August 16, 2013

The Honorable Dave Camp
Chairman
Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Camp:

On behalf of AARP's over 37 million members, and millions of Medicare beneficiaries, thank you for soliciting public feedback on reforming Medicare. We agree health care spending generally needs to be brought under control in order to preserve the program for future generations. Growing spending on health care has strained the Medicare Hospital Insurance Trust Fund (Part A) and has required an increasingly larger portion of general revenues (Parts B and D). However, the options presented by the Committee do nothing to address the underlying causes of high health care spending. Instead, they merely shift the financial burden onto older Americans and others who depend on Medicare for their health security.

In addition to high health care costs, increased Medicare expenditures are due primarily to a growing Medicare population. Spending per beneficiary has actually grown slower than both GDP and private insurance in recent years. Proposals which force beneficiaries to pay more, without improving the value and quality of care received, essentially punish the beneficiary for being sick. Moreover, when half of all beneficiaries earn less than $22,000 per year and already spend 17% of their income on health care expenses, adding to their personal costs is no solution – it simply shifts costs and reduces access to care. The three specific ideas the Committee puts forth – increasing the Part B deductible; increasing income-relating of premiums; and adding a home-health copay – are prime examples of shifting costs to beneficiaries without addressing the causes of high health costs.

First, when confronted with paying a deductible or copay, the patient considers whether to utilize the service or not. If the provider orders a test, the patient either accepts the doctor's advice or chooses to forgo care; the patient is not thinking about finding a better deal elsewhere. Once engaged with their physician, the patient usually follows the doctor's recommendations. Seldom do beneficiaries second-guess the doctor's decision as to the necessity of the service. Increased cost-sharing may reduce utilization, but it reduces both necessary and unnecessary care. Patients forgoing necessary care due to higher cost may end up costing Medicare more in the long run.

In particular, Medicare beneficiaries in need of home-health services are likely to be older, sicker and poorer. These beneficiaries could forgo necessary home-health if there is a copay, which could lead to higher Medicare costs through increased inpatient costs, such

as unnecessary hospitalizations, or the use of higher cost care. Currently, the home health benefit does not require beneficiary cost-sharing for home health services. Originally, home health services covered under Part B were subject to a 20% coinsurance of the Medicare-approved amount and the Part B deductible. The Social Security Amendments of 1972 (P.L. 92-603) eliminated the 20% coinsurance and Omnibus Budget Reconciliation Act of 1980 (OBRA 80, P.L. 96-499) eliminated the Part B deductible for home health services. Previous experience with a Medicare home-health copay led Congress to repeal it, due to the burden it placed on seniors and the services it shifted to costly settings. Home-health copays would also increase Medicaid costs for state governments, since Medicaid would pay in many cases for the copays of individuals dually eligible for Medicare and Medicaid. Likewise, Medigap and employer costs for supplemental retiree coverage would also increase, as supplemental plans would pay the cost sharing amounts previously covered by Medicare.

Second, raising the applicable percentage amount for premiums and expanding income-relating to 25 percent of the beneficiary population is essentially a tax increase placed squarely on the middle class. To put this in perspective, presently only 5 percent of beneficiaries reach the income threshold for higher premiums. If the 25-percent quota were instituted today, the threshold would have to be set under $50,000 (instead of the current $85,000). This would be in addition to the existing tax paid to Medicare by middle-income Social Security beneficiaries with incomes over $34,000 ($44,000 couple filing jointly) -- aside from premiums and other cost-sharing, middle class beneficiaries above these thresholds continue to finance Medicare during their retirement through a dedicated Medicare income tax on up to 35 percent of their Social Security benefit.

Moreover, when determining who is subject to the income-related premium, the Medicare program relies on the beneficiary's tax return from the prior year (which reports income from the year before). Thus, new retirees (whose income is likely to have dropped precipitously from their working years) would be subject to higher income-related premiums based on their previous wages, not their current financial situation.

Unfortunately, a common refrain among proponents of greater cost-sharing is Medicare beneficiaries receive three times more in benefits than they contribute. There is significant limitation of a dollar-in/dollar-out assessment of the Medicare program. For instance, the "average" lifetime benefit does not reflect any individual's circumstances. We know, for instance, the small percentage of beneficiaries with multiple chronic conditions use a significant percent of Medicare resources. In fact, recent numbers indicate Medicare spending on those with even one chronic condition is 5.4 times greater in Part A and 2.35 times greater in Part B compared to beneficiaries without chronic conditions.[1] Thus, most beneficiaries never reach the "average" lifetime benefit.

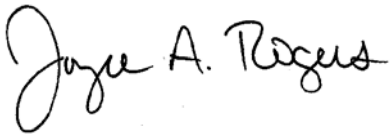
More importantly, the numbers do not reflect value. Some experts have argued that up to 30 percent of Medicare spending is wasteful and does little to improve health. These lifetime benefit estimates, therefore, include wasteful spending. The problem with concentrating on the gap between contribution and benefit is it inevitably calls for either

[1] Centers for Medicare and Medicaid Services; *Medicare & Medicaid Research Review,* Medicare Payments: How Much Do Chronic Conditions Matter? 2013, volume 3, number 2.

increasing taxes or cutting benefits, or both, without addressing the underlying inefficiencies in the system. Instead, we must focus on responsible solutions to get better value for our health care dollars. As the health care system embraces the goals of better care, better health, and lower costs, the gap between Medicare taxes paid and benefits received will likely fall.

We can and should first reduce wasteful and ineffective Medicare spending before forcing a greater financial burden onto beneficiaries. AARP looks forward to working with you to reduce the cost of care in Medicare, for example, by improving care coordination; reducing waste, fraud, and abuse; and lowering the high prices of brand name prescription drugs and durable medical equipment. Ultimately, the higher the value of the program, the better the quality of care, and the lower the cost to both taxpayers and beneficiaries. Please feel free to contact me or have your staff contact Ariel Gonzalez of our Government Affairs staff at agonzalez@aarp.org or 202-434-3770 if you have any questions.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs