

# Medicare Reform: The Seniors' Perspective

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## Leadership Council of Aging Organizations

*James P. Firman, Chair  
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Leadership Council  
of Aging Organizations

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The Leadership Council of Aging Organizations (LCAO) is a coalition of 68 prominent national aging advocacy organizations that represent millions of older Americans. Together, we work to preserve and strengthen the well-being of America's older population and are committed to representing their interests in the policy-making arena.

LCAO's purpose is to foster communication and resource sharing among its member organizations, to serve as a source of information about issues affecting older persons, to initiate joint advocacy strategies as appropriate, and to provide leadership and vision as America meets the challenges and opportunities presented by its aging society.

AARP	National Adult Day Services Association (NADSA)
AFL-CIO	National Adult Protective Services Association (NAPSA)
AFSCME Retirees (AFSCME)	National Alliance for Caregiving
Alliance for Aging Research	National Asian Pacific Center on Aging (NAPCA)
Alliance for Retired Americans	National Association for Home Care and Hospice (NAHC)
Alzheimer's Association	National Association of Area Agencies on Aging (n4a)
Alzheimer's Foundation of America	National Association of Nutrition and Aging Services Programs (NANASP)
American Association for International Aging (AAIA)	National Association of Professional Geriatric Care Managers (NAPGCM)
American Federation of Teachers Program on Retirement & Retirees (AFT)	National Association of Retired and Senior Volunteer Program Directors, Inc. (NARSVPD)
American Foundation for the Blind (AFB)	National Association of Social Workers (NASW)
American Geriatrics Society (AGS)	National Association of State Long-Term Care Ombudsman Programs (NASOP)
American Postal Workers Union Retirees (APWU)	National Association of States United for Aging and Disabilities (NASUAD)
American Public Health Association (APHA)	National Caucus and Center on Black Aged, Inc. (NCBA)
American Society of Consultant Pharmacists (ASCP)	National Committee to Preserve Social Security and Medicare (NCPSSM)
American Society on Aging (ASA)	The National Consumer Voice for Quality Long-Term Care
Asociacion Nacional Pro Personas Mayores (ANPPM)	National Council on Aging (NCOA), <b>2012-13 Chair</b>
<i>(National Association for Hispanic Elderly)</i>	National Hispanic Council on Aging (NHCOA)
Association for Gerontology and Human Development in Historically Black Colleges and Universities (AGHDHBCU)	National Indian Council on Aging (NICOA)
The Association of BellTel Retirees, Inc.	National Osteoporosis Foundation (NOF)
Association of Jewish Aging Services (AJAS)	National Senior Citizens Law Center (NSCLC)
B'nai B'rith International	National Senior Corps Association (NSCA)
Catholic Health Association of the United States (CHA)	OWL, The Voice of Midlife and Older Women
Center for Medicare Advocacy, Inc.	Pension Rights Center
Easter Seals	PHI - Quality Care <i>through</i> Quality Jobs
Experience Works	Senior Service America, Inc.
Families USA	Service Employees International Union (SEIU)
The Gerontological Society of America (GSA)	Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE)
Gray Panthers	Southeast Asia Resource Action Center (SEARAC)
International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW)	Visiting Nurse Associations of America (VNAA)
The Jewish Federations of North America	Volunteers of America
LeadingAge	Wider Opportunities for Women (WOW)
Lutheran Services in America (LSA)	Women's Institute for a Secure Retirement (WISER)
Meals On Wheels Association of America (MOWAA)	
Medicare Rights Center	
Military Officers Association of America (MOAA)	
National Academy of Elder Law Attorneys (NAELA)	
National Active and Retired Federal Employees Association (NARFE)	

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*To view and download each of these documents individually, please visit [www.lcao.org](http://www.lcao.org).*

## **LCAO Federal Budget Principles**

The Leadership Council of Aging Organizations (LCAO) is a coalition of 68 national nonprofit organizations concerned with the well-being of America's older population and committed to representing their interests in the policy-making arena. As the budget process continues to move forward, we believe the nation can and should reduce the deficit over time through a balanced approach that includes budget savings from increases in revenue and thoughtful, targeted reductions in spending when and where necessary, without increasing poverty or income inequality.

Spending cuts to discretionary programs enacted last year, primarily in the Budget Control Act, have produced \$1.5 trillion in savings for fiscal years 2013 to 2022. In the name of deficit reduction, some have called for additional deep cuts in funding for senior services, health care, workforce development, affordable housing, and other vital domestic programs while extending and expanding tax cuts for those who do not need them and continuing unnecessarily high military spending. Some would cut Social Security, Medicare, and Medicaid in ways that would darken the future for millions of vulnerable Americans - young and old. In particular, it is important to note that Social Security has not contributed to the current budget problem.

The reality is these federal programs form a successful backbone of initiatives that provide support to millions of older Americans, workers and families in need. These kinds of proposed cuts run counter to American values of opportunity and security for all.

There are other more equitable, budget balancing options, specifically on the revenue side. Numerous recent surveys support the mounting consensus that the solution to addressing the deficit must include significant revenues, and that the richest households should not receive continued tax cuts. In an April 2012 survey by CNN/ORC International, 68 percent of Americans agreed that “the present tax system benefits the rich and is unfair to the ordinary working man or woman.” A June 2012 poll by Hart Research Associates found that 68 percent of respondents supported continuing the Bush tax cuts for income below \$250,000 but ending them for income above \$250,000. In a July 2012 survey by the Pew Research Center, by a two-to-one margin, respondents said that raising taxes on incomes above \$250,000 would help the economy rather than hurt it.

It is also important to note that, according to the Congressional Budget Office, Americans paid the lowest tax rates in 30 years to the federal government in 2009, and that permitting the 2001 and 2003 tax cuts to expire for income above \$250,000 would reduce the federal deficit by \$950 billion over 10 years.

A responsible solution to current fiscal challenges need not threaten the economic and health security of elders and their families. Instead, the federal government must continue to be an engine for shared prosperity and a defender of older Americans.

The Leadership Council of Aging Organizations believes these principles should guide any negotiation to address the budget gap:

1. Any budget agreement should be developed with the overarching goal of building economic security for older Americans and their families, strengthening the middle class, and promoting job growth.
2. In addressing the annual deficit and accumulated national debt, any budget agreement must adopt a balanced approach, including revenue raisers, whether through reform of tax expenditures or promoting an equitable tax system, as well as savings from mandatory and discretionary spending which yields the resources necessary to address national needs, reduce the deficit, and retire debt. Given our nation's significant fiscal challenges and difficult budget choices, a universal, across-the-board extension of the

2001 and 2003 tax cuts should be rejected. We particularly have very serious reservations about the affordability and fairness of extending tax cuts for the highest income individuals.

3. Any budget agreement must protect those older adults (and ALL Americans) in greatest need, both socially and economically, by fairly balancing budget resources against sacrifices, protecting low-income Americans and, ultimately, taking no actions that increase economic vulnerability, hunger, or poverty. Any budget agreement should protect income and health security for low-income Americans.
4. Any budget agreement must be sensitive to the impact of the current economic downturn, which demands budget solutions that stabilize both the American economy and the budgets of low- and middle-income American families, in line with the economic situation of working and retired older Americans.
5. Any budget agreement should recognize that Social Security does not contribute to the federal deficit and that negotiations to ensure long-term solvency should be addressed independently. Among other things, attempts to means-test Social Security benefits, impose a chained CPI, or raise the retirement age would result in benefit cuts that would drastically harm both today's and future generations of older Americans while doing nothing to reduce the federal deficit. Similarly, the Civil Service Retirement System is fully funded, actuarially sound and does not contribute to the federal deficit.
6. ***Any budget agreement, in building on the cost savings and efficiencies of the Affordable Care Act, must reduce the rate of increase in federal health spending by addressing the systemic causes of health care inflation, not by shifting costs on to consumers, to states or singling out Medicare and Medicaid. The essential structure and integrity of the Medicare and Medicaid programs must be maintained.***
7. ***In addressing the nation's rising health care costs -- and their growing share of federal budget expenditures -- any budget agreement must protect consumers, maintain the health care workforce and access to needed health and long-term care, and preserve the federal government's authority to determine eligibility and consumer protections for federal programs serving older adults and people with disabilities, particularly those dually eligible for both Medicare and Medicaid, and others living on low, fixed incomes.***
8. Any budget agreement must avoid resorting to any additional automatic, arbitrary spending caps and sequestration mechanisms which deny legislators the opportunity to set priorities in the allocation of tax dollars, now and in the future. The across-the-board sequestration called for under the Budget Control Act is an example of arbitrary cuts that will harm supports and services for the elderly and their families. Sequestration should be averted in keeping with the principles stated in this document. The reductions in discretionary spending that the 112th Congress and the President have already achieved should be counted toward any deficit reduction target, and further cuts to domestic discretionary programs below the caps established in the Budget Control Act should be rejected.

## Medicare Beneficiary Characteristics and Out-of-Pocket Costs

Containing Medicare costs is an important goal, both in terms of improving affordability for those who need care and ensuring long-term sustainability of the program. Some policy makers, however, believe that seniors do not have enough “skin in the game” and are proposing to shift more out-of-pocket costs onto beneficiaries – this approach would fail to address the underlying causes of cost growth. It does not take into account three key facts: (1) The vast majority of beneficiaries have low or modest incomes; (2) The Medicare benefit package is not overly generous; and (3) Medicare beneficiaries already pay significant out-of-pocket costs.

Some plans propose increasing Medicare cost sharing, which is already high, has been increasing rapidly, and would make health care unaffordable for millions of older Americans. It is critical to understand that most beneficiaries struggle financially, already have high health costs, and cannot pay more.

LCAO recognizes the need to bring down the nation’s deficit and reduce health care spending. With respect to Medicare, we support savings mechanisms that address system-wide health care inflation and build on the cost savings and efficiencies of the Affordable Care Act, not merely shifting even more costs on to the backs of Medicare beneficiaries. Even the American Academy of Actuaries agrees: “[I]mproving Medicare’s long-term sustainability requires slowing the growth in overall health spending – not simply shifting costs from one payer to another.”<sup>i</sup>

### Medicare Beneficiary Characteristics

- **Most people with Medicare have low or modest incomes.** In 2012, half of all people with Medicare lived on incomes of [\\$22,500](#) or less per year— just under 200% of the federal poverty level. And half of beneficiaries had [\\$77,500](#) or less in savings. One quarter of Medicare beneficiaries have annual incomes at or below [\\$14,000](#).<sup>ii</sup>
- **Older women and people of color live on even less.** In 2011, median income for older women amounted to just [\\$15,072](#) per year. Median annual incomes are also lower for diverse communities—[\\$15,252](#) for African American Medicare beneficiaries and [\\$13,805](#) for Hispanic beneficiaries. The incidence of poverty is higher among women and communities of color. Older people of color are twice as likely to live in poverty – [18%](#) among African Americans and Hispanic households vs. [7%](#) among white households.<sup>iii</sup>
- **Many beneficiaries are in poor health.** Almost half ([40%](#)) of the Medicare population is living with three or more chronic conditions and an estimated [23%](#) have a cognitive or mental impairment.<sup>iv</sup> These individuals rely on Medicare to help afford essential treatment.

### Medicare Beneficiary Out-of-Pocket Costs

- **Health care costs are a significant expense for Medicare beneficiaries.** In 2010, the average Medicare household spent [\\$4,500](#) per year on health care. Medicare premiums account for the most significant expense – [10%](#) of spending per household. In the last 5 years of life, beneficiaries spend [\\$38,688](#) on average. For 25% of beneficiaries, out-of-pocket costs average [\\$101,791](#) during this period. Almost half of Americans die with less than [\\$10,000](#) in financial assets.<sup>v</sup>
- **Beneficiary out-of-pocket costs are increasing.** The cost of Medicare Part B and D premiums and cost sharing as a share of the average Social Security benefit increased from [7%](#) in 1980 to [14%](#) in 2000 and up to [26%](#) in 2010.<sup>vi</sup>
- **Under Medicare, many health care needs are not covered.** Medicare coverage is not comprehensive and tends to be less generous than typical large employer plans. For instance, Medicare does not cover dental, vision and most long-term care services and supports. Further, one study found that, for the average senior,



Medicare covered [\\$11,930 of the \\$14,890](#) in estimated annual health care spending – less than would be covered under either the federal employee plan ([\\$12,260](#)) or the typical Preferred Provider Organization (PPO) comparison plan ([\\$12,800](#)) for an employee who is 65 or older.<sup>vii</sup>

- **Families on Medicare pay more for health care than non-Medicare households.** On average, in 2010, Medicare households spent [15%](#) of total costs on health care; whereas, non-Medicare households spent just [5%](#). Medicare and non-Medicare households spent similar shares on other basic needs, including housing, transportation, food and other necessities. This fact is attributable to lower average household budgets overall ([\\$30,800](#) vs. [\\$49,600](#) in 2010) and higher average health care spending among Medicare households than non-Medicare households ([\\$4,500](#) vs. [\\$2,450](#) in 2010).<sup>viii</sup>
- **Increased cost sharing often leads to adverse health consequences and can increase total spending on health care.** Some policymakers want to increase beneficiary cost-sharing in order to reduce perceived over-utilization of unnecessary medical services. Such efforts, however, will also lead people to forgo medically necessary services, such as not complying with prescribed drug use due to cost, or putting off care and prevention until expensive emergency services are needed. As a result, higher cost sharing backfires, since sicker patients will require more costly and invasive care down the road.<sup>ix</sup>
- **Baby Boomers face increased financial uncertainty due to the economic downturn.** Today's working adults need Medicare to remain affordable, particularly due to declining home values, diminished retirement accounts, and job loss caused by the recession. Estimates suggest half of all Baby Boomers will live on incomes less than [\\$27,000](#) per year. Moreover, from 1992 to 2007, the average overall debt for 55 to 64 year old households more than doubled to [\\$70,370](#). Debt among older adults (age of 55+) continues to increase—[63%](#) had some level of debt.<sup>x</sup>
- **Medicare low-income protection programs are broken and must be modernized.** According to the most recent estimates by CBO, only [33%](#) of eligible beneficiaries were enrolled for Qualified Medicare Beneficiary (QMB) benefits and only [13%](#) were enrolled for Specified Low-Income Medicare Beneficiary (SLMB) benefits.<sup>xi</sup> In addition, rigid, unreasonably low asset tests (not imposed on those under age 65 to receive low-income protections) penalize beneficiaries by denying eligibility to those who did the right thing during their working years by setting aside a modest nest egg of savings.

<sup>i</sup> ["Letter to the Joint Select Committee on Deficit Reduction"](#) American Academy of Actuaries (August 2011)--

<sup>ii</sup> Cubanski, J. ["An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use"](#) Kaiser Family Foundation testimony to the U.S. Senate Special Committee on Aging (February 2013)

<sup>iii</sup> ["Key Issues in Understanding the Economic and Health Security of Current and Future Generations of Seniors"](#) Kaiser Family Foundation (March 2012); Cubanski, J. ["An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use"](#) Kaiser Family Foundation testimony to the U.S. Senate Special Committee on Aging (February 2013)

<sup>iv</sup> Cubanski, J. ["An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use"](#) Kaiser Family Foundation testimony to the U.S. Senate Special Committee on Aging (February 2013)

<sup>v</sup> ["Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households"](#) Kaiser Family Foundation (March 2012); Kelley AS, McGarry K, Fahle S, Marshall SM, Qingling D and JS Skinner. ["Out-of-pocket spending in the last five years of life"](#) *Journal of General Internal Medicine* (October 2012); ["Were they prepared for retirement? Financial status at advanced ages in the HRS and Ahead Cohorts"](#) National Bureau of Economic Research (February 2012)

<sup>vi</sup> Cubanski, J. ["An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use"](#) Kaiser Family Foundation testimony to the U.S. Senate Special Committee on Aging (February 2013)

<sup>vii</sup> ["How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?"](#) Kaiser Family Foundation (April 2012)

<sup>viii</sup> ["Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households"](#) Kaiser Family Foundation (March 2012)

<sup>ix</sup> ["Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper"](#) National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup (October 2011); Amal N. Trivedi, et. al. ["Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly"](#) *New England Journal of Medicine* (January 2010); Swartz, K. ["Cost-Sharing: Effects on Spending and Outcomes"](#) Robert Wood Johnson Foundation Research Synthesis Report No. 20 (December 2010)

<sup>x</sup> ["Projecting Income and Assets: What Might the Future Hold for the Next Generation of Medicare Beneficiaries?"](#) (Kaiser Family Foundation (June 2011); ["Debt of the Elderly and Near Elderly"](#) Employee Benefits Research Institute (February 2013)

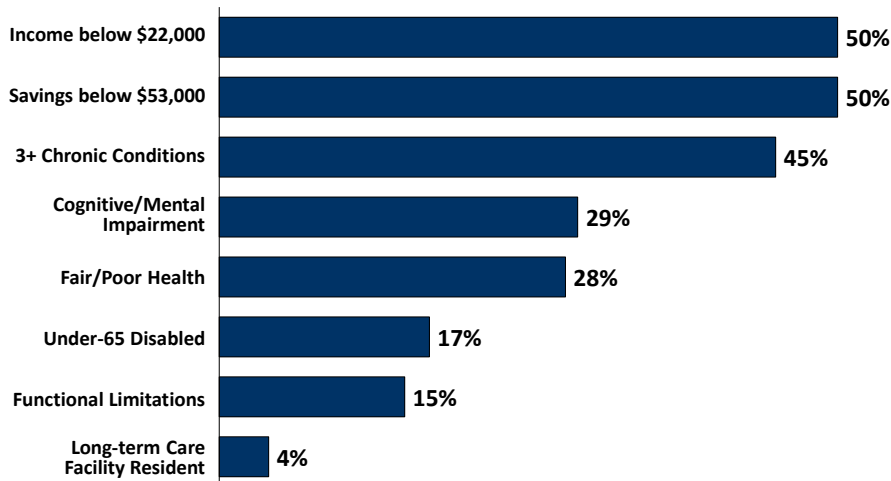
<sup>xi</sup> ["Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment"](#) GAO-12-871 (September 2012)

## Medicare Beneficiary Characteristics and Costs

EXHIBIT 1

### Characteristics of the Medicare Population

Percent of total Medicare population:



NOTE: \*Total household income and savings for couples is split equally between husbands and wives to estimate income for married beneficiaries. Income includes IRA and 401k withdrawals. ADL is activity of daily living.

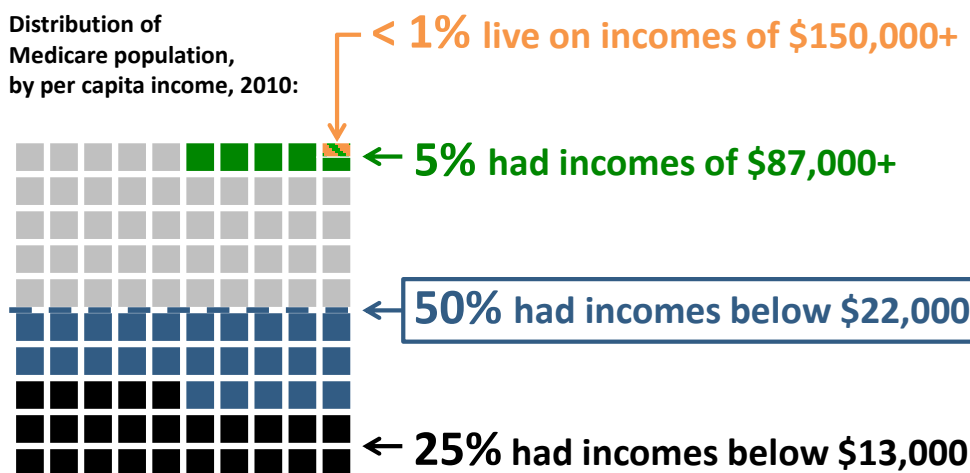
SOURCE: Income data for 2009 from U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement. All other data from Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary 2008 Access to Care file.



EXHIBIT 2

### Relatively few Medicare beneficiaries have really high incomes Half live on incomes of less than \$22,000 (2010)

Distribution of Medicare population, by per capita income, 2010:



NOTE: Total household income for couples is split equally between husbands and wives to estimate income for married beneficiaries. SOURCE: Kaiser Family Foundation, "Projecting Income and Assets: What Might the Future Hold for the Next Generation of Medicare Beneficiaries?" June 2011.

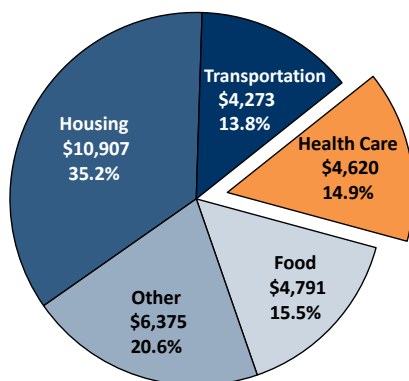




EXHIBIT 3

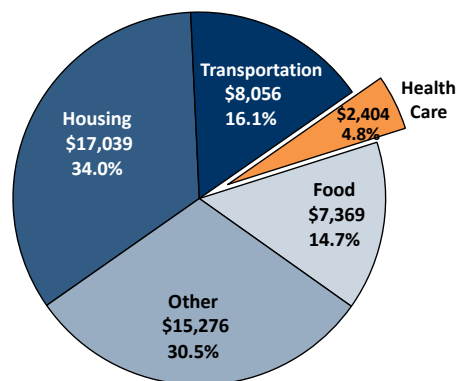
## Medicare households spend significantly more than non-Medicare households on health care expenses

Medicare Household Spending



Average Household Spending =  
\$30,966

Non-Medicare Household Spending



Average Household Spending =  
\$50,143

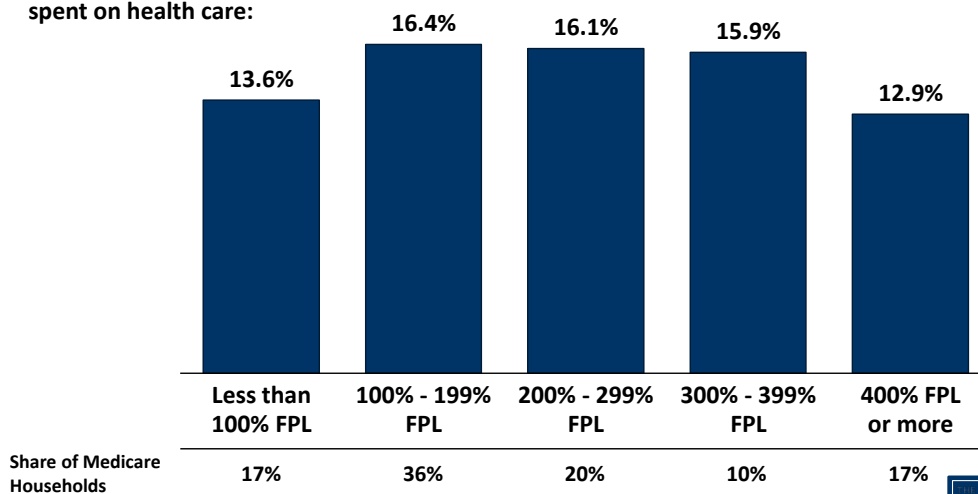
SOURCE: Kaiser Family Foundation analysis of the Bureau of Labor Statistics Consumer Expenditure Survey Interview and Expense Files, 2009.



EXHIBIT 4

## Medicare households just above the poverty level spend a greater share of their household budgets on health care than the poorest and highest-income households

Share of household budget  
spent on health care:



SOURCE: Kaiser Family Foundation analysis of the Bureau of Labor Statistics Consumer Expenditure Survey Interview and Expense Files, 2009.



## Numerous Public Opinion Surveys Consistently Show Americans Strongly Oppose Additional Medicare Cuts

1. In order to reduce the budget deficit, would you favor or oppose reducing spending on Medicare – the government health insurance program for seniors?

**Percentage opposed to reducing Medicare spending to reduce the deficit:**

- **All respondents: 80%**
- **Democrats: 87%**
- **Republicans: 72%**

March 20-24, 2013 – CBS News Poll (Question 36)<sup>i</sup>

2. Would you increase, decrease, or keep spending the same for Medicare?

- **Decrease spending: 15%**
- **Same spending: 46%**
- **Increase spending: 36%**

February 13-18, 2013 – Pew Research Center for People and the Press (Question 2B)<sup>ii</sup>

3. If the president and Congress decide to reduce the deficit by reducing spending on federal programs and services, in which programs you would be willing to see spending reduced? (responses on Medicare spending):

- **Major reductions: 10%**
- **Minor reductions: 31%**
- **No reductions: 58% (66% of Democrats; 50% of Republicans)**

January 3-9, 2013 – Kaiser Family Foundation/Robert Wood Johnson Foundation/Harvard School of Public Health Poll (Question 10)<sup>iii</sup>

4. Please tell me whether you support or oppose each of the following to reduce the federal budget deficit: Cut spending for Medicare?

- **Percentage opposing Medicare cuts:**
  - **All voters: 74%**
  - **Democrats: 85%**
  - **Republicans: 68%**

December 4-6, 2012 – McClatchy-Marist Poll (Page 17)<sup>iv</sup>

5. Should spending on Medicare be cut back a lot, some, or not at all to help reduce the deficit?

- **Not at all: 79%**
- **Some: 17%**
- **A lot: 3%**

November 29-December 2, 2012 – Princeton Survey Research Associates International for National Journal Poll (Question CC4)<sup>v</sup>

6. How much do you support or oppose reducing Medicare benefits as a means to reduce the budget deficit?

	<u>Total</u>	<u>Dem</u>	<u>Rep</u>	<u>Ind</u>
<b>Strongly support</b>	<b>4%</b>	<b>2%</b>	<b>5%</b>	<b>4%</b>
<b>Somewhat support</b>	<b>14%</b>	<b>11%</b>	<b>18%</b>	<b>15%</b>
<b>Somewhat oppose</b>	<b>19%</b>	<b>21%</b>	<b>17%</b>	<b>22%</b>
<b>Strongly oppose</b>	<b>58%</b>	<b>64%</b>	<b>53%</b>	<b>53%</b>

Many candidates promised during the campaign that any proposed changes to Medicare would not affect current beneficiaries. How important is it to you that (INSERT Obama/Romney) ensures benefits are not reduced for current Medicare beneficiaries?

	<u>Total</u>	<u>Dem</u>	<u>Rep</u>	<u>Ind</u>
<b>Very important</b>	<b>76%</b>	<b>80%</b>	<b>70%</b>	<b>75%</b>
<b>Somewhat important</b>	<b>18%</b>	<b>16%</b>	<b>20%</b>	<b>20%</b>
<b>Not very important</b>	<b>3%</b>	<b>1%</b>	<b>5%</b>	<b>3%</b>
<b>Not at all important</b>	<b>2%</b>	<b>1%</b>	<b>3%</b>	<b>2%</b>

November 7-8, 2012 – AARP (Questions 13 and 17)<sup>vi</sup>

7. As you know, the US federal budget has a significant deficit. Here are the main expenses for the government. In your view, which of the following areas can we afford to cut back on? (Select all that apply)

- **Percentage supporting Medicare cuts:**
  - **All voters: 10%**
  - **Democrats: 5%**
  - **Republicans: 16%**

August 27-31, 2012 – Ipsos Public Affairs Poll for Reuters (Question 6)<sup>vii</sup>

<sup>i</sup> [http://www.cbsnews.com/8301-250\\_162-57576433/poll-80-of-americans-unhappy-with-washington/?pageNum=2](http://www.cbsnews.com/8301-250_162-57576433/poll-80-of-americans-unhappy-with-washington/?pageNum=2) (1,181 adults interviewed)

<sup>ii</sup> <http://www.people-press.org/2013/02/22/as-sequester-deadline-looms-little-support-for-cutting-most-programs/> (1,504 adults interviewed)

<sup>iii</sup> <http://www.kff.org/kaiserpolls/upload/8405-T.pdf> (1,347 adults interviewed)

<sup>iv</sup> <http://maristpoll.marist.edu/1212-four-in-ten-with-high-expectations-for-obamas-second-termapproval-rating-at-50> (553 registered voters interviewed)

<sup>v</sup> <http://www.scribd.com/doc/115382029/NJ-CC-Poll-Topline-Results-Dec-3-2012> (1,003 adults interviewed)

<sup>vi</sup> [http://www.aarp.org/content/dam/aarp/research/surveys\\_statistics/general/2012/Americans-50-and-the-Future-of-Medicare-and-Social-Security-AARP.pdf](http://www.aarp.org/content/dam/aarp/research/surveys_statistics/general/2012/Americans-50-and-the-Future-of-Medicare-and-Social-Security-AARP.pdf) (800 adults age 50+ interviewed)

<sup>vii</sup> <http://www.ipsos-na.com/download/pr.aspx?id=11913> (1,632 registered voters interviewed)

## Building on Health Delivery System Reforms: Potential for Medicare Savings, but Must be Designed with Beneficiaries in Mind

### **BACKGROUND**

One of the main goals of the Affordable Care Act (ACA) is to implement new health delivery reforms that would bend the health care cost curve. According to ACA architects, realigning the delivery system to drive out inefficiencies in the health care system will reduce costs and improve quality of care. The ACA, therefore, established five priority areas for delivery system reform: (1) payment reform; (2) primary and preventive care; (3) measuring and reporting quality; (4) administrative simplification; and (5) health information technology.<sup>1</sup>

There is tremendous potential for improved care and cost savings from these priority areas of health care delivery system reform. Innovation in these areas can drive “virtuous cycles” of improvement in care, efficiency in delivery, transparency in information, and reduction in cost. Various studies that have looked at the collective potential for health care savings from such strategies have arrived at annual savings as high as \$700 billion to \$1 trillion.<sup>2</sup> Reforms, however, must take into account the special considerations of the beneficiary population if they are to deliver on promised efficiencies and cost savings while not sacrificing needed care or positive outcomes.

**Payment Reform:** Most health reimbursement is currently based on volume of services provided. The ACA introduces payment reforms for individual physicians and for larger, organized health care systems, ranging from bundled payments to payment adjustments for hospital-acquired conditions.<sup>3</sup> Empirical evidence shows that payment structures such as these improve care delivery, costs, and quality.<sup>4</sup>

**Primary and Prevention Care:** The ACA includes a number of reforms that realign incentives toward prevention and reinforces the role of primary care providers. These provisions include: the Community Transformation Grant program (§4201), the Community-Based care Transitions program (§3026) and a program to fund community health teams to support the development of primary care practices into medical homes (§3502). In addition, the Center for Medicare and Medicaid Innovation (CMMI) (§3021) is administering the Comprehensive Primary Care Initiative, a program to strengthen primary care practices and help primary care doctors deliver better-coordinated care.<sup>5</sup> Under this initiative, the Centers for Medicare and Medicaid Services (CMS) is working with public and private payers to offer a bonus payment or monthly care management fee to participating primary care doctors who coordinate care for their Medicare patients. When targeted effectively at high-risk patients and preventable, high-cost events, such efforts can reduce total health care costs.<sup>6</sup>

**Quality Care:** Data shows that the health system has significant opportunities for quality improvement in areas such as chronic disease management, prevention, safety, efficiency, and patient experience.<sup>7</sup> The ACA includes incentives for high-performing physicians and hospitals, and quality measurement and improvement are key

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<sup>1</sup> A Report from Senator Sheldon Whitehouse for the U.S. Senate Committee on Health, Education, Labor & Pensions (HELP), *Health Care Delivery System Reform and The Patient Protection & Affordable Care Act* (March 2012), p.6.

<http://www.whitehouse.senate.gov/imo/media/doc/Health%20Care%20Delivery%20System%20Reform%20and%20The%20Affordable%20Care%20Act%20FINAL2.pdf>

<sup>2</sup> See, Institute of Medicine. (2011, February 24). The healthcare imperative: Lowering costs and improving outcomes – Workshop series summary. Washington, DC: National Academies Press; Simon, C., Wolcott, J., & Hogan, P. (2009, October 26). Can we reduce health care spending? Searching for low-hanging fruit in the garden of health system reform.

<sup>3</sup> See Patient Protection and Affordable Care Act (Pub. L. 111-148) §§ 2702, 2704, 2705, 2706, 2707, 3001, 3006, 3008, 3021, 3022, 3023, 3025, and 3403. (2010).

<sup>4</sup> See, Senate HELP Committee Report, p. 6.

<sup>5</sup> See, Senate HELP Committee Report, p.8.

<sup>6</sup> Reid, R., Coleman, K., Johnson, E., Fishman, P., Hsu, C., Soman, M., Larson, E. (2010). The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Affairs*, 29(5), 835 – 843.

<sup>7</sup> Institute of Medicine. *Crossing the quality chasm: A new healthy system for the twenty-first century* (2001)

components to ACA payment and care coordination reforms.<sup>8</sup> To improve consistency and address gaps in quality measurement, the ACA includes provisions to identify, update, and expand health quality measures; to publicly report these efforts; and to develop strategic plans for health care quality.

**Administrative Simplification:** Easing the administrative burden on health care providers, particularly the back and forth between providers and Medicare contractors, can reduce costs and improve efficiency in the health care system. The ACA promotes uniform electronic communication between providers and contractors for the purposes of patient eligibility verification, claims status inquiries and payment, and referral authorization requests, among other functions.<sup>9</sup>

**Health IT:** Health information technology (IT) will radically transform the health care industry, and is the essential, underlying framework for health care delivery system reform. The ACA's payment reforms, pilot projects, and other delivery system reforms are built with the expectation of having IT-enabled providers. In particular, the shift to new models of care, like Accountable Care Organizations (ACOs), will rely heavily on having providers "online" to transfer information and patient records, and report quality measures.<sup>10</sup> Health IT will enable health providers to update vital information in real time; access the best practices, treatment information and strategies; and keep patients better informed and engaged.

## OUR POSITION

**Payment Reform:** LCAO supports efforts to promote efficiencies and decrease waste, fraud and abuse within provider reimbursement. Yet, too deep cuts could cause access issues and provide disincentives from providers participating in federal health care programs like Medicare and Medicaid. **Any proposed payment reforms should not limit patients' access to necessary health care services.**

**Primary and Preventive Care:** LCAO supports efforts to extending primary care services and providing preventive care services with no copayment requirements to Medicare beneficiaries. Still, **more outreach and education needs to be conducted to inform Medicare beneficiaries of these benefits and encourage their utilization. In addition, such concentration on primary care cannot and should not diminish access to specialty or post-acute care services that provide care to millions of Medicare beneficiaries.**

**Quality Care:** LCAO supports adoption of quality metrics and comparable measurement tools to allow Medicare beneficiaries to make decisions based on quality of care. **Such tools, however, must be user-friendly and accessible to Medicare beneficiaries, some of whom do not have computer capabilities or the ability to go online. The development of quality metrics and standards must also be improved, particularly for vulnerable populations such as those with multiple chronic conditions or functional impairments.**

**Administrative Simplification:** LCAO supports provisions in the ACA to create administrative simplification for health providers. **Adequate safeguards must be taken, however, to ensure simplification does not make it easier for bad actors to participate and defraud the program.** Providers, however, can't use administrative simplification as an excuse to rollback important and necessary regulations that protect the consumer. **As rules are simplified, therefore, it's important to maintain these important consumer protections.**

**Health IT:** Technology has the potential to lower costs and increase efficiencies. Yet, **health information and senior personal data needs to be protected and shielded** from hackers, scammers and identity thieves. There needs to be proper safeguards in place to ensure Health IT security and **meaningful procedures need to be developed if such security is breached** and personal health information or other data is compromised.

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<sup>8</sup> See, Senate HELP Committee Report, p.8.

<sup>9</sup> See, Patient Protection and Affordable Care Act (Pub. L. 111-148) §§ 1104, 1413, and 6105. (2010).

<sup>10</sup> See, Senate HELP Committee Report p. 9.

## Building on What Works: Restoring Medicare Drug Rebates

### Background:

Upon passage of the Medicare Modernization Act (MMA), millions of older adults and people with disabilities gained access to prescription drug coverage through private plans approved by the federal government, known as Medicare Part D. As of September 2012, more than half of all Medicare beneficiaries—[32 million](#)—were enrolled in a Part D plan.<sup>i</sup>

At the same time, however, the MMA severely limited the federal government's ability to control drug prices in the Medicare program. The MMA scaled back rebates offered by pharmaceutical companies for drugs provided to beneficiaries dually eligible for Medicare and Medicaid. Yet, under the Medicaid program federally determined rebates for pharmaceuticals still apply.

Restoring Medicaid-level drug rebates for low-income Medicare beneficiaries is one of several options under consideration as part of deficit reduction. Several notable deficit reduction proposals endorse some form of drug rebates for Medicare. President Obama has endorsed applying brand name and generic Medicaid-level drug rebates for dually eligible Medicare beneficiaries and for those with the Part D Low-Income Subsidy (also known as Extra Help)—creating [\\$135 billion](#) in Medicare savings over ten years.<sup>ii</sup> Similarly, the proposal developed by Alan Simpson and Erskine Bowles, Co-Chairs of the National Commission on Fiscal Responsibility and Reform, included drug rebates for dually eligible beneficiaries.<sup>iii</sup>

### Our Position:

The Leadership Council of Aging Organizations (LCAO) recognizes the need to bring down the nation's deficit and reduce health care spending. With respect to Medicare, we support savings mechanisms that address system-wide health care inflation and build on the cost savings and efficiencies of the Affordable Care Act.

Unlike proposals that create federal savings by shifting costs onto beneficiaries, restoring Medicaid-level drug rebates for low-income Medicare beneficiaries meets our standard as a cost saving solution that works. We recommend that Congress and the Administration restore drug rebate prices for Medicare beneficiaries who are dually eligible for Medicare and Medicaid and for beneficiaries with Extra Help.

### Our Rationale:

**Medicaid drug rebates translate into significant savings.** A 2011 report by the House Committee on Oversight and Government Reform found that the cost of the top 100 drugs for dually eligible beneficiaries was [30%](#) higher under Medicare than it would have been under Medicaid.<sup>iv</sup> A 2011 analysis by the Department of Health and Human Services (DHHS) Office of Inspector General that compared the prices of 100 brand name drugs under Medicaid and Medicare Part D reached similar conclusions. The study finds that Medicaid rebates required by law reduced expenditures by [45%](#) for the drugs under review. In comparison, Part D rebates secured through negotiations with private plans reduced expenditures by only [19%](#).<sup>v</sup>

### Restoring Medicare drug rebates saves significantly more than proposals that merely shift costs.

President Obama's proposal to use Medicaid-level drug rebates for low-income Medicare beneficiaries saves an estimated [\\$135 billion](#) over ten years. These savings significantly dwarf those achieved by more harmful proposals that would shift costs to people with Medicare. For instance, the President's proposal to increase Medicare Part B deductibles for newly eligible beneficiaries saves just [\\$1 billion](#) over ten years and the proposal to add a surcharge to select Medigap supplemental plans saves a mere [\\$2.5 billion](#) over ten years.<sup>vi</sup>

**Research and development by the pharmaceutical industry is not at risk.** Preserving the pharmaceutical industry's ability to innovate is often a top concern when considering altering drug prices and potentially diminishing industry profits. Studies show that research and development investments in particular types of drugs



are not directly linked to specific revenue sources. These findings, coupled with an examination of PhRMA spending trends, suggest that reinstating Medicare drug rebates will not limit research and development.<sup>vii</sup>

**Costs for private purchasers—namely employers—will be largely unaffected.** A 1997 RAND study examined how the “best price” formula for determining Medicaid drug rebates affects other private drug purchasers, such as employers. Under this rebate formula, the Medicaid program receives either the “best private price” for which a manufacturer sells a drug or a price 23.1% lower than the average manufacturer price, whichever is the lower of these. The 1997 study concluded that the Medicaid “best price” formula had a “small, but visible” effect on drug prices for other private purchasers. Yet, these small increases would amount to even less in today’s market given the increased use and availability of lower cost generic drugs.<sup>viii</sup>

**Claims that Medicare Part D premiums will rise for higher income beneficiaries are unfounded.** Some stakeholders suggest that restoring Medicaid-level drug rebates for low-income Medicare beneficiaries would increase drug prices and Part D premiums for other beneficiaries in Part D. This argument is based on faulty reasoning. Research suggests that the negotiating power of Part D plans would not be compromised and that Part D drug prices and premiums would not be affected by restoration of the Medicaid-level drug rebates for a segment of the Medicare Part D population.<sup>ix</sup>

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<sup>i</sup> [“The Medicare Prescription Drug Benefit”](#) – Kaiser Family Foundation (November 2012)

<sup>ii</sup> [“Living within Our Means and Investing in Our Future: The President’s Plan for Economic Growth and Deficit Reduction.”](#) – Office of Management and Budget (September 2011)

<sup>iii</sup> [“Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals”](#) – Kaiser Family Foundation (September 2011)

<sup>iv</sup> [“67 House Members Urge Boehner to Include Medicare Drug Price Negotiation in Final Debt Reduction Deal”](#) – Letter to Speaker Boehner from Rep. Hinchey, Rep. Schakowsky, Rep. Sam Barr and Rep. Peter Welch (June 2011)

<sup>v</sup> [“Higher Rebates for Brand-Name Drugs Results in Lower Costs for Medicaid Compared to Medicare Part D.”](#) – Department of Health and Human Services – Office of the Inspector General (August 2011)

<sup>vi</sup> [“Living within Our Means and Investing in Our Future: The President’s Plan for Economic Growth and Deficit Reduction.”](#) – Office of Management and Budget (September 2011)

<sup>vii</sup> [“Prescription Drug Procurement and the Federal Budget.”](#) – R. Frank, Kaiser Family Foundation (May 2012); [“Debunking Medicare Myths: Drug Rebates for Dual Eligibles.”](#) – Center for Medicare Advocacy (2011)

<sup>viii</sup> [“Prescription Drug Procurement and the Federal Budget.”](#) – R. Frank, Kaiser Family Foundation (May 2012)

<sup>ix</sup> [“The Medicare Part D Drug Rebate Proposal: Rebutting An Unpersuasive Critique.”](#) – R. Frank and J. Hoadley in Health Affairs Blog (December 2012)

## Principles to Reform the Medicare Physician Payment System

In December 2012, Congress once again postponed a scheduled reduction in reimbursements paid under the Physician Fee Schedule to physicians and other health care practitioners participating in the Medicare program. Due to the Sustainable Growth Rate (SGR) formula, reimbursement rates were scheduled to be cut 27% on January 1, 2013, in addition to a 2% budget cut mandated by sequestration. This year scheduled cuts will result in a nearly 25% reduction in Medicare payment rates in January 2014.

According to the MedPAC, particularly for newly eligible beneficiaries, it is becoming increasingly difficult to find a primary care physician.<sup>i</sup> The threat of looming cuts creates uncertainty and needless stress for Medicare providers and beneficiaries. The SGR formula is fundamentally flawed and permanent changes to the Medicare reimbursement system are long overdue. The Congressional Budget Office (CBO) recently estimated that freezing payment rates at current levels would cost roughly \$138 billion over ten years.<sup>ii</sup> Past CBO estimates on the cost of repealing the SGR, often estimated at between \$250 and \$300 billion over ten years, hindered prior attempts to secure a permanent solution.

The health needs of the Medicare population demand a reformed payment system that appropriately rewards high-quality, patient-centered primary care, care coordination and preventive services. On the whole, people with Medicare 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. Nearly one in four people with Medicare live with a cognitive or mental impairment, requiring extensive, ongoing care.<sup>iii</sup>

Despite the long-standing need to revisit the Medicare payment reimbursement system, repeal and replacement of the SGR must be pursued responsibly, taking into account the health and economic needs of the 50 million older adults and people with disabilities who rely on Medicare. Towards this end, the Leadership Council of Aging Organizations (LCAO) believes that any attempt to reform the SGR must adhere to the following principles:

### 1. Protect people with Medicare from cost shifting

A legislative proposal to repeal or replace the SGR must not be paid for by shifting costs to Medicare beneficiaries. Half of all Medicare beneficiaries—nearly 25 million—live on annual incomes of \$22,500 or less. People with Medicare already contribute a significant amount of their income towards health care. As a share of Social Security income, Medicare premiums and cost-sharing has risen steadily over time. In 2010, Medicare premiums accounted for 26% of the average monthly Social Security benefit compared to 7% in 1980.<sup>iv</sup>

- **Reject offsets that shift costs to people with Medicare.** Proposals to shift costs to people with Medicare, such as by raising the Medicare age of eligibility, redistributing the burden of Medicare cost sharing through increased deductibles, coinsurances or copayments, limiting first dollar Medigap coverage and further income-relating Medicare Part B and D premiums, must not be used to pay for a permanent SGR solution.
- **Ensure beneficiaries are held harmless from payment adjustments.** Because beneficiary premiums and cost sharing are based on overall Medicare expenditures, provider payment adjustments should not lead to increased Medicare spending. Instead, innovative reimbursement and delivery models should be implemented, which reduce Medicare expenditures by incentivizing quality and value, rather than quantity and volume.

### 2. Extend a permanent fix to critical Medicare benefits

Averting steep cuts to physician payments is not the only Medicare policy revisited on an annual basis. We are very concerned that a permanent SGR fix could significantly diminish the prospects for continued bipartisan agreements on extenders packages, which always included extensions of two critical provisions with expiration dates that

correspond with the SGR. Any permanent SGR solution must also account for these benefits, including the Qualified Individual (QI) program and therapy cap exceptions.

- **Make the QI program permanent.** The QI benefit pays Medicare Part B premiums for individuals with incomes that are 120% to 135% of the federal poverty level—about \$13,800 to \$15,500 per year. This benefit is essential to the financial stability of people with Medicare living on fixed incomes.
- **In the absence of full repeal of Medicare therapy caps, make the exceptions process permanent.** Therapy cap exceptions ensure access to critical, medically necessary services that allow beneficiaries to live with independence and dignity each day.

### 3. Promote quality care

SGR reform must gradually replace the current volume-based payment system with a value-driven model. New payment models must reward quality, safety, value and coordination of care, as opposed to the number of services provided. Emphasis on team-based care coordination, effective care transitions, and preventive care can lead to better care, better health and lower costs for people with Medicare.

- **Address the imbalance between primary and specialty reimbursement.** Medicare beneficiaries often have multiple chronic conditions, may have cognitive impairments, and need extra attention from their health care providers. Time spent by primary care providers explaining treatment options or following up with patients is not adequately valued by current reimbursement policies, as reflected in recommendations by the MedPAC.<sup>i</sup>
- **Build a strong primary care workforce.** The current payment system discourages providers from pursuing or continuing careers in primary care, including those with the training and skills needed to meet the unique care needs of our nation's growing population of older adults. Reimbursement rates which appropriately reflect the demand for primary care services will strengthen the primary care workforce.
- **Encourage promising delivery models.** A permanent SGR solution must build on lessons learned through ongoing pilot programs, including Patient Centered Medical Homes and Accountable Care Organizations, to coordinate and better manage care. It also should promote better coordination between primary and specialty care providers to address gaps in the quality of care.
- **Utilize consensus-based quality measures.** In order to provide reliable, useful data to practitioners, quality measures must be consensus based, and endorsed by such organizations as the National Quality Forum that include consumers, employers and other purchasers. Allowing non-consensus-based measures undermines the current measure-selection process used by other programs and limits the ability to share quality data across programs. Moreover, a multi-stakeholder process ensures acceptance of and confidence in the measures which are ultimately selected for payment and other purposes. In addition, any new payment system must include quality measures constructed for vulnerable and frail older adults, so that multiple chronic illnesses are accounted for and providers are rewarded for treatment that improves quality of life.
- **Engage the beneficiary community.** Any process to enact a permanent SGR solution must involve the beneficiary community, including people with Medicare, family caregivers, and consumer advocates.

Staying true to the principles outlined above is critical to designing a reformed payment system that provides economic stability and ensures access to high quality care for people with Medicare.

<sup>i</sup> MedPAC, [Report to Congress: Medicare Payment Policy](#) (March 2012)

<sup>ii</sup> Congressional Budget Office, [The Budget and Economic Outlook: Fiscal Years 2013 to 2023](#) (February 2013)

<sup>iii</sup> Kaiser Family Foundation, [An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Services Use](#) (Statement by J. Cubanski before the Senate Special Committee on Aging, February 2013)

<sup>iv</sup> Kaiser Family Foundation, [Policy Options to Sustain Medicare for the Future](#) (January 2013)

<sup>v</sup> MedPAC, [Re: Moving forward from the sustainable growth rate \(SGR\) system](#) (Letter to Congress, October 2011)

## Raising the Medicare Eligibility Age: Bad Policy All Around

### Background:

Medicare is the principal source of health insurance coverage for 50 million Americans, including over 8 million workers with disabilities who have been receiving Social Security benefits for two years or longer.<sup>i</sup> For over 47 years, since the program's inception in 1965, America's seniors have been able to count on Medicare's guaranteed health care benefits when they reach age 65. But now, some in Washington who are looking for ways to reduce federal spending want to make older adults wait for up to two additional years - to age 67 - in order to qualify for Medicare. Recent proposals to increase the Medicare eligibility age are included in a proposal introduced by Senator Corker,<sup>ii</sup> a proposal by Senator Hatch to reform Medicare and Medicaid,<sup>iii</sup> the recent Bowles-Simpson proposal, "A Bipartisan Path Forward to Securing America's Future,"<sup>iv</sup> and in H. Con. Res 112, the House-passed budget resolution for Fiscal Year 2013.

### Our Position:

The Leadership Council of Aging Organizations (LCAO) is opposed to increasing the Medicare eligibility age. This amounts to a benefit cut, one that is being advanced solely for budgetary considerations, namely to reduce the federal deficit. Little attention is being given to the harmful consequences for Medicare beneficiaries who have paid into the program during their working lives and count on receiving Medicare.

Supporters of increasing the eligibility age argue that people are living longer and that the Social Security retirement age is increasing to 67. Yet, there are great disparities in longevity increases,<sup>v</sup> and longevity cannot be equated with healthy life expectancy.<sup>vi</sup> Many Americans 50 years and older live with chronic diseases,<sup>vii</sup> and the likelihood of being diagnosed with a chronic condition increases with age. Among adults 65 years and older, more than 90% have been diagnosed with one chronic condition, and almost 75% have two or more diagnosed chronic conditions.<sup>viii</sup> Such conditions often impede older adults' ability to work.<sup>ix</sup> Other older adults may be capable of working but must leave the paid workforce to care for one or more family members with a chronic condition.<sup>x</sup> These health limitations and caregiving responsibilities also contribute to many older adults' decision to receive Social Security retirement benefits beginning at age 62 - an option exercised by which is what about one-half of workers.

LCAO recognizes the need to bring down the nation's deficit and reduce health care spending. With respect to Medicare, we support savings mechanisms that address system wide health care inflation. Raising the Medicare eligibility age fails to meet this standard because it actually increases overall health spending.<sup>xi</sup>

### Our Rationale:

**Many seniors would pay more for health insurance.** If implemented in 2014, two-thirds of 65- and 66-year olds losing Medicare coverage would face an average of \$2,200 each year in higher out-of-pocket health care costs.<sup>xii</sup>

**Medicare beneficiaries over age 67 would face higher premiums.** As younger and healthier individuals leave the Medicare risk pool, it would leave an older, sicker and more expensive group to insure.<sup>xiii</sup>

**Many low-income seniors would not be able to afford health insurance.** While the Affordable Care Act (ACA) expanded access to those with incomes up to 133 percent of the federal poverty level, states are not obligated to expand their Medicaid programs.<sup>xiv</sup>

**Communities of color would be the hardest hit.** People of color tend to be in poorer health at earlier ages. Due to lower lifetime earnings and shorter life expectancies, they accumulate less wealth that could be used to pay for health care.<sup>xv</sup>

**Employers and states would pay more.** Employers who provide health care coverage to their retirees would face higher costs as more 65- and 66- year olds received primary coverage through their employer rather than Medicare. State Medicaid programs would have rising costs as some of the people who lost Medicare coverage would shift to Medicaid.<sup>xvi</sup>

**Raising the Medicare eligibility age would increase overall health spending.** With respect to savings, increasing the Medicare eligibility age 67 only benefits the federal government. The Kaiser Family Foundation (KFF) and the Center on Budget and Policy Priorities conclude that "increased state and private-sector costs would be twice as large as the net federal savings."<sup>xvii</sup> If the proposal were fully in effect in 2014, KFF estimates, the proposal would generate \$5.7 billion in net federal savings but \$11.4 billion in higher health costs to individuals, employers, and the states.<sup>xviii</sup> As such, raising the Medicare eligibility age further compounds the overarching problem of system-wide health care inflation.

<sup>i</sup> Kaiser Family Foundation. "Medicare: At a Glance." (November 2012)

<sup>ii</sup> Corker "Dollar for Dollar" Bill Summary. [http://www.corker.senate.gov/public/\\_cache/files/d48f7abd-73fc-4989-b0b6-62fb7f2130b7/12-12-12%20Summary%20Corker%20Dollar%20for%20Dollar%20Act.pdf](http://www.corker.senate.gov/public/_cache/files/d48f7abd-73fc-4989-b0b6-62fb7f2130b7/12-12-12%20Summary%20Corker%20Dollar%20for%20Dollar%20Act.pdf)

<sup>iii</sup> Hatch Outlines Structural Medicare, Medicaid Reforms That Should Be Part of Deficit Reduction Package.

<http://www.finance.senate.gov/newsroom/ranking/release/?id=b9f2e6eb-658a-4014-8a18-5c93d995e60e>

<sup>iv</sup> A Bipartisan Path Forward to Securing America's Future. <http://www.momentoftruthproject.org/publications/bipartisan-path-forward-securing-america's-future>

<sup>v</sup> Centers for Disease Control and Prevention. Table 7: Life Expectancy at Selected Ages by Race, Hispanic Origin, Race by Non-Hispanic Population, and Sex: United States, 2010. [http://www.cdc.gov/nchs/data/dvs/deaths\\_2010\\_release.pdf](http://www.cdc.gov/nchs/data/dvs/deaths_2010_release.pdf)

<sup>vi</sup> World Health Organization. "Health Status Statistics: Mortality, Health Life Expectancy (HALE)." <http://www.who.int/healthinfo/statistics/indhale/en/>

<sup>vii</sup> Institute of Medicine. "U.S. Health in International Perspective: Shorter Lives, Poorer Health." [http://www.nap.edu/catalog.php?record\\_id=13497](http://www.nap.edu/catalog.php?record_id=13497) (January 2013)

<sup>viii</sup> Robert Wood Johnson Foundation. "Chronic Care: Making the Case for Ongoing Care."

<http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf54583> (January 2010)

<sup>ix</sup> Robert Wood Johnson Foundation. "Chronic Care: Making the Case for Ongoing Care."

<http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf54583> (January 2010)

<sup>x</sup> National Alliance for Caregiving (with AARP). "Caregiving in the U.S. 2009."

[http://www.caregiving.org/pdf/research/Caregiving\\_in\\_the\\_US\\_2009\\_full\\_report.pdf](http://www.caregiving.org/pdf/research/Caregiving_in_the_US_2009_full_report.pdf) (November 2009)

<sup>xi</sup> Center on Budget and Policy Priorities. "Raising Medicare's Eligibility Age Would Increase Overall Health Spending and Shift Costs to Seniors, States, and Employers." [www.cbpp.org/cms/?fa=view&id=3564](http://www.cbpp.org/cms/?fa=view&id=3564) (August 2011)

<sup>xii</sup> Kaiser Family Foundation. "Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform."

<http://www.kff.org/medicare/upload/8169.pdf> (July 2011)

<sup>xiii</sup> Center on Budget and Policy Priorities. "Raising Medicare's Eligibility Age Would Increase Overall Health Spending and Shift Costs to Seniors, States, and Employers." [www.cbpp.org/cms/?fa=view&id=3564](http://www.cbpp.org/cms/?fa=view&id=3564) (August 2011)

<sup>xiv</sup> Center on Budget and Policy Priorities. "Raising the Medicare Age: Supreme Court Decision Makes the Proposal More Problematic." (October 2012)

<sup>xv</sup> Medicare News Group. "Raising the Medicare Eligibility Age Harms Minorities, Is a 'Benefits Reduction,' Experts Say."

<http://www.medicarenewsgroup.com/context/understanding-medicare-blog/understanding-medicare-blog/2012/08/24/raising-the-medicare-eligibility-age-harms-minorities-is-a-benefits-reduction> (August 2012)

<sup>xvi</sup> Kaiser Family Foundation. "Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform."

<http://www.kff.org/medicare/upload/8169.pdf> (July 2011)

<sup>xvii</sup> Kaiser Family Foundation. "Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform."

<http://www.kff.org/medicare/upload/8169.pdf> (July 2011); Center on Budget and Policy Priorities. "Raising Medicare's Eligibility Age Would Increase Overall Health Spending and Shift Costs to Seniors, States, and Employers." [www.cbpp.org/cms/?fa=view&id=3564](http://www.cbpp.org/cms/?fa=view&id=3564) (August 2011)

<sup>xviii</sup> Kaiser Family Foundation. "Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform."

<http://www.kff.org/medicare/upload/8169.pdf> (July 2011)

## Premium Support: A Flawed Approach to Medicare Reform

### Background:

Numerous proposals have been put forth to control the growth in Medicare spending by changing it from a defined benefit package to a defined contribution program. Under such a plan, the federal government would provide a fixed contribution – a premium support payment or voucher – to be used to purchase insurance for Medicare beneficiaries.

Many premium support proposals, which vary as to whether or not traditional Medicare would remain an option alongside private plans, have been introduced. These include proposals authored by several current and past Members of Congress.<sup>i</sup> In addition, among the proposals presented by Erskine Bowles and Alan Simpson, the Co-Chairs of The National Commission on Fiscal Responsibility and Reform, is a cap on federal health spending. This could lead to drastic structural changes to Medicare, including replacing traditional Medicare with a premium support system.

Currently, the most notable premium support plan is the one that passed in March 2012 by the House of Representatives. Under the House Budget Resolution for FY2013, H. Con. Res. 112, introduced by House Budget Committee Chairman Paul Ryan (R-WI), people becoming eligible for Medicare beginning in 2023 would receive a voucher to purchase private health insurance or traditional Medicare through a Medicare exchange rather than enrolling in the current Medicare program. The 2012 Ryan plan fails to provide the details needed to determine how much costs would rise for Medicare beneficiaries. However, an estimate by the Congressional Budget Office (CBO) of a similar 2011 Ryan plan shows that costs to beneficiaries would increase by nearly \$6,400 beyond what would otherwise be paid out-of-pocket in the first year alone.<sup>ii</sup>

### Our Position:

The Leadership Council of Aging Organizations (LCAO) is opposed to Medicare premium support proposals that privatize Medicare and achieve savings for the federal government by reducing care and shifting costs onto Medicare beneficiaries. The Medicare voucher plan introduced by Chairman Ryan would leave seniors at the mercy of private insurance companies, make it harder for older adults to choose their own health care providers, and increase health care costs for both current and future retirees. Further, the Ryan plan does nothing to address overall health care inflation and could cause an increase in health spending.

LCAO recognizes the need to bring down the nation's deficit and reduce health care spending. With respect to Medicare, we support savings mechanisms that address system wide health care inflation and build on the cost savings and efficiencies of the Affordable Care Act. Premium support proposals, like the Ryan plan, fail to meet these standards.

### Our Rationale:

**Medicare is not in crisis; yet, premium support would end Medicare as we know it.** Of the four parts to the Medicare program (Parts A, B, C, and D), only the Part A Hospital Insurance Trust Fund – which accounts for about one-third of Medicare spending – faces a future shortfall. Spending for Parts B, C, and D is guaranteed to remain in balance for all future years. Medicare Part A can pay fully on its claims until 2024 when its funding will cover 87% of benefits. Improvements passed in the Affordable Care Act (ACA) that improve efficiencies, reign in waste and fraud, and reduce overpayments, extended Part A Trust Fund solvency an additional eight years – from 2016 to 2024.

Projections of a Medicare Part A shortfall have varied widely over the last 40 years, for example, with the Trustees in 1970 projecting a shortfall in two years, and in 1997 projecting a shortfall in just 4 years. However, the fact is, the trust fund has never run out of money because Congress has always taken action to ensure that Medicare continues to meet its obligations.<sup>iii</sup> Claims that Medicare is going bankrupt are simply not true, and radical restructuring under a premium support scheme is not needed to ensure long-term solvency.



**Private plans are not as successful as Medicare in controlling costs.** Per capita Medicare costs have risen, on average, 1% less than private insurance each year since 1970.<sup>iv</sup> And recent estimates show that Medicare spending is expected to grow at rates of 3.1% per enrollee per year over the next ten years compared to 5% for private insurance plans.<sup>v</sup> Medicare's size and scale provide greater bargaining power with health care providers than any private insurance plan.

**Reliance on private insurers will not hold costs down - Medicare Part D is not a model.** While the Part D program has had lower-than-expected costs, its private plan structure has little to do this; instead, lower costs have been due to lower than expected enrollment and a general decline in the costs of drugs.<sup>vi</sup>

**Premium support proposals do not “save” costs – they merely “shift” costs.** Replacing Medicare's guaranteed benefits with a voucher program would significantly raise costs for people with Medicare due to the proposed cap on Medicare spending that is lower than the growth rate of costs in the health care sector overall. Over time, the value of the voucher would decrease, leaving Medicare beneficiaries the choice of paying higher out-of-pocket costs or being vastly underinsured, with access to fewer health care providers.<sup>vii</sup>

**Most people with Medicare cannot afford to pay more.** In 2010, half of Medicare beneficiaries – about 25 million seniors and people with disabilities – lived on incomes below \$22,000, just under 200% of the federal poverty level;<sup>viii</sup> and Medicare households already spend on average 15 percent of their income on health care costs, three times as much as the non-Medicare population.<sup>ix</sup>

**Vouchers may not have enough value, making it harder for beneficiaries to choose their own doctor.** Under the Ryan premium support program, the amount of the voucher would be what the second-least expensive private plan or traditional Medicare agreed to accept to provide care to Medicare beneficiaries. Some beneficiaries could find that their health providers may be in a plan they could not afford, or that traditional Medicare is more expensive than the second-least-expensive plan in their area.

**Premium support could result in a “death spiral” for traditional Medicare.** The Ryan proposal would allow private insurance companies to tailor their plans to attract the youngest and healthiest seniors, as long as benefits are actuarially equivalent to the benefit package in traditional Medicare. This would leave traditional Medicare with older, sicker beneficiaries whose higher health costs would lead to higher premiums that people would be unable or unwilling to pay; thus, creating a Medicare death spiral.

Medicare's ability to negotiate fair and efficient provider rates would erode<sup>x</sup>, and the movement of more beneficiaries into private plans would likely substantially reduce the pool of physicians willing to see those who remained in traditional Medicare.<sup>xi</sup> This, along with higher premiums for traditional Medicare, would adversely impact people age 55 and older today, including people currently enrolled in traditional Medicare, despite the assertion that nothing will change for them but only for people becoming eligible for Medicare beginning in 2023.

<sup>i</sup> “Comparison of Premium Support Proposals” – Kaiser Family Foundation (July 2012)

<sup>ii</sup> [http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan\\_letter.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf)

<sup>iii</sup> 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)

<sup>iv</sup> National Health Expenditures Web Tables: Table 13 (2009) – Centers for Medicare and Medicaid Services (CMS)

<sup>v</sup> Holohan, J. and S. McMorro (August 2012) “Medicare and Medicaid Spend Trends and the Deficit Debate” – *New England Journal of Medicine*

<sup>vi</sup> “Lower-Than-Expected Medicare Drug Costs Mostly Reflected Lower Enrollment and Slowing of Overall Drug Spending, Not Reliance on Private Plans” – Center on Budget and Policy Priorities (May 2012); Hoadley, J. (May 2012) “Medicare Part D Spending Trends: Understanding Key Drivers and the Role of Competition” – Kaiser Family Foundation

<sup>vii</sup> Van de Water, P. (March 2012) “Medicare in the Ryan Budget” – Center for Budget and Policy Priorities

<sup>viii</sup> “Medicare at a Glance” – Kaiser Family Foundation (November 2011)

<sup>ix</sup> “Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare Households” – Kaiser Family Foundation (March 2012)

<sup>x</sup> Van de Water, P. (March 2012) “Medicare in the Ryan Budget” – Center for Budget and Policy Priorities

<sup>xi</sup> Orszag, P. (September 18, 2012) “Ryan's Proposal Would Shrink Medicare's Doctor Pool” – *Bloomberg News*

# Medicare Home Health Copayments: Harmful for Beneficiaries

## Background:

Some policymakers have suggested adding copayments for Medicare home health services as a means of both reducing the deficit and limiting the growth of Medicare home health expenditures. Some Medicare Advantage (MA) plans have already imposed home health copays.

## Our Position:

Congress should oppose any copay proposal for Medicare home health services. Congress eliminated the home health copayment in 1972 for the very reasons that it should not be resurrected now—detering care at home and creating incentives for more expensive institutional care.<sup>i</sup> Congress should also oppose any proposal to cap payments for episodes of care that would reduce beneficiary access or otherwise restrict the number of home health visits to which beneficiaries are entitled.<sup>ii</sup> LCAO recognizes the need to bring down the nation's deficit and reduce health care spending. With respect to Medicare, we support savings mechanisms that address system wide health care inflation and build on the cost savings and efficiencies of the Affordable Care Act. Proposals that shift costs onto beneficiaries, like adding copayments to home health services, fail to meet these standards.

## Our Rationale:

- **Home health copayments would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall.** The Urban Institute's Health Policy Center found that home health copays "...would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays."<sup>iii</sup> Similarly, a study in the *New England Journal of Medicine* found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes, and greater expense.<sup>iv</sup> The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copay. According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by \$6-13 billion over ten years.<sup>v</sup>
- **Copayments are an inefficient and regressive "sick tax" that would fall most heavily on the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries.** About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30 percent 85 or older. Sixty-three percent are women.<sup>vi</sup> Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.<sup>vii</sup> The Commonwealth Fund cautioned that "cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs."<sup>viii</sup>
- **Most people with Medicare cannot afford to pay more.** In 2010, half of Medicare beneficiaries—about 25 million seniors and people with disabilities—lived on incomes below \$22,000, just under 200 percent of the federal poverty level.<sup>ix</sup> Medicare households already spend on average 15 percent of their income on health care costs, three times as much as the non-Medicare population.<sup>x</sup>
- **Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100% of poverty (\$11,412 for singles, \$15,372 for couples) and non-housing assets below just \$6,940 for singles and \$10,410 for couples. In sharp contrast, eligibility for cost sharing assistance for individuals under age 65 is set at 138% of poverty, with no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third actually have it.<sup>xi</sup>

- **Individuals receiving home care and their families already contribute to the cost of their home care.** With hospital and nursing home care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services are provided by family members or paid out-of-pocket by individuals without family support. Family members are frequently trained to render semi-skilled support services for home health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated \$450 billion a year in unpaid care to their loved ones,<sup>xii</sup> and too frequently having to cut their work hours or quit their jobs.
- **Copayments as a means of reducing utilization would be particularly inappropriate for home health care.** Beneficiaries do not “order” home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary, that beneficiaries are homebound and meet other stringent standards. There is scant evidence of overutilization. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.<sup>xiii</sup>
- **Home health copayments would shift costs on to states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by MedPAC) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.
- **Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copay and only 17 percent of Medicare beneficiaries have Medigap coverage. For the 34 percent of Medicare beneficiaries who have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree coverage.<sup>xiv</sup> Likewise, the 25 percent of beneficiaries enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.
- **Copayments would impose costly administrative burdens and increase Medicare costs.** Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and re-bill.

<sup>i</sup> *Congressional Record*, October 5, 1972, p. 33939.

<sup>ii</sup> Similarly, Congress removed a 100 visit limit on home health care services in the Omnibus Budget Reconciliation Act (OBRA) of 1980. See forthcoming LCAO document opposing episode payment caps.

<sup>iii</sup> Urban Institute Health Policy Center, “A Preliminary Examination of Key Differences in Medicare Savings Bills,” July 13, 1997.

<sup>iv</sup> Trivedi, Amal N., Husein Moloo and Vincent Mor, “Increased Ambulatory Copayments and Hospitalizations among the Elderly,” *New England Journal of Medicine*, January 2010.

<sup>v</sup> Avalere Health LLC, “Potential Impact of a Home Health Co-Payment on Other Medicare Spending,” July 12, 2011.

<sup>vi</sup> CMS Office of Information Services, Medicare & Medicaid Research Review/2011 Supplement, Table 7.2.

<sup>vii</sup> Avalere Health LLC, “A Home Health Copayment: Affected Beneficiaries and Potential Impacts,” July 13, 2011.

<sup>viii</sup> The Commonwealth fund, “One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems,” September 2001.

<sup>ix</sup> “Medicare at a Glance,” Kaiser Family Foundation, November 2011.

<sup>x</sup> “Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare households”—Kaiser Family Foundation.

<sup>xi</sup> Government Accountability Office, “Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment,” GAO-12-871 (September 2012)

<sup>xii</sup> L. Feinberg, S.C. Reinhard, A. Houser, and R. Choula, “Valuing the Invaluable: 2011 Update, the Growing Contributions and Costs of Family Caregiving,” AARP Public Policy Institute Insight on the Issues 51 (Washington, DC: AARP, June 2011).

<sup>xiii</sup> CMS Research, Statistics, Data, and Systems/Statistics, Trends and Reports, Medicare Medicaid Stat Supp/2011 (Tables 3.1 and 7.1).

<sup>xiv</sup> Kaiser Family Foundation, “Examining Sources of Supplemental Insurance and Prescription Drug Coverage Among Medicare Beneficiaries: Findings from the Medicare Current Beneficiary Survey, 2007,” August 2009.

## Reforming Medigap Plans by Shifting Costs onto Beneficiaries: A Flawed Approach to Achieve Medicare Savings

### Background:

In order to help pay for Medicare's significant out-of-pocket costs, most Medicare beneficiaries have some form of supplemental coverage, such as retiree plans, private Medicare Advantage plans, Medicaid or Medigap policies. Medigap policies are individual, standardized insurance policies designed to fill in some of the gaps in Traditional Medicare's coverage. Nearly one in five Medicare beneficiaries – 9.6 million – rely on Medigap policies to provide financial security and protection from high, unexpected out-of-pocket costs due to unforeseen medical care. Most beneficiaries who select Medigap policies do not have access to another form of supplemental coverage, like retiree benefits or Medicaid.<sup>i</sup>

Despite serving Medicare beneficiaries well for years, Medigap plans are being targeted by some public policymakers as a means to cut Medicare spending by shifting costs onto people who have these policies. Under the assumption that charging beneficiaries more in upfront out-of-pocket costs will deter them from using unnecessary medical care – and therefore save the Medicare program money – some proposals seek to increase Medigap deductibles and other cost-sharing. Other proposals would add a surcharge or tax on plans offering “first-dollar” or “near first-dollar” coverage – costs which insurance companies offering Medigap policies will pass on to policyholders.

### Our Position:

LCAO is opposed to adding further cost-sharing to Medigap plans or otherwise penalizing individuals who have “first-dollar coverage” through increased premiums or surcharges.

We strongly disagree with the argument that Medigap plans are a driver of unnecessary medical care. Instead, adding costs to Medigap policies will deter beneficiaries from seeking medically necessary care. Increased Medigap cost-sharing is not an effective tool for reducing Medicare spending and may harm the health and well-being of beneficiaries who forgo needed health care because they can no longer afford it. LCAO recognizes the need to bring down the nation's deficit and reduce health care spending over the long term. With respect to Medicare, we support savings mechanisms that address system wide health care inflation and build on the cost savings, innovations and efficiencies of the Affordable Care Act. Proposals that shift costs onto beneficiaries, like eliminating or discouraging “first dollar coverage,” fail to meet these standards.

### Our Rationale:

- **As cost-sharing goes up, utilization of services – both necessary and unnecessary – goes down.** Increased cost-sharing in health insurance programs often result in either a barrier to or delay in accessing needed treatment, which could lead to adverse health outcomes and greater programmatic costs in the future. For example, multiple studies show that increased cost-sharing on specific services, such as ambulatory care or prescription medications, can lead to increased emergency room visits, hospitalizations, and outpatient care among older adults.<sup>ii</sup>
- **The Medicare program – not Medigap policies – determines what care is medically necessary.** If Medicare determines that a given service is not medically necessary, it won't pay for it. Since Medigap policies follow the lead of Medicare, a Medigap policy will not make a payment when Medicare has indicated that a service is not medically necessary. In short, penalizing policyholders for choosing to buy certain Medigap policies will not affect whether care sought by beneficiaries is appropriate.<sup>iii</sup>

- **Eliminating first dollar coverage will not lead to beneficiaries choosing better value services.** Increased Medigap cost-sharing would inappropriately place the burden on beneficiaries to determine in advance whether a covered service is necessary or unnecessary. Instead of making such a determination, beneficiaries are more likely to avoid initiating a health care service or treatment as a result of cost-sharing, whereas once a person is engaged in the health care system, cost-sharing has little effect on whether or not a treatment is pursued. With added cost-sharing, people are more likely to forgo outpatient care and doctors visits outright, than to forgo treatments or services recommended by their provider.<sup>iv</sup> In other words, it is health care providers – not patients – who order medical services.
- **Most people with Medicare cannot afford to pay more.** In 2010, half of Medicare beneficiaries lived on incomes below \$22,000, just under 200% of the federal poverty level;<sup>v</sup> and Medicare households already spend on average 15 percent of their income on health costs, three times as much as the non-Medicare population.<sup>vi</sup> Two-thirds of people with Medigap (66%) have incomes below \$40,000 per year and one-third (31%) have incomes below \$20,000 per year. People living in rural communities are more likely to purchase a Medigap policy. Increasing cost-sharing for or adding surcharges to Medigap plans will harm those who can least afford it – those who are sick or chronically ill and those with low or moderate incomes.<sup>vii</sup>
- A subgroup of the non-partisan, expert **National Association of Insurance Commissioners (NAIC)** tasked with reviewing potential Medigap changes concluded that various proposals to reform Medigap policies:
 

“[...] do not consider the potentially serious and unintended impacts for beneficiaries and the Medigap program. Namely, in response to increased costs beneficiaries may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs to the Medicare program in the long term. [...] Further, no consideration is being given to the disproportionate impact on those with low or modest incomes, those who live in rural areas who have less access to other choices such as Medicare Advantage plans, retiree health or other supplemental coverage, or those who are the sickest or have chronic conditions and need regular care.”<sup>viii</sup>
- **Interfering with Medigap contracts currently in force raises serious concerns.** There is a significant difference between applying new prohibitions or penalties to new Medigap policyholders, as opposed to altering private insurance contracts already in place – many for decades. The NAIC expressed serious concerns about this issue, stating: “An abrupt alteration of the Medigap cost-sharing benefits for in force policies will cause a major market disruption and cause serious confusion for seniors. Medigap policyholders will look to their state insurance regulators for assistance and to their congressional representatives for answers when they find out that the guaranteed renewability provisions of their Medigap policies have not been honored.”<sup>ix</sup>
- **Recent, significant changes to Medigap policies already include cost-sharing in some policies.** Several of the standardized Medigap policies already give beneficiaries the choice of purchasing products with less coverage, usually in exchange for smaller premiums. For example, Plans K and L cover a percentage of Medicare cost-sharing (e.g., 50% or 75% instead of 100%), beneficiaries with Plan M pay 50% of the Medicare Part A hospital deductible, and Plan N charges \$20 copay for physician office visits and a \$50 copay for emergency room visits.

<sup>i</sup> *Medigap Reform: Setting the Context*, Kaiser Family Foundation, September 2011.

<sup>ii</sup> See *Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper*, National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPCA Subgroup, October 2011. See also, e.g., Amal N. Trivedi, et. al. *Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly*, *New England Journal of Medicine*, January 2010; Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcomes*, Robert Wood Johnson Foundation Research Synthesis Report No. 20, December 2010.

<sup>iii</sup> *Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper*, National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPCA Subgroup, October 2011.

<sup>iv</sup> *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*, RAND Health Research Highlights, January 2006.

<sup>v</sup> “*Medicare at a Glance*” – Kaiser Family Foundation (November 2011)

<sup>vi</sup> “*Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare Households*” – Kaiser Family Foundation (March 2012)

<sup>vii</sup> *Medigap Reform: Setting the Context*, Kaiser Family Foundation, September 2011.

<sup>viii</sup> *Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper*, National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPCA Subgroup, October 2011, pp. 2-3.

<sup>ix</sup> NAIC letter to Senators Murray and Hensarling (Sept. 21, 2011), available at

[http://www.naic.org/documents/committees\\_ex\\_grlc\\_110921\\_letter\\_murray\\_hensarling\\_medigap\\_first\\_dollar.pdf](http://www.naic.org/documents/committees_ex_grlc_110921_letter_murray_hensarling_medigap_first_dollar.pdf)



## Further Income-Relating (Means Testing) Medicare Premiums Would Shift More Costs onto the Middle Class

### Background:

The Medicare program provides vital health insurance coverage to approximately 50 million seniors and people with disabilities. While Medicare offers coverage for a range of health care services, it is neither comprehensive in scope nor is it without cost to beneficiaries. In addition to cost-sharing for certain services, most people pay a monthly Part B premium of \$104.90 (2013) and many also pay additional premiums for coverage under a Medicare Advantage plan, a Medicare Part D prescription drug plan, a Medigap plan or some other type of supplemental insurance.

Among the proposals to address the nation's long-term deficit by lowering Medicare spending is to further income-relate, or means test, Medicare premiums based upon beneficiaries' income. Medicare beneficiaries with incomes above \$85,000 (\$170,000 for a couple), however, already pay higher Part B premiums due to a provision in the Medicare Modernization Act of 2003. The Affordable Care Act of 2010 required higher-income individuals to also start paying higher Part D premiums in 2011 and froze the income limits (\$85,000 individual/\$170,000 couple) through 2019 so that each year more middle class people will be subject to higher premiums for Parts B and D.

### Our Position:

LCAO is opposed to further income-relating (means testing) Medicare premiums. Over the last several years, Congress imposed greater costs on higher-income individuals through higher Part B and D premiums. Going further down this path will negatively impact more middle-income individuals and will do nothing to rein in overall health care costs.

LCAO recognizes the need to bring down the nation's deficit and reduce health care spending. With respect to Medicare, we support savings mechanisms that address system wide health care inflation and build on the cost savings and efficiencies of the Affordable Care Act. Further income-relating Medicare premiums, however, would only create federal savings by shifting additional costs onto Medicare beneficiaries.

### Our Rationale:

**Wealthier Medicare beneficiaries already pay more.** Medicare beneficiaries with incomes above \$85,000 for an individual/\$170,000 for a couple already pay higher premiums for Medicare Parts B and D. In 2013, higher-income individuals pay between \$146.90 and \$335.70 per month for Part B and an extra \$11.60 to \$66.60 per month for Part D premiums. Today, income-related Part B premiums apply to approximately 5% of Medicare beneficiaries.<sup>i</sup>

### **Income levels are frozen under current law so each year more people will be subject to higher premiums.**

Under current law, income thresholds for higher premiums are frozen until 2019, meaning they are not indexed to increase annually. At that time, it is estimated that approximately 10% of Medicare beneficiaries will have incomes above this threshold and will be subject to higher premiums.<sup>ii</sup> If higher premiums were applied to Medicare beneficiaries with the top 10% of income today, it would affect people earning approximately \$63,000.<sup>iii iv</sup>

**Some proposals to expand means testing could apply to individuals earning as little as \$47,000 today.** Some proposals to expand Medicare means testing would increase income-related premiums under Parts B and D until 25% of beneficiaries are subject to these premiums.<sup>v</sup> According to a study by the Kaiser Family Foundation, if such a proposal were implemented today, this would affect individuals with income equivalent to \$47,000 for an



individual and \$94,000 for a couple.<sup>vi</sup> In other words, this would impact individuals earning almost half of the current income threshold of \$85,000.

**Medicare costs are already high.** In addition to any Medicare premiums required of beneficiaries, under the Traditional Medicare program, individuals are responsible for a 20% coinsurance for Part B services after meeting a \$147 deductible (2013); cost-sharing under Part A includes a hospital deductible of \$1,184. Health care costs are already a significant expense for Medicare beneficiaries, and are increasing; families on Medicare already pay more of their household budgets for health care (15% on average, compared to 5% for non-Medicare households).<sup>vii</sup> Requiring more people with less income to pay more of their Medicare premiums will only increase these burdens.

**Further means testing undermines the integrity and universality of Medicare.** Medicare has enjoyed consistent, broad-based support as insurance for people over 65 and certain individuals under 65 with disabilities. Additional means testing would further undermine the social insurance nature of Medicare and could ultimately raise costs for middle and lower-income individuals who rely on it. As noted by the Kaiser Family Foundation, “there is a possibility that proposals [to further means test Medicare] could lead some higher-income beneficiaries to drop out of Medicare Part B and self-insure, which could result in higher premiums for all others who remain on Medicare ...”<sup>viii</sup>

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<sup>i</sup> According to the Kaiser Family Foundation, in 2012, 5.1% of Part B enrollees (2.4 million beneficiaries) were estimated to pay the income related Part B premium. See “Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?” Kaiser Family Foundation, February 2012, available at: <http://www.kff.org/medicare/8276.cfm>.

<sup>ii</sup> The share of Medicare beneficiaries required to pay the income-related Part B premium is projected to rise to 9.7% in 2019 (5.5 million beneficiaries); once income thresholds begin to rise with inflation again in 2020, this number is projected to fall back to 6.6% of beneficiaries. See “Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?” Kaiser Family Foundation, February 2012, available at: <http://www.kff.org/medicare/8276.cfm>.

<sup>iii</sup> According to Urban Institute/Kaiser Family Foundation analysis in 2011, the 90<sup>th</sup> percentile of income among Medicare beneficiaries in 2010 was \$63,251. See “Projecting Income and Assets: What Might the Future Hold for the Next Generation of Medicare Beneficiaries?” Kaiser Family Foundation, June 2011, available at: <http://www.kff.org/medicare/upload/8172.pdf>.

<sup>iv</sup> Note that some proposals suggest keeping the share of beneficiaries subject to higher premiums at roughly the levels they will reach in 2019. For example, the Center for American Progress’ “Senior Protection Plan” (November 2012) suggests that the share of beneficiaries who pay higher premiums for Part B and D should remain constant at 10% beyond 2019 (in addition, they call for the amount that higher-income individuals pay to increase by 15% starting in 2014). See <http://www.americanprogress.org/issues/healthcare/report/2012/11/14/44590/the-senior-protection-plan/>.

<sup>v</sup> See, e.g., President Obama’s FY 2013 Budget (February 2012) available at <http://www.whitehouse.gov/omb/budget> and the Office of Management and Budget, “Living Within our Means and Investing in our Future: The President’s Plan for Economic Growth and Deficit Reduction” (September 2011) available at: <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf>.

<sup>vi</sup> “Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?” Kaiser Family Foundation, February 2012, available at: <http://www.kff.org/medicare/8276.cfm>.

<sup>vii</sup> For more information about fiscal challenges facing Medicare beneficiaries, see LCAO’s Fact Sheet “Medicare Beneficiary Characteristics and Out-of-Pocket Costs” (October 2012), available at: <http://www.lcao.org/docs/LCAO-Medicare-Characteristics-Costs-Issue-Brief-10-12.pdf>.

<sup>viii</sup> “Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?” Kaiser Family Foundation, February 2012, available at: <http://www.kff.org/medicare/8276.cfm>.