August 16, 2013

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

Dear Committee Member:

On behalf of the Leadership Council of Aging Organizations (LCAO), a coalition of national not-for-profit organizations representing over 60 million older Americans, we are writing to express strong opposition to Medicare policy proposals to increase Part B and D premiums for select Medicare beneficiaries, to increase the Part B deductible, and to introduce a home health copayment. It would be particularly problematic to pay for increased reimbursement to physicians, which will in turn increase Part B premiums, by shifting even more costs to older adults and people with disabilities.

We recognize the long-term fiscal challenges facing our nation's health care system, and we stand willing to work with members of Congress to identify health care savings that do not burden American families with added health care costs. Towards this end, LCAO supports cost saving solutions that build on delivery system reforms and reduce the rate of increase in federal health spending by addressing the systemic causes of health care cost growth. It is also important to account for the fact that, over the past three years, Medicare spending has slowed dramatically to historically low rates of growth.

The draft proposals circulated by the Committee on Ways and Means, Subcommittee on Health seek savings for the federal government solely by shifting added costs to people with Medicare. These and similar proposals do nothing to solve the underlying problem with our health care system overall: systemic health care inflation, a challenge facing both the private and public health care sectors. Further, these proposals threaten the already fragile health and economic security of our nation's older adults and people with disabilities.

Most people with Medicare cannot afford to pay more for health care. Half of all people with Medicare—nearly 25 million—live on annual incomes of $22,500 or less, and one quarter live on annual incomes of $14,000 or less.[1] Health care costs are already a significant expense for Medicare beneficiaries and are increasing. In 2010, Medicare out-of-pocket costs consumed 26% of the average monthly Social Security benefit compared to only 7% in 1980. Today the average Medicare household spends 15% of their income on health care, three times that of non-Medicare households.[2]

Medicare coverage is not comprehensive and tends to be less generous than typical large employer plans. 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

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[1] J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013); Also see LCAO fact sheet: "Medicare Beneficiary Characteristics and Out-of-Pocket Costs" (May 2013)
[2] Kaiser Family Foundation, Policy Options to Sustain Medicare for the Future (January 2013)

($12,260) or the typical Preferred Provider Organization (PPO) comparison plan ($12,800) for an employee who is 65 or older.[3]

The burden of added beneficiary liability for health care costs, like increased deductibles or added copayments, falls heaviest on Medicare beneficiaries with low, fixed incomes and those with significant health care needs. Decades of research confirm that higher cost sharing deters access to both *needed* and unneeded care indiscriminately and most notably for those living on modest incomes.[4] Further, forcing "wealthy" beneficiaries to pay more for Medicare translates to a premium hike on middle class retirees and people with disabilities, while also fracturing one of our nation's most successful social insurance programs.

**More means testing of Medicare premiums strikes at the heart of the middle class:** Many policy makers suggest that wealthier beneficiaries are positioned to contribute more in Medicare costs, specifically through higher premiums. Yet, higher income beneficiaries are already means-tested, paying higher Part B and Part D premiums well above the standard premiums.

The draft proposal circulated by the Subcommittee would increase already higher premiums while also forcing a larger share of the Medicare population to pay more.[5] Recent analysis by the Kaiser Family Foundation shows that if one in four people with Medicare were subjected to higher premiums as proposed, then beneficiaries with incomes as low as $47,000 today would pay an increased premium. In addition to imposing an added expense on middle-class beneficiaries, the plan introduces needless complication to the Medicare program while likely increasing administrative expenses.

In short, the proposal circulated by the Subcommittee amounts to little more than a cost shift to middle class retirees and people with disabilities, essentially seeking federal savings through a premium hike on older adults and people with disabilities already confronting high health care costs.[6]

**Increasing the Part B deductible harms the poorest and deters access to needed care:** Proposals such as the one circulated by the Subcommittee to increase the Part B deductible are most alarming because of the harm that will result for Medicare beneficiaries with low- and fixed-incomes.[7] Beneficiaries who are "near poor"—those with incomes too high to qualify for federal assistance programs, like the Medicare Savings Programs, but still living on limited incomes—currently spend the highest percentage of their

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[3] Kaiser Family Foundation, "How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?" (April 2012)

[4] National Association of Insurance Commissioners, "Medigap PPACA (B) Subgroup, Cost-sharing Research and Literature" (as of June 2011); Katherine Swartz, "Cost-Sharing: Effects on Spending and Outcomes" (December 2010), Robert Wood Johnson Foundation Research Synthesis Report No. 20

[5] Under the plan circulated by the Subcommittee, income-related premiums would be restructured as follows: premiums would increase within income brackets; four additional income brackets would be introduced, moving from five to nine brackets; and starting in 2017 income thresholds would be frozen until one in four Medicare beneficiaries paid income-related Part B and D premiums.

[6] See LCAO Issue Brief: "Further Income-Relating (Means Testing) Medicare Premiums Would Shift More Costs Onto the Middle Class" (January 2013)

[7] Under the plan circulated by the Subcommittee, the Part B deductible would be increased as follows: $25 would be added to the Part B deductible in 2017, 2019 and 2021 for new beneficiaries. This policy would create two beneficiary cohorts, those with unchanged deductibles and those with higher deductibles based on the year of Part B enrollment.

income on health care and are most at risk. This is, in part, because the Medicare low-income protection programs are inadequate and need to be improved.

The additional upfront costs of a higher Part B deductible for physician visits and other outpatient services will make necessary care unaffordable, leading some beneficiaries to forgo needed care altogether. Faced with a higher deductible, some people with Medicare will have no choice but to self-ration needed care or other basic needs, like food or heating.

Further, the proposal introduces added complexity and unequal treatment of future beneficiaries based solely on the date of Medicare eligibility—complications that would prove difficult to explain to beneficiaries and costly to administer.

**Adding a home health copayment deters access to needed care for the sickest:** Home health users are among the oldest, sickest and most vulnerable people with Medicare. A third of home health users (30%) are over the age of 80 and well over half (63%) are women. In addition, home health users tend to have lower incomes than the general Medicare population and more limitations in one or more activities of daily living.[8]

The introduction of a $100 home health copayment per home health episode, as drafted by the Subcommittee, 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.[9] According to an Avalere analysis, a home health copayment could increase Medicare hospital inpatient spending by $6-13 billion over ten years.[10]

Faced with a new copayment, people with Medicare are likely to forgo needed home health services, putting their health at risk and threatening their ability to stay in their homes and communities. In 1972, Congress eliminated the home health copayment for the very reasons that it should not be resurrected now—deterring care at home and creating incentives for more expensive institutional care.

In conclusion, rather than shifting costs to people with Medicare—an approach that yields only short-term and harmful savings—we urge members of the Subcommittee to focus their attention on reforms that diminish wasteful Medicare spending and advance the transformation of our health care system from one that rewards high volume care to one that rewards high value care. Such reforms represent a commonsense approach to containing health care spending, while preserving the promise of Medicare for our nation's older adults and people with disabilities.

Thank you for the opportunity to submit feedback.

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[8] See LCAO Issue Brief: "Medicare Home Health Copayments: Harmful for Beneficiaries" (December 2012)

[9] Under the plan circulated by the Subcommittee, starting in 2017 new Medicare beneficiaries would be subjected to a $100 home health copayment per home health episode. Episodes of care that follow a hospitalization or inpatient post-acute stay would be exempt from the copayment.

[10] Avalere Health LLC, "Potential Impact of a Home Health Co-Payment on Other Medicare Spending," (July 2011)

Sincerely,

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Leadership Council of Aging Organizations
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