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August 16, 2013

Committee on Ways and Means, Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Members of the Subcommittee:

On behalf of the Medicare Rights Center, I am writing to reinforce our strong opposition to the policy proposals circulated by the Committee on Ways and Means, Subcommittee on Health, including further increasing Part B and Part D premiums for select Medicare beneficiaries, increasing the Part B deductible, and introducing a home health copayment.

In May 2013, I was honored to testify before the Subcommittee on these very proposals. I appreciate the Subcommittee's commitment to ensuring these proposals are vetted through the solicitation of public feedback. As the Subcommittee weighs various policy options, it is important to understand the current facts about Medicare beneficiaries and the common challenges facing this population.

We know these challenges firsthand through our work counseling and educating people with Medicare on a daily basis, and we offer the following summary of our concerns with the draft proposals circulated by the Subcommittee:

Most people with Medicare cannot afford to pay more for health care. Today, half of all people with Medicare—25 million older adults and people with disabilities—are living on annual incomes of $22,500 or less, and one quarter live on $14,000 or less. The average Medicare household already spends 15 percent of their household income on health care compared to only 5 percent among non-Medicare households.

Through our national helpline, we field up to 15,000 calls from beneficiaries, family caregivers and health care professionals each year. The most common call to our helpline is from a Medicare beneficiary overwhelmed by high health care costs, and for these callers there are few, if any, avenues for relief.

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Added cost sharing deters access to *needed* and unneeded care. As proposed by the Subcommittee, an increased Part B deductible and home health copayment would exacerbate already impossible choices for many people with Medicare, like to see the doctor about a persistent cough or to make a weekly trip to the grocery store. Added cost sharing would leave many beneficiaries with no choice but to self-ration health care. Almost 40 years of data consistently demonstrates that while higher out-of-pocket costs certainly deter health care utilization, it deters utilization of *needed* care as well as unneeded care indiscriminately. In the long run, reductions in the use of needed care are likely to increase health care spending through the greater likelihood of emergency room visits, ambulance rides and hospital stays.

These risks would be most pronounced among beneficiaries with low incomes and high health care needs. In short, the burden of a higher Part B deductible and the addition of a home health copayment would fall heaviest on the most vulnerable people with Medicare.

More Medicare means testing translates to a premium hike on the middle class. Higher-income beneficiaries (individuals with incomes of $85,000 and couples with incomes of $170,000) are *already* means-tested, paying higher Part B and Part D premiums well above the standard premiums. The proposal circulated by the Subcommittee would take this practice several steps further by increasing already higher premiums while also forcing a larger share of the Medicare population to pay more. Recent analysis by the Kaiser Family Foundation shows that if one in four people with Medicare were subjected to higher premiums today as proposed by the Subcommittee, then individuals with incomes of $47,000 would pay more.

Reaching into the pockets of middle class beneficiaries for federal health care savings is a slippery slope with far-reaching consequences for the Medicare program. More income relating of premiums would erode popular support for Medicare, causing some higher-income beneficiaries to opt out of Medicare altogether and further undermining the social insurance model inherent to the historical, quantifiable success of the program.

Please review my original testimony (see attached) for a detailed analysis of the risks posed to people with Medicare by the draft proposals circulated by the Subcommittee. Thank you for the opportunity to provide additional comment.

Sincerely,

Joe Baker
President
Medicare Rights Center

Testimony of Joe Baker
President, Medicare Rights Center

Prepared for the
United States House of Representatives
Committee on Ways and Means, Subcommittee on Health

"The President's and Other Bipartisan Proposals to Reform Medicare"

May 21, 2013

Introduction:

Chairman Brady, Ranking Member McDermott, and distinguished members of the Subcommittee on Health, I am Joe Baker, President of the Medicare Rights Center. The Medicare Rights Center is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

Thank you for the opportunity to testify on proposals to modify Medicare cost sharing, including those that would: increase the Medicare Part B deductible; introduce home health copayments; and expand the number of people with Medicare subject to higher income-related Part B and Part D premiums and further increase those premiums.

While each proposal would affect different parts of the Medicare program, and the added costs would be borne by different segments of the beneficiary population, these plans share a common, pernicious theme. Each of these proposals achieves savings for the federal government by shifting costs, or the risk of such costs, to the very people that Medicare was designed to protect. Today, half of all people with Medicare—25 million older adults and people with disabilities—are living on annual incomes of $22,500 or less, and already the average person with Medicare spends 15 percent of their household income on health care costs.[1]

Most people with Medicare cannot afford to pay more for health care, and the burden of added cost sharing falls heaviest on those with low- and fixed- incomes and those with significant

[1] J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicare-beneficiaries-costs-and-service-use-testimony.pdf

health care needs. Further, forcing "wealthy" beneficiaries to pay more for Medicare translates to a premium hike on middle class retirees and people with disabilities, while also fracturing one of our nation's most successful social insurance programs.

Rather than shifting costs to people with Medicare—an approach that yields only short-term and harmful savings—Congress should focus its attention on reforms that diminish wasteful Medicare spending and continue to encourage the transformation of our health care system from one that rewards high volume care to one that rewards *high value* care.

People with Medicare – Income, Assets and Health Care Costs

We know firsthand the economic and health challenges facing people with Medicare and their families. The Medicare Rights Center provides answers 15,000 Medicare questions on our national helpline each year, serving older adults, people with disabilities, family caregivers, social workers, attorneys and other service providers. Through our educational initiatives, including peer-to-peer learning networks, we touch the lives of an additional 65,000 people with Medicare and their families. In addition, our online learning tool, Medicare Interactive, receives approximately 650,000 visits annually.

The most common call to our helpline comes from a Medicare beneficiary having difficulty affording a health care service or a prescription medicine—callers like Pat.

Pat is 75 years old and lives with her husband in Missouri. Pat called our helpline because she was recently diagnosed with colon cancer. Her husband is also not well, living with diabetes and high blood pressure, and faces his own health care costs. Pat called for help because she cannot afford her cancer treatments, amounting to $600 per month for chemotherapy and $700 every three weeks for cancer medications.

Pat and her husband live on $2,500 per month (or $30,000 per year), an income too high to allow them to qualify for low-income assistance programs, like the Medicare Savings Program (MSP) or the Low-Income Subsidy of Part D, also known as Extra Help. With no place to turn, Pat's remaining options will be to skip needed treatments or to sacrifice other needs, like paying for groceries or keeping up with her car insurance payments.

Pat's story is commonplace. As such, any attempt to modify Medicare cost sharing must begin with a close examination of the financial and health realities facing our nation's older adults and people with disabilities. As noted before, most people with Medicare are living on low, fixed incomes. In 2012, half of all Medicare beneficiaries lived on annual incomes at or below $22,500—just under 200% of the federal poverty level. And half had $77,500 or less in personal

savings.[2] The Baby Boomers, many of whom will retire within the next two decades, are not expected to fare much better. Among the next generation of retirees, one quarter are expected to have annual incomes below $15,000 and half are expected to have annual incomes below $27,000.[3]

People with Medicare already spend a significant share of their income on health care, and their contributions have increased steadily over time. In 2010, Medicare out-of-pocket costs accounted for 26% of the average Social Security benefit, compared to only 7% in 1980. These numbers are particularly startling given that one in three beneficiaries relies on Social Security for more than 90% of their income. The average Social Security benefit amounts to $1,230 per month for the average retired worker and $1,185 for the average older widow or widower.[4] And today the average Medicare household spends three times on health care-related costs as the average non-Medicare household—15% vs. 5% as a share of total income.[5]

Some public assistance to help pay for Medicare cost sharing is made available through MSPs and Extra Help. But these protections are woefully insufficient, failing to fully extend to those who cannot afford to pay for needed health care. Currently, full Part A, B and D subsidy protection is provided only for those with incomes up to 100% of FPL, about $11,500 in 2013. In addition, extremely low asset tests deny eligibility to those who set aside modest savings.[6]

Medicare beneficiaries have multiple and significant health needs—40% of beneficiaries have three or more chronic health conditions, and more than one quarter of beneficiaries (27%) report being in fair or poor health. Further, nearly one in four people with Medicare live with a cognitive or mental impairment, requiring extensive, ongoing care.[7] And one in four people with Medicare spend all of their assets on health care needs in the last year of life.[8]

Most people with Medicare (90%) have coverage to supplement basic Medicare benefits. Some have retiree benefits through former employment (30%), Medicare Advantage plans (29%), Medicaid (14%) or Medigap coverage (18%), and others who have only Medicare (8%) may also

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[2] J. Cubanski, "Testimony: An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicare-beneficiaries-costs-and-service-use-testimony.pdf

[3] Kaiser Family Foundation, "Projecting Income and Assets: What Might the Future Hold for the Next Generation of Medicare Beneficiaries?" (June 2011), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8172.pdf

[4] National Academy of Social Insurance, "Social Security Benefits, Finances and Policy Options: A Primer" (April 2012), available at: http://www.nasi.org/sites/default/files/research/Social_Security_Primer_PDF.pdf

[5] J. Cubanski, "Testimony: An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicare-beneficiaries-costs-and-service-use-testimony.pdf

[6] Medicare Rights Center, "Extra Help: Income and Asset Limits 2013" (2013) available at: http://www.medicarerights.org/fliers/Help-With-Drug-Costs/Extra-Help-Chart.pdf?nrd=1; Medicare Rights Center, "Medicare Savings Program Financial Eligibility Guidelines" (2013) available at: http://www.medicareinteractive.org/uploadedDocuments/mi_extra/MSPFinancialEligibiltyGuidelines.pdf

[7] J. Cubanski, "Testimony: An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicare-beneficiaries-costs-and-service-use-testimony.pdf

[8] S. Kliff, "Why the health care cost slowdown is great for grandparents" (*Washington Post*: May 2013), available at: http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/16/why-the-health-cost-slowdown-is-great-for-grandparents/

be entitled to benefits through the Veterans Administration.[9] Many of these supplemental insurance plans allow Medicare beneficiaries to manage significant cost sharing.

Yet, even with a supplemental benefit, most people with Medicare lack coverage for most long-term care services and supports, such as ongoing nursing home care or long-term home health services, as well as dental and vision care. And most people with Medicare would be unable to afford or would have their life savings depleted by the average annual cost of a private nursing home room—about $84,000 per year.[10]

Most Medicare beneficiaries, people like Pat, cannot endure added costs without facing significant hardship. The stark financial reality facing most people with Medicare makes clear that added cost sharing would impose a harsh burden on the older adults, people with disabilities, and families who rely on Medicare.

Effects of Cost Shifting to People with Medicare

Increasing Medicare cost sharing, whether through increased deductibles, coinsurances, copayments, or restricting Medigap insurance coverage, threatens the economic and health security of people with Medicare in two ways. First, added cost sharing imposes financial hardship, particularly for beneficiaries living on low- and moderate-incomes. Increased deductibles, coinsurances or copayments would exacerbate already impossible choices: to pay for a needed prescription or to pay the heating bill; to see the doctor about a persistent cough or to make a weekly trip to the grocery store; to pay the car insurance bill or to pay a lingering hospital bill; and so on.

Second, added cost sharing leaves many beneficiaries with no choice but to self-ration health care. Faced with higher upfront costs, beneficiaries living on fixed- incomes are likely to forgo doctors' visits—a decision made on the basis of affordability as opposed to health needs. Almost 40 years of data consistently demonstrates that, while higher out-of-pocket costs certainly deter health care utilization, it deters utilization of *needed* care as well as unneeded care indiscriminately.[11]

The equation is simple: higher out-of-pocket costs will require the majority of Medicare beneficiaries to go without: either going without heating or rent payments, or going without needed medical care. In the long run, reductions in the use of medically necessary care can, in

[9] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), "Variations and Trends in Medigap Premiums" (December 2011), available at: http://aspe.hhs.gov/health/reports/2011/medigappremiums/index.pdf
[10] Genworth, "2013 Cost of Care Survey: Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes," (March 2013), available at: https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032213_Cost%20of%20Care_Final_nonsecure.pdf
[11] National Association of Insurance Commissioners, "Medigap PPACA (B) Subgroup" (as of June 2011) available at: http://www.naic.org/committees_b_sitf_medigap_ppaca_sg.htm; See literature under: "Cost-sharing Research and Literature"

fact, increase health care spending through the increased likelihood of emergency room visits, ambulance rides and hospital stays.[12]

The Medicare Payment Advisory Commission (MedPAC) and the Congressional Budget Office (CBO) acknowledge these access challenges.[13] Further, a major Harvard School of Public Health review of the research on cost sharing made several conclusions about its utility in controlling health care costs, including: "We do not know if increased patient cost sharing would reduce the growth in total national health care spending;" "Increased cost sharing disproportionately shifts financial risk to the very sick;" "Low-income older adults with chronic conditions are at increased risk for poor health outcomes due to increased cost sharing."[14]

In addition, research shows that individuals are most likely to skip doctor's visits altogether. According to a 2006 RAND study, added cost sharing is most likely to deter a person from seeking an initial physician visit. And cost sharing has little utility in controlling service use once a beneficiary enters the health care system.[15] This finding confirms what we know to be true through our experience serving people with Medicare: health care providers—not beneficiaries—order services and ultimately drive utilization trends.

These conclusions served, in part, as the basis for a recent recommendation by the National Association of Insurance Commissioners (NAIC) to the U.S. Department of Health and Human Services cautioning against adding cost sharing to specific Medigap plans. Pursuant to the Affordable Care Act (ACA), the NAIC was directed to "review and revise the standards for benefits in Medigap Plan C and Plan F" and to update those standards to include cost sharing, if practicable, so as to "encourage the use of appropriate physicians' services…"[16] Toward this end, the NAIC convened the Medigap PPACA (B) Subgroup, on which the Medicare Rights Center served, which included state insurance regulators, insurers and trade associations, consumer advocates and other Medicare experts. This subgroup spent almost two years reviewing available literature on cost sharing and patient behaviors.[17]

The subgroup's research demonstrates that cost sharing has dubious utility in holding down health care spending and can actually lead to increased total spending on health care if people

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[12] Katherine Swartz, "Cost-Sharing: Effects on Spending and Outcomes" (December 2010), Robert Wood Johnson Foundation Research Synthesis Report No. 20, available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1

[13] Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Medicare and the Health Care Delivery Payment System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf; Congressional Budget Office, "Budget Options Volume 1: Health Care" (December 2008), page 155, available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf

[14] Katherine Swartz, "Cost-Sharing: Effects on Spending and Outcomes" (December 2010), Robert Wood Johnson Foundation Research Synthesis Report No. 20, available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1

[15] RAND, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate" (January 2006), available at: http://www.rand.org/pubs/research_briefs/RB9174.html

[16] Patient Protection and Affordable Care Act, §3210.

[17] National Association of Insurance Commissioners, "Medigap PPACA (B) Subgroup" (as of June 2011) available at: http://www.naic.org/committees_b_sitf_medigap_ppaca_sg.htm; See literature under: "Cost-sharing Research and Literature"

forgo medically necessary services. In a letter to Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services, the NAIC concluded:

> We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost sharing designed to encourage the use of appropriate physicians' services. Therefore, our recommendation is that no nominal cost sharing be introduced to Plans C and F.[18]

We strongly support the NAIC's determination. The conclusions drawn by this subgroup are applicable not only to Medigap reform proposals, but also to proposals to increase Medicare deductibles, coinsurances or copayments.

While some proposals seek savings by way of increased Medicare cost sharing as a vehicle for limiting utilization of care, others find savings merely by charging people with Medicare more. Proposals to increase Medicare Part B and D premiums achieve federal savings by forcing people with Medicare to contribute more for their benefits, the very same taxpayers who paid into the program over the course of their working lives. Similarly, proposals that would add a surcharge or tax to supplemental Medicare coverage, like Medigap plans, aim to accomplish one of two related goals: (1) to deter beneficiaries from opting for coverage that shields them from sporadic and high cost sharing; or (2) to collect revenue from people who choose these plans.

Some proponents of cost shifting to Medicare beneficiaries argue that because most people with Medicare have supplemental coverage, the known harms of added cost sharing, such as self-rationing needed care, would be minimized. Yet, these same proponents suggest that supplemental Medicare coverage, such as Medigap plans or employer-sponsored insurance, should be scaled back, either by prohibiting "first-dollar" coverage or through a premium tax, like that noted above. No matter the combination of cost shifting mechanisms suggested, as demonstrated above, the basis for these plans is fundamentally flawed.

Advancing Value-Driven Care

Cost shifting to Medicare beneficiaries does not solve the underlying problem with our health care system: the long-term challenge of systemic health care inflation. Because these proposals do nothing to reform our health care delivery system or fundamental reimbursement methodologies, they are doomed to a double failure. Not only will these proposals increase costs and limit access to care, they will fail in their stated goal of long-term sustainability for the Medicare program. If wedded to this approach, when again faced with the challenge of reining in health care spending, the only remaining options will be to shift more of the same costs to future beneficiaries.

[18] National Association of Insurance Commissioners, Letter to Secretary Kathleen Sebelius on PPACA Section 3210 (December 2012), available at: http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf

Consequently, while we cannot support cost shifting to beneficiaries, we support Medicare savings solutions that eliminate wasteful spending and promote the delivery of high value care—meaning better quality at a lower price. Restoring Medicare drug rebates for low-income beneficiaries and equalizing reimbursements to private Medicare Advantage (MA) plans are proven cost savers, which do no harm and shift no costs to people with Medicare.

Delivery system and payment reforms are now being implemented in the private sector, in Medicare, and in other public programs, through a variety of initiatives, many contained in the ACA. The ACA offers a starting point to build the high value health care system our nation needs. Medicare is now the incubator for many of these critical reforms.[19]

Despite what some claim, Medicare is *not* in crisis. Cost saving measures taken in the ACA extended the solvency of the Medicare Hospital Insurance (Part A) Trust Fund for eight years, until 2024.[20] This represents one of the longer periods of projected solvency throughout the program's history.[21] For this reason, we reject the notion that we must cut Medicare benefits or shift costs to current retirees and people with disabilities to preserve the program for future generations.

In fact, Medicare cost growth has slowed dramatically in recent years to levels "unprecedented in the history of the Medicare program."[22] Recent analysis illustrates that "health care costs have decelerated over the past few years, and Medicare costs have decelerated more than other health costs."[23] While some of this slowdown is attributable to the continued effects of the economic downturn, research demonstrates much of this change is structural.[24]

We believe that fixing our broken, volume-driven payment system is the right path forward for the Medicare program—both to improve health care delivery and to secure savings. Given slowed Medicare spending growth and promising early returns on certain delivery system reforms, we believe that there is little justification for advancing proposals that increase or shift costs to people with Medicare, like those discussed in more detail below.

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[19] J. Blum, "Delivery System Reform: Progress Report from CMS" (February 2013), available at: http://www.finance.senate.gov/imo/media/doc/CMS%20Delivery%20System%20Reform%20Testimony%202.28.13%20(J.%20Blum).pdf

[20] The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "The 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds" (April 2012), available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf

[21] P.A. Davis, "Medicare: History of Insolvency Projections" (Congressional Research Service: June 2012), available at: http://www.fas.org/sgp/crs/misc/RS20946.pdf

[22] DHHS Office of the Assistant Secretary for Planning and Evaluation, "Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows" (January 2013), available at: http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.cfm

[23] S&P Dow Jone Indices, "Press Release: Deceleration in Annual Growth Rate for All Nine Indices in June 2012, According to the S&P Healthcare Economic Indices" (January 2012); J. Weisenthal, "Peter Orszag's Chart Of The Year Could Change Everything You Think About Healthcare And The Federal Budget" (*Business Insider*: December 2012), available at: http://www.businessinsider.com/peter-orszag-chart-shows-medicare-costs-slowing-2012-12

[24] A. Ryu, T. Gibson, McKeller, M.R., and M.E. Chernew, "The Slowdown in Health Care Spending in 2009-11 Reflected Factors Other Than the Weak Economy and Thus May Persist" (*Health Affairs*: May 2013); D. Cutler and N.R. Sahni, "If Slow Rate of Health Care Spending Growth Persists, Projects May Be Off $770 Billion" (*Health Affairs*: May 2013)

Increasing the Medicare Part B Deductible

Increasing the Medicare Part B deductible, either alone or by combining the Medicare Part A and B deductible, is the centerpiece of several prominent health care savings or deficit reduction plans, including an illustrative proposal offered by MedPAC, and comprehensive plans developed by Erskine Bowles and Alan Simpson (Bowles-Simpson), co-chairs of the National Commission on Fiscal Responsibility and Reform, the Bipartisan Policy Center, and others.[25]

One such proposal, contained in the President's FY2014 budget plan would increase the Part B deductible for future beneficiaries. This proposal would gradually increase the Part B deductible in 2017, 2019 and 2021—adding $25 to the deductible for each cohort joining Medicare each of those years. Current beneficiaries and those entering the program from 2014-2015 would continue to pay the "standard" Part B deductible—$147 in 2013 and likely to rise each year through indexing under current law.[26] New cohorts would pay the standard deductible plus the added $25, and this higher amount would then be indexed each year—essentially creating four separate Medicare deductibles. By the year 2023, this proposal is projected to save $3.3 billion over ten years.[27]

The complexity of this proposal may result from an attempt to lessen the impact of these cost increases. While this motivation is admirable, the proposal is confusing and complex nonetheless. Given our experience counseling people with Medicare, we know that complicated rules and differential treatment creates needless confusion and strain for older adults and people with disabilities. Establishing four separate cohorts within Medicare with four distinct deductibles furthers complication within the program and may increase administrative expenses.

More alarming, however, is that these added costs would impose greater hardship on beneficiaries living on low- and fixed-incomes. Beneficiaries who are "near poor"—those with incomes too high to qualify for low-income assistance programs but still living on limited incomes—are most at risk. As the studies discussed above demonstrate, the additional upfront costs of a higher Part B deductible for doctor's visits and other outpatient services will make necessary care unaffordable and will lead some to forgo such care. This concern is relevant not

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[25] Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Medicare and the Health Care Delivery Payment System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf; National Commission on Fiscal Responsibility and Reform, "The Moment of Truth" (December 2010), available at: http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf; The Moment of Truth Project, "A Bipartisan Path Forward to Securing America's Future" (April 2013), available at: http://www.momentoftruthproject.org/sites/default/files/Full%20Plan%20of%20Securing%20America's%20Future.pdf; Bipartisan Policy Center, "A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment" (April 2013), available at: http://bipartisanpolicy.org/library/report/health-care-cost-containment

[26] Department of Health and Human Services, "Notice: Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2013", available at: http://www.gpo.gov/fdsys/pkg/FR-2012-11-21/pdf/2012-28275.pdf

[27] Congressional Budget Office (CBO), "Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's FY2014 Budget," (May 2013), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44247_APB_HealthCarePrograms.pdf

only for this proposal, but for any plan that would increase the Medicare deductible for outpatient care.

The President's proposal to increase the Part B deductible is distinct from plans, like that suggested by Bowles-Simpson and the Bipartisan Policy Center, to combine the Medicare Part A and B deductible, standardize Part B coinsurances or copayments and introduce a maximum out-of-pocket cap. While benign on their face, many of these proposals would shift added costs to most people with Medicare. A Kaiser Family Foundation analysis of the original Bowles-Simpson scheme found that an overwhelming majority (71%) of people with Medicare would pay more for health coverage.[28]

A second iteration of the Bowles-Simpson plan made attempts to mitigate the known harms of this significant cost shift by, for example, suggesting a lower deductible for individuals living below 200% of the federal poverty level. The Bipartisan Policy Center makes similar attempts through the exemption of physician visits from the combined Medicare Part A and Part B deductible and an increase in income eligibility for low-income subsidy programs. Again, these attempts to soften the self-rationing effect of added cost shifting introduce further complexity to the Medicare program. And while well intentioned, these attempts at harm mitigation beg the question: given the well-documented risk of added cost shifting and the complexity required to prevent resulting harms, is this policy approach a worthwhile one?

Introducing a Home Health Copayment

Another proposal in the President's FY2014 budget would introduce a $100 copayment for home health episodes involving five or more visits not preceded by a hospital visit or a post-acute stay at a skilled nursing or rehabilitative facility. By 2023, this proposal is expected to save $700 million over ten years.[29] MedPAC suggested a similar copayment of $150 for home health services not preceded by some inpatient post-acute care, and the Bipartisan Policy Center proposed a $150 home health episode copayment.[30]

It is worth noting that home health copayments existed in the Medicare program until 1972, when Congress acted to remove them. This action was prompted by the finding that copayments deterred the appropriate use of home health services and contributed to over-utilization of more

[28] Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending." (November 2011), available at: http://kff.org/medicare/report/restructuring-medicares-benefit-design/

[29] Congressional Budget Office (CBO), "Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's FY2014 Budget," (May 2013), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44247_APB_HealthCarePrograms.pdf

[30] Office of Management and Budget, "The President's Budget for FY2014" (April 2013), available at: http://www.whitehouse.gov/omb/budget; Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Medicare and the Health Care Delivery Payment System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf; Bipartisan Policy Center, "A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment" (April 2013), available at: http://bipartisanpolicy.org/library/report/health-care-cost-containment

costly institutional care. In eliminating home health copayments in 1972, Congress presaged the findings of the studies cited above about the negative effects cost shifting has on access to care.[31]

The notion of reintroducing a home health copayment is most alarming because its implications would be most damaging for the most vulnerable: the poorest, the oldest and the sickest. Among home health users, 30% are age 85 or older, compared to 13% among the general Medicare population, and 63% are women. Home health users tend to have lower incomes than the average Medicare beneficiary and already higher health care costs. Home health users also have more limitations in one or more activities of daily living than the average Medicare beneficiary. [32]

While some proposals, like the President's and MedPAC's, attempt to mitigate the harm imposed by a home health copayment by limiting the charge to care that is not preceded by an inpatient stay, this feature perversely imposes the most significant cost burden on the most vulnerable. Beneficiaries who need longer-term maintenance care and ongoing home health services to remain in their homes and communities are most at risk of skipping needed care if forced to pay a copayment. In forgoing this care, they may end up being hospitalized more often or be ultimately forced to enter a more expensive long-term institutional setting, such as a custodial nursing home. In short, those who would be most harmed by the added copayment are the very same beneficiaries who need this care the most.

Proponents of the home health copayment sometimes point to rampant fraud and abuse of the home health benefit in certain areas of the country as a justification for added cost sharing, suggesting that the copayment is an effective method to deter unnecessary use and cut needless Medicare spending. Yet, most, if not all, of this fraud is committed by unscrupulous providers—not beneficiaries. While we should empower older adults and people with disabilities with information and enlist them in the fight against fraud, people with Medicare should not bear the burden of enforcing laws against fraud or be punished for the abusive activities of others.

Further Income-Relating Medicare Part B and Part D Premiums

Many policy makers suggest that wealthier beneficiaries are positioned to contribute more in Medicare costs, specifically through higher premiums, a practice known as means-testing or income-relating. Yet, higher income beneficiaries are *already* means-tested, paying higher Medicare Part B and Part D premiums, well above the standard Part B and Part D premiums.

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[31] Leadership Council of Aging Organizations, "Medicare Home Health Copayments: Harmful for Beneficiaries" (December 2012), available at: http://www.lcao.org/files/2013/02/LCAO-Medicare-Home-Health-Copayments-Issue-Brief-Dec2012.pdf

[32] Leadership Council of Aging Organizations, "Medicare Home Health Copayments: Harmful for Beneficiaries" (December 2012), available at: http://www.lcao.org/files/2013/02/LCAO-Medicare-Home-Health-Copayments-Issue-Brief-Dec2012.pdf; J. Cubanski, "Testimony: An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicare-beneficiaries-costs-and-service-use-testimony.pdf

Specifically, under current law, individuals with annual incomes at or above $85,000 and couples with incomes above $170,000 pay higher Medicare Part B and Part D premiums. Five income brackets exist under this scheme, and contributions steadily increase with income. Today, the vast majority of Medicare beneficiaries pay the standard Part B premium of $105 per month (calculated as 25% of projected annual Part B costs per person aged 65+) and the standard Part D premium for his or her selected plan.[33]

In contrast, beneficiaries who fall into the current highest income tier, those with an annual income at or above $214,000, pay a Part B premium of $336 per month (calculated as 80% of projected annual Part B costs per person aged 65+) and an additional $67 per month on top of his or her selected Part D premium.[34] Couples in the highest income tier pay twice this amount, with Part B premiums reaching nearly $700 per month. An estimated 5% of Medicare beneficiaries (2.4 million) pay an income-related Part B and Part D premium. This share is expected to increase to 9.7% by 2019 as income thresholds were frozen through the ACA. In addition, because there is no cap on Medicare payroll tax deductions, higher income individuals and couples pay higher taxes towards Medicare benefits during their working lives.

Despite the sizable added contribution already made by higher income individuals, several proposals increase both the share of Medicare beneficiaries who pay higher premiums and the amount of those premiums. The President's FY2014 budget proposal further income-relates Medicare premiums by increasing the premium by 5% in each income tier for Part B program costs; by establishing four additional income tiers, from the present five tiers to nine, within the income-relating schedule; and by freezing income thresholds until one in four people with Medicare are subject to the higher premiums. This proposal is expected to save over $56 billion over ten years.[35]

This plan and other similar proposals increase already higher premiums while also forcing a larger share of the Medicare population to pay more. Achieving savings of any scope under these proposals requires reaching relatively far down the income spectrum for people with Medicare. Given that most people with Medicare have low- and moderate-incomes, this necessitates forcing middle class beneficiaries to pay higher premiums. Recent analysis by the Kaiser Family Foundation shows that if one in four people with Medicare were subjected to higher premiums today as proposed, then individuals making $47,000 per year would pay more.[36]

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[33] Kaiser Family Foundation, "Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?" (February 2012), available at: http://kff.org/medicare/issue-brief/income-relating-medicare-part-b-and-part/; Medicare.gov "Part B Costs" (2013), available at: http://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html

[34] Kaiser Family Foundation, "Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?" (February 2012), available at: http://kff.org/medicare/issue-brief/income-relating-medicare-part-b-and-part/; Medicare.gov "Part B Costs" (2013), available at: http://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html

[35] Congressional Budget Office (CBO), "Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's FY2014 Budget," (May 2013), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44247_APB_HealthCarePrograms.pdf

[36] Kaiser Family Foundation, "Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?" (February 2012), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8276.pdf

Proposals to further income-relate Medicare premiums are characterized as seeking a fairer contribution from the wealthiest people. Yet, these proposals define wealth arbitrarily and differently from our tax code. The notion of a wealthy household for purposes of tax policy tends to start at an annual income of $200,000 or higher for an individual—the American Taxpayer Relief Act of 2012 established higher tax rates for individuals earning over $400,000 per year. [37] Yet, under current law people with Medicare fall into the category of "wealthy" with annual incomes of $85,000.

As proposed, added income-relating in Medicare premiums constitutes little more than a cost shift to middle class retirees and people with disabilities. This slippery slope has broader consequences for the Medicare program, eroding popular support for one of society's most successful pillars of retirement security. Further means-testing Medicare would undermine the social insurance model inherent to the historical, quantifiable success of the program. Though taxes paid over a lifetime of work, Americans jointly bear the responsibility of ensuring that our nation's older adults and people with disabilities have access to health care when they need it the most—this is the social insurance value of Medicare. The financing of Medicare Part A, Part B, Part C and Part D, whether paid for through payroll taxes, income taxes or premiums, have no bearing on this social contract. To qualify for the Medicare program, a person must have paid these taxes. Arbitrarily determining that some share of people with Medicare should be forced to pay more chips away at what makes Medicare a success.

Splintering Medicare's social insurance foundation is likely to have real-world consequences. Through our helpline and education initiatives, we hear stories of wealthier beneficiaries opting to leave the Medicare program altogether, rather than paying Medicare's income-related premiums. This trend threatens the size and overall health of the Medicare beneficiary pool and also the desired savings attached to these proposals.

Finally, these proposals again introduce needless complexity to an already complicated Medicare system, as well as higher administrative costs. Five existing income-related premium tiers in Medicare are difficult to explain to newly eligible Medicare beneficiaries. Four additional tiers will only worsen this conundrum.

Conclusion

We remain deeply concerned about the effects of further cost shifting to people with Medicare, and we believe the proposals described here pose substantial risks to the health and economic security of beneficiaries, namely those with low- and modest-incomes and people with significant health needs. We acknowledge, however, that we must find savings in the Medicare program to sustain this guaranteed health benefit for today's beneficiaries and future generations.

[37] M.L. Crandall-Hollick, "An Overivew of the Tax Provisions in the American Taxpayer Relief Act of 2012" (Congressional Research Service: January 2013), available at: http://www.fas.org/sgp/crs/misc/R42894.pdf

Toward this end, we support prudent reform and cost-containment to help solve the real threat to our nation's fiscal health: rising health care costs system-wide. To realize this goal, we endorse cost saving solutions that eliminate wasteful spending and promote the delivery of high value care, meaning higher quality and more cost-effective care. Examples of these savings mechanisms include:

Advance delivery and payment system innovations. The federal government should maximize its authority to test delivery system reforms designed to enhance health care quality while simultaneously driving down the cost of care. Kick started by the ACA, these reforms are meant to improve care quality by promoting better coordination among providers, patients and caregivers to prevent harmful drug interactions, unnecessary hospitalizations and more.[38]

Restore Medicare drug rebates. The passage of Medicare Part D rescinded prescription drug rebates—a critical tool that allows the federal government to secure lower drug prices—for beneficiaries dually eligible for Medicare and Medicaid. As reflected in the Medicare Drug Savings Act of 2013 (S. 740 and H.R. 1588) and the President's FY2014 budget, restoring Medicaid-level drug rebates for low-income Medicare beneficiaries would save taxpayers between almost $133.7 to $141.2 billion over 10 years.[39]

Eliminate wasteful overpayments to Medicare Advantage (MA) plans. The ACA made strides to reduce overpayments to private Medicare health plans, but more could be done by expediting implementation of lowered benchmarks, the maximum cost that Medicare will pay MA plans per enrollee in a given area, or revisiting plan benchmarks to equalize spending between MA plans and traditional Medicare.[40]

Risk scoring—the formula Medicare uses to determine MA plan payments based on estimated costs per beneficiary adjusted for health status—could also be adjusted to eliminate overpayments caused by differences in diagnostic coding between people with MA plans and

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[38] Medicare Rights Center, "Build on What Works: Medicare Cost Savers" (May 2013), available at: http://www.medicarerights.org/pdf/Medicare-Cost-Savers.pdf; National Coalition on Health Care. "Curbing Costs, Improving Care: The Path to an Affordable Health Care Future" (November 2012), available at: http://nchc.org/sites/default/files/NCHC%20Plan%20for%20Health%20and%20Fiscal%20Policy.pdf

[39] Congressional Budget Office (CBO), "Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's FY2014 Budget," (May 2013), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44247_APB_HealthCarePrograms.pdf; Committee on Energy and Commerce, "Democratic Leaders Introduce Legislation to Save Taxpayers More Than $140 Billion in Medicare Drug Costs," (April 2013), available at: http://democrats.energycommerce.house.gov/index.php?q=news/democratic-leaders-introduce-legislation-to-save-taxpayers-more-than-140-billion-in-medicare-dr; Office of Senator J. Rockefeller, "Press Release: Rockefeller and 18 Other Senators Introduce Legislation to Protect Seniors & Reduce Deficit by $141.2 Billion", available at: http://www.rockefeller.senate.gov/public/index.cfm/press-releases?ID=617fffeb-4c5a-4123-a5b3-1f8b790e5f8b

[40] Kaiser Family Foundation, "Policy Options to Sustain Medicare for the Future" (February 2013), available at: http://kff.org/medicare/report/policy-options-to-sustain-medicare-for-the-future/

people with traditional Medicare—saving $8.6 billion over 10 years as reflected in the President's FY2014 budget.[41]

In addition to these solutions, we encourage members of Congress to explore the following: introducing a public Part D drug benefit, creating or piloting a publicly-administered Medicare supplemental plan, expanding competitive bidding for medical equipment to products like lab tests and advanced imaging services, and lowering cost sharing for generic pharmaceutical drugs.

We look forward to working with the Subcommittee and members of Congress to examine additional cost saving options in the Medicare program that simultaneously address the systemic issue of rising health care costs that concern not only Medicare, but also the private health insurance market. We implore you to reject proposals that fail to build a better health care system and instead achieve only ephemeral savings by shifting costs to people with Medicare.

Thank you for the opportunity to testify.

[41] Congressional Budget Office (CBO), "Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's FY2014 Budget," (May 2013), available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44247_APB_HealthCarePrograms.pdf