Leadership Council of Aging Organizations

Max Richtman, Chair

March 29, 2016

Chairman Pat Tiberi
House Ways and Means Committee
Subcommittee on Health
Washington, DC 20515

Ranking Member Jim McDermott
House Ways and Means Committee
Subcommittee on Health
Washington, DC 20515

Dear Chairman Tiberi and Ranking Member McDermott:

The Leadership Council of Aging Organizations (LCAO) is a coalition of 72 national nonprofit organizations concerned with the well-being of America's older population and committed to representing their interests in the policymaking arena. LCAO appreciates the opportunity to submit this statement for the record.

Medicare is a remarkable success story. Now in its 50th year, the Medicare program, together with Social Security, has kept millions of retirees from poverty by ensuring access to affordable health care for those who would otherwise lack coverage.

Today, 54 million older adults and people with disabilities depend on Medicare for basic health insurance. Since its inception, the Medicare program has evolved, including the addition of a prescription drug benefit and, more recently, low-to-no cost preventive care. Recently, for example, the program has experienced historically low rates of spending growth.

Despite these successes, most people with Medicare still struggle financially: half lived on incomes less than $24,150 a year and one-quarter lived on incomes at or below $14,350 a year in 2014. They also possess little savings: Half of all Medicare beneficiaries had less than $63,350 in lifetime savings and one- quarter had less than $11,900 in savings in 2014.

Seniors and persons with disabilities also face high health care costs. On average, Medicare households spend nearly three times the proportion of annual income on health care costs, compared to non-Medicare households.

Given this stark reality, we must protect core Medicare benefits and ensure that no additional health care costs are shifted onto beneficiaries. To this end, we must preserve the fundamental structure and administration of the Medicare program.

10 G Street, NE, Washington, DC 20002 ♦ (202) 216-8387 ♦ (202) 787-3726 (Fax)
Email: LCAO@NCPSSM.org ♦ Website: www.LCAO.org

In addition, Medicare benefits are modest. Unfortunately, too many still forgo needed care because of high costs, particularly when Medicare doesn't cover a service. Rather than scale back Medicare, we need to expand it. Potential improvements include enhancing existing low-income protections and eliminating long-standing gaps in coverage for services including dental, hearing and vision care.

We submit for the record a number of materials pertaining to Medicare published by LCAO. We hope you will use them in your efforts to improve the Medicare program.

Sincerely,

Max Richtman
Chair, Leadership Council of Aging Organizations

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FACT SHEET

March 2016

MEDICARE BENEFICIARY CHARACTERISTICS AND OUT-OF-POCKET COSTS

Containing Medicare costs is an important goal, both to improve affordability for those who need care and to ensure the long-term sustainability of the program. Yet, some policy makers believe that older adults do not have enough "skin in the game" and propose shifting more out-of-pocket costs onto beneficiaries—an approach that would fail to address the underlying causes of cost growth. Proposals to shift costs to people with Medicare do not take into account three key facts: (1) Most beneficiaries have low or modest incomes; (2) Medicare benefits are 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 control health care spending. With respect to Medicare, we support savings mechanisms that address system-wide health care inflation and build on the cost savings of the Affordable Care Act. 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."[1]

Medicare Beneficiary Characteristics

- **Most people with Medicare have low or modest incomes.** In 2014, half of all people with Medicare lived on incomes less than $24,150 per year – just above 200% of the federal poverty level. And one quarter of Medicare beneficiaries had annual incomes at or below $14,350.[2]

- **Most Medicare beneficiaries lack sufficient savings.** In 2014, half of all Medicare beneficiaries had less than $63,350 in lifetime savings, such as retirement account holdings and other financial assets. One in four Medicare beneficiaries had less than $11,900 in savings.[3]

- **Women and people of color live on even less.** In 2014, among Medicare beneficiaries, median annual income for women amounted to $22,500, compared to $26,350 for men. In 2014, median annual incomes were also significantly lower for diverse communities—$16,150 for black Medicare beneficiaries and $12,800 for Hispanic beneficiaries. Median savings for white beneficiaries were more than eight to nine times the median savings for black beneficiaries ($12,350) and Hispanic beneficiaries ($9,800).[4]

[1] American Academy of Actuaries, "Letter to the Joint Select Committee on Deficit Reduction," (August 2011)
[2] Jacobson, G., Swoope, C., and T. Neuman, "Income and Assets of Medicare Beneficiaries, 2014 – 2030," (Kaiser Family Foundation, September 2015)
[3] Ibid.
Jacobson, G., Swoope, C., and T. Neuman, "Income and Assets of Medicare Beneficiaries, 2014 – 2030," (Kaiser Family Foundation)

- **Many beneficiaries are in poor health.** 45% of the Medicare population is living with four or more chronic conditions, more than 30% have a cognitive or mental impairment, and more than one-third have a functional impairment. About 15% of Medicare beneficiaries have limitations with two or more activities of daily living, such as eating, bathing or dressing.[5]

Medicare Beneficiary Out-of-Pocket Costs

- **Health care costs are a significant expense for Medicare beneficiaries.** In 2014, Medicare beneficiaries spent an average of $5,342 on health care costs.[6] In 2010, more than 5 million people with Medicare (10%) spent more than $8,030.[7] In the last 5 years of life, beneficiaries spend $38,688 on average.[8] 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.[9]

- **The sickest, the oldest and the near poor bear the most significant cost burdens.** In 2010, Medicare beneficiaries who reported being in fair or poor health spent a median 20% of their income on health care costs, compared to 14.2% among those in very good or excellent health. The average beneficiary age 85 or older spent more than twice as much on health care as the average beneficiary ages 65-69. The burden of out-of-pocket health care spending was the greatest among those with incomes between 100% - 200% FPL. For instance, those with incomes between 100% - 150% FPL spent 26% on health care as a share of income.[10]

- **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.[11]

- **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, hearing services, and most long-term care services and supports. In 2011, for the average senior, Medicare covered $11,930 of the $14,890 in estimated annual health care spending—less than would be covered under the federal employee plan ($12,260) or the typical Preferred Provider Organization (PPO) comparison plan ($12,800) for an employee age 65 or older.[12]

- **Families on Medicare pay more for health care than non-Medicare households.** On average, in 2014, Medicare households spent 15% of total costs on health care; whereas, non-Medicare

[5] Cubanski, J. "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use," (Kaiser Family Foundation: February 2013)
[6] "The Latest Trends in Income, Assets, and Personal Health Care Spending Among People on Medicare" (Kaiser Family Foundation: November 2015)
[7] Noel-Miller, C. "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care," (AARP Public Policy Institute, December 2013)
[8] Cubanski, J., Swoope, C., Boccuti, C., Jacobson, G., Casillas, G., Griffin, S. and Tricia Neuman, "A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers," (Kaiser Family Foundation, March 2015)
[9] Kelley AS, et. al. "Out-of-pocket spending in the last five years of life," *Journal of General Internal Medicine* (October 2012); National Bureau of Economic Research, "Were they prepared for retirement? Financial status at advanced ages in the HRS and Ahead Cohorts," (February 2012)
[10] Noel-Miller, C. "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care," (AARP Public Policy Institute, December 2013)
[11] Cubanski, J. "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February 2013)
[12] Kaiser Family Foundation, "How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?" (April 2012)

households spent just 5%.[13] In 2010, more than half of all Medicare beneficiaries spent more than 16.4% of their income on health care costs.[14]

- **Increased cost sharing often leads to adverse health consequences and can increase total health care spending.** Some policymakers want to increase beneficiary cost-sharing in order to reduce perceived over-utilization of unnecessary medical services. Decades of empirical research confirms that increased cost sharing leads people to forgo medically *necessary* services. In 2012, 8% of older Medicare beneficiaries and 28% of non-elderly Medicare beneficiaries reported delaying care because of cost concerns.[15] Higher cost sharing ultimately backfires, since sicker patients will require more costly and invasive care down the road.[16]

- **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. In 2030, estimates suggest half of all Medicare beneficiaries will live on annual incomes of $28,450 or less.[17] 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. In 2014, 8% of Medicare beneficiaries had no savings or were in debt. [18]

- **Medicare low-income protection programs are broken and must be modernized**. According to the most recent estimates, 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.[19] In addition, rigid, unreasonably low asset tests 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.

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[13] "The Latest Trends in Income, Assets, and Personal Health Care Spending Among People on Medicare" (Kaiser Family Foundation: November 2015)

[14] Cubanski, J., Swoope, C., Damico, A., P. Neuman, "Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households," (Kaiser Family Foundation: January 2014); Noel-Miller, C. "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care," (AARP Public Policy Institute, December 2013)

[15] Cubanski, J., Swoope, C., Boccuti, C., Jacobson, G., Casillas, G., Griffin, S. and Tricia Neuman, "A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers," (Kaiser Family Foundation, March 2015)

[16] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper," (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)

[17] Jacobson, G., Swoope, C., and T. Neuman, "Income and Assets of Medicare Beneficiaries, 2014 – 2030," (Kaiser Family Foundation, September 2015)

[18] Ibid.; Employee Benefits Research Institute, "Debt of the Elderly and Near Elderly" (February 2013)

[19] Government Accountability Office, "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment." (September 2012)

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FACT SHEET

March 2016

MEDICARE "REDESIGN" PROPOSALS COULD HARM MANY BENEFICIARIES

Background

The Medicare program provides vital health coverage to approximately 54 million seniors and people with disabilities. While traditional Medicare guarantees coverage for a range of health care services, it is neither comprehensive in scope nor is it without cost to beneficiaries. Cost-sharing under traditional Medicare (including deductibles, copayments and coinsurance) can be both significant and complicated, especially for those who lack retiree insurance or other supplemental coverage.

In order to both achieve federal savings and seemingly simplify the program, some policymakers have suggested redesigning the traditional Medicare benefit. While details vary, most proposals would combine the Part A and B deductibles, implement a single coinsurance rate for health care services (including new home health cost-sharing), limit first dollar coverage in Medigap plans, and create an out-of-pocket spending cap for beneficiaries.

Our Position

Congress should tread carefully with respect to redesigning the Medicare benefit. While we welcome a discussion about expanding Medicare benefits and reducing all beneficiaries' out-of-pocket costs, the Leadership Council of Aging Organizations (LCAO) opposes redesigning or restructuring benefits for the purpose of achieving savings for the federal government by shifting even higher health care costs on to beneficiaries. As long as redesigning the Medicare program is approached with the aim of securing federal savings, such efforts are likely to unfairly redistribute costs to beneficiaries, including those with fixed incomes, and limit access to needed health care.

Our Rationale

- **Many redesign proposals would increase the costs on the majority of Medicare beneficiaries.** For example, one typical cost-sharing proposal examined by the Kaiser Family Foundation includes a combined Part A and Part B deductible of $550, 20% coinsurance rates for health care services, and a $5,500 out-of-pocket cap. Under this proposal, 71% of people with Medicare would pay more for health coverage and only 5% would pay less. Further, for the 5 million people who would experience annual increased costs greater than $250, the average increase total would be $660 each in 2013.[20]

- **Most people with Medicare cannot afford to pay more.** In 2014, half of Medicare beneficiaries—more than 25 million seniors and people with disabilities—lived on incomes at or below $24,150.

[20] Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8256.pdf.

One quarter of Medicare beneficiaries had annual incomes at or below $14,350.[21] On average, Medicare households already spend 14 percent of their income on health care costs, about three times as much as non-Medicare households.[22]

- **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 (plus $20 a month, totaling $12,012 for singles and $16,176 for couples in 2015) and non-housing assets below just $7,280 for singles and $10,930 for couples. This is far less generous than cost-sharing protections available to those under age 65, with eligibility at 138% of poverty and no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third are actually enrolled in the program.[23] Changing Medicare cost-sharing in the manner suggested by many redesign proposals would redistribute the burden of health care costs onto the most vulnerable, including those with moderate incomes and those with persistent and chronic health needs.[24]

- **As cost-sharing goes up, utilization of services—*both* necessary and unnecessary—goes down.** Many Medicare redesign proposals would increase costs on beneficiaries by either increasing cost-sharing amounts or imposing cost-sharing for services that currently do not require them. Often, the justification for such proposals is based on the flawed assumption that charging beneficiaries more in upfront out-of-pocket costs will deter them from using unnecessary medical care, will steer them towards "higher-value" services, and therefore save the program money. Conversely, decades of empirical research confirm that higher cost-sharing deters access to both needed and unneeded care indiscriminately, and most notably for those living on modest incomes.[25]

- **Beneficiary cost-sharing does not get at the real cost drivers.** It is health care providers—not beneficiaries—who determine the necessity of health care services, yet many proposals would increase cost-sharing, essentially forcing beneficiaries to self-ration their care. Research illustrates that once an individual enters the health care system, it is their providers that dictate treatments and services.[26]

- **Home health copayments would harm the most vulnerable and likely increase program costs.** This proposal would primarily impact lower income, chronically ill women over age 75, and would deter many vulnerable beneficiaries from accessing needed care. Forgoing Medicare home health services may increase the incidence of premature nursing home placement, as well as hospitalizations and other more costly acute care. As a result, this could increase hospital inpatient spending by $6 to $13 billion over 10 years, in addition to significantly increasing Medicaid spending on long-term

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[21] Kaiser Family Foundation, " Income and Assets of Medicare Beneficiaries, 2014 – 2030" (September 2015), available at: http://files.kff.org/attachment/issue-brief-income-and-assets-of-medicare-beneficiaries-2014-2030.

[22] Kaiser Family Foundation, "Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households" (January 2014) available at: http://kff.org/medicare/issue-brief/health-care-on-a-budget-the-financial-burden-of-health-spending-by-medicare-households/; also see LCAO Issue Brief "Medicare Beneficiary Characteristics and Out-of-Pocket Costs" (June 2014), available at: http://www.lcao.org/files/2014/07/LCAO-issue-brief-bene-characteristics-updated-June-2014-7.8.14.pdf.

[23] Government Accountability Office, "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment," GAO-12-871 (September 2012), available at http://www.gao.gov/assets/650/648370.pdf.

[24] Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8256.pdf.

[25] See, e.g., National Association of Insurance Commissioners (NAIC), Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper" (October 2011), available at: http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.

[26] See, e.g., Rand and other studies cited in National Association of Insurance Commissioners, *ibid.*

care.[27]

- **Medigap proposals would shift additional costs onto beneficiaries.** Nearly one in four Medicare beneficiaries pay for and rely on Medigap plans to provide financial security and protection from high, unexpected out-of-pocket costs due to unforeseen medical care. Yet, some lawmakers suggest shifting additional costs onto people with Medigap policies by increasing deductibles or other cost-sharing, or by adding a surcharge or tax on plans offering "first-dollar" coverage. Most Medigap enrollees (86%) have incomes below $40,000 per year and nearly half (47%) have incomes below $20,000 per year.[28] 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.[29]

[27] Avalere Health LLC, "Potential Impact of a Home Health Co-Payment on Other Medicare Spending" (July 2011); also see LCAO Issue Brief "Medicare Home Health Copayments: Harmful for Beneficiaries" (February 2015), available at: http://www.lcao.org/files/2015/02/LCAO-Copay-Issue-Brief-Feb-2015.pdf.
[28] Kaiser Family Foundation, "Medigap Reform: Setting the Context for Understanding Recent Proposals" (January 2014), available at: http://kff.org/medicare/issue-brief/medigap-reform-setting-the-context/.
[29] *Ibid. Also see* LCAO Issue Brief "Reforming Medigap Plans by Shifting Costs onto Beneficiaries: A Flawed Approach to Medicare Savings" (July 2014), available at: http://www.lcao.org/files/2014/07/LCAO-IB-Medigap-July-2014-Update-7.8.14.pdf.