paid into and depend on - especially as part of any rushed, end of year discussions.

Based on a recent AARP survey, 70 percent of Americans age 50 and older want Washington to listen to them, focus on improving and strengthening Medicare for current and future generations, and are strongly opposed to the inclusion of harmful changes to Medicare in any end-of-the-year package.

As you know, most Americans age 65+ live on limited, fixed incomes. The typical Medicare beneficiary lives on an annual income of roughly \$20,000 and already struggles to pay for their ever-rising health and prescription drug costs. In fact, according to some estimates, nearly 20 percent of their income currently goes to health care costs. As individuals age, they tend to spend more on their health care – for example, people 85 years and older spend \$7,975 a year out-of-pocket, on average, for their health care. Beneficiaries with cancer and other common medical conditions also tend to carry higher out-of-pocket costs. The average out-of-pocket costs for an individual with Alzheimer's, for example, are about \$7,670 per year.

As Congress debates proposals to change Medicare and Medicaid, it is important to keep in mind that many beneficiaries lack the resources to shoulder additional cost-sharing. Older Americans have also been hit hard by the economic downturn – with little or no time to recover – including a diminution of retirement savings and assets and a drop in home values.

As we move forward, it is clear that older Americans want the focus of the debate to be on reducing overall health costs and not simply targeting Medicare and Medicaid for budget cuts. Simply reducing government expenditures by shifting costs does not lower the cost of health care; it merely shifts the cost to beneficiaries and other payers.

Medicare

Over 50 million older Americans and Americans with disabilities depend on Medicare today, the bedrock of health security for these families. As you know, significant savings (\$716 billion) related to the Medicare program have already been enacted as part of the Affordable Care Act (ACA).[1] AARP's support for this law was based in part on many of the delivery system reforms—such as Accountable Care Organizations (ACOs), patient-centered medical homes, value-based purchasing, quality-based payments, and patient safety initiatives – included in the law.

AARP believes the implementation of these significant delivery system reforms will take time, planning, and commitment from Congress, the Administration, and providers to help achieve a new way of delivering care: one that focuses on improving primary and coordinated care for beneficiaries, and payment incentives that reward quality and improved outcomes rather than volume.

Medicare is only one part of our health care system – which includes other federal programs, private plans, state insurance plans, and individuals. Our entire health care

system is consuming an increasingly larger share of the nation's gross domestic product. Singling out the Medicare program – either for arbitrary cuts or for increased costs to beneficiaries – will not control overall health care costs, nor will it reduce the percentage of our GDP that goes to health care. To address growing health care costs, we need a system-wide approach, which will in turn benefit not only Medicare, but also state and local governments, employers, and individuals.

Towards that end, AARP recommends that we focus on ways to truly lower overall health costs. Medicare, as a large purchaser, can play an important role in improving our health care delivery system. We know that there is no magic bullet, and a number of approaches must be implemented, including: greater care coordination, particularly for those with multiple chronic conditions; payment incentives that encourage better care at lower cost; better use of evidence based medicine to deliver the right care at the right time; better use of health information technology; better transitional care between settings; greater access to less costly generic medicine; improved wellness and prevention; and improved efforts to weed out fraud and abuse.

In contrast, proposals to raise the Medicare eligibility age or boost beneficiary co-payments simply restrict access to care and shift costs to beneficiaries and other payors. Similarly, imposing arbitrary limits or cuts to federal Medicaid spending does not make costs disappear; they simply shift costs to individuals, providers, and state governments.

Raising the age of eligibility from 65 to 67 would have negative effects, leading to higher costs for seniors and for the health care system generally. If implemented in 2014, about 7 million beneficiaries would lose eligibility they would otherwise have had. Forcing these 65 and 66 year olds into the private insurance market will cause them to pay higher premiums than they otherwise would in Medicare. Even in the Exchanges, older Americans can be charged three times more for insurance than younger individuals. According to one report[2], if fully implemented in 2014, net increases in out-of-pocket spending for 65 and 66 year olds would be \$3.7 billion for that year. Approximately two-thirds of 65 and 66 year olds would pay an average of \$2,200 more per year. Many of these individuals will either fall back into the private market – either through employer insurance or through individual coverage – or into other government programs, particularly Medicaid. [3] Increasing the age of eligibility also means that the overall remaining Medicare population would be an older, less healthy, and more costly population, leading to higher premiums for those remaining in Medicare. In short, raising the Medicare eligibility age, rather than reducing costs, will increase overall health costs for everyone.

Raising the age of eligibility means all people would face reduced benefits over a lifetime. However, the impact is far worse for minorities. African Americans and Native Americans have lower life expectancies. While they would have paid into Medicare all their lives, they are more likely to die before reaching the age of eligibility or shortly thereafter. And there is another way this proposed change would disproportionately harm minorities who tend to have lower incomes and poorer health status. Because the cost of health insurance

increases with age, those with lower incomes and chronic health conditions will find it much harder to afford the increased cost of private health insurance. And during these difficult economic times, Hispanics and African Americans face a much higher unemployment rate, and therefore, are less likely to have access to employer sponsored health insurance.

Similarly, increasing deductibles and co-payments for seniors fails to lower health costs in Medicare and simply shifts costs onto beneficiaries. Again, the economic reality of seniors must be considered as we consider appropriate contributions towards deficit reduction. Targeting of services for additional cost sharing due to perceived over utilization of services is a very crude tool, which takes aim at the sickest and the people with the fewest resources. Moreover, because co-pays deter the use of necessary as well as unnecessary care; care that is needed may be foregone, resulting in more serious medical problems, and higher costs such as hospitalizations. Finally, consumers are not in the best position to decline medical treatments prescribed by their care providers, and a more effective way to control over utilization is through provider oversight and better payment policies and incentives.

Other proposals, such as combining the Part A and Part B deductible, would also add costs for the vast majority of Medicare beneficiaries, even if total costs are equal. Nearly three quarters could face higher out of pocket costs and about 40 percent could see increases of at least \$250.

Medicaid

Medicaid is a critical safety net for low-income people and formerly middle-income individuals who have spent their life savings paying for long-term services and supports (LTSS). About 30 percent of those turning age 65 will have LTSS costs that exceed their ability to pay and will at some point need Medicaid assistance to help with LTSS. Limited financing options are currently available to pay for LTSS, and individuals who exhaust their own resources turn to the joint federal-state program as a last resort to help meet their long-term care needs. At this point, Medicaid becomes a lifeline, with the program providing either nursing home care or the specific services they need in order to stay in their homes and communities and out of institutions.

Without an adequately funded Medicaid program, costs would be shifted to individuals, providers, and states, none of whom are able to bear these costs. Proposals to block grant or place other arbitrary caps on Medicaid would shift costs to state budgets and result in cutbacks to provider reimbursements, which are already very low, and potentially cuts in enrollment and benefits as states try to compensate for the reduced federal contribution. For those who are already receiving home and community-based services (HCBS) or are in nursing homes, Medicaid cut-backs could lead to reduced access and inadequate care. For individuals who do not yet need LTSS, and who one day may exhaust their savings and need services, they could be turned away or offered insufficient care that neither meets

their needs nor maintains their dignity.

When states cut back on their Medicaid LTSS spending, they often target HCBS, since these are defined as “optional services” under Medicaid law (even though they are critical services for many people). Cutting HCBS could result in more people having to go to nursing homes – with national median costs of about \$70,000 per year for a semi-private room – and their care being paid for by Medicaid. This is not cost-effective, since on average, Medicaid can provide HCBS to three older adults and adults with physical disabilities for the cost of serving one person in a nursing home. In addition, an AARP study found that 9 out of 10 Americans age 50+ want to stay in their current residence for as long as possible.

Cuts to Medicaid could also shift additional costs to family caregivers. An AARP report released last year found that the estimated value of family caregivers’ unpaid contributions was approximately \$450 billion. It is unfair and ineffective to shift even more costs on to these family caregivers, many of whom help their loved ones remain where they prefer – at home and out of more expensive nursing home care. In addition, at a time when jobs are of the utmost importance, Medicaid cuts often translate into job losses for medical and health centers and nursing homes (which are major employers in many communities), other service providers, and the health workforce more broadly. This employment effect can reduce access to care for many older persons – even those whose care is not paid for by Medicaid.

Finally, changing Medicaid to a block grant or placing an arbitrary limit on Medicaid funds is not necessary to give states flexibility in administering the program. States currently have considerable flexibility in defining the scope and amount of benefits, choosing delivery care models including managed care, and adjusting how providers and plans are paid. There is already broad flexibility within the current Medicaid system, where important checks and balances on both sides of the federal-state relationship allow states the opportunity to develop solutions that work for them while guaranteeing essential benefits to individuals in need who have already depleted their own resources. To the contrary, under a block grant or arbitrary spending cap, much of the existing flexibility would diminish as federal funds are drained from the state’s revenue streams leaving them with fewer dollars to cover essential services.

As Congress discusses ideas and develops legislation to address our nation’s deficit and the health care system generally, AARP strongly urges that the impact of any changes to the Medicare and Medicaid programs on beneficiaries – particularly changes that simply shift costs to seniors – be a major part of the equation. It is critical to take into account that most beneficiaries live on modest incomes, and many already struggle to pay for their ever-rising health and prescription drug costs. We are eager to work with you and others to help lower overall health care costs while preventing seniors from shouldering the burden of additional costs in the Medicare and Medicaid programs. Improving the delivery of care can yield better outcomes at lower costs, without impeding access for the most

vulnerable populations.

AARP looks forward to working with legislators from both sides of the aisle on proposals that would save money and improve our health care system – including our public programs – without harming beneficiaries. Please feel free to contact Joyce A. Rogers, Senior Vice President, Government Affairs, at xxx-xxx-xxxx for any additional information.

Sincerely,

A. Barry Rand
Chief Executive Officer

AARP is a nonprofit, nonpartisan organization, with a membership of more than 37 million, that helps people 50+ have independence, choice and control in ways that are beneficial to them and society as a whole. AARP does not endorse candidates for public office or make contributions to either political campaigns or candidates. We produce AARP The Magazine, the definitive voice for Americans 50+ and the world's largest-circulation magazine; AARP Bulletin, the go-to news source for the 50+ audience; AARP VIVA, a bilingual lifestyle multimedia platform addressing the interests and needs of Hispanic Americans; and national television and radio programming including My Generation and Inside E Street. The AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors. AARP has staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Learn more at www.aarp.org.