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THE PRESIDENT'S AND OTHER BIPARTISAN PROPOSALS TO REFORM MEDICARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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THE PRESIDENT'S AND OTHER BIPARTISAN PROPOSALS TO REFORM MEDICARE

TUESDAY, MAY 21, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:03 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Tuesday, May 14, 2013
No. HL–04

CONTACT: (202) 225–3943

Chairman Brady Announces Hearing on the President's and Other Bipartisan Proposals to Reform Medicare

House Committee on Ways and Means, Subcommittee on Health Chairman Kevin Brady (R–TX) today announced that the Subcommittee on Health will hold its first in a series of hearings to explore the bipartisan proposals, including those contained in President Obama's Fiscal Year 2014 Budget to reform Medicare. This hearing will focus on review of proposals to change cost-sharing for services received under the Medicare program. **The hearing will take place on Tuesday, May 21, 2013, in 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of witnesses will follow.

BACKGROUND:

Created in 1965, the Medicare benefit was originally modeled on the Blue Cross Blue Shield plans that were prevalent throughout the Nation at that time. However, since its creation, Medicare's cost-sharing has been largely unchanged and has not kept up with changes in the growth of the Medicare population or how health care is delivered. The current Medicare spending trajectory is unsustainable and has led the Medicare trustees to estimate that the Part A trust fund will be bankrupt in 2023 and insolvent in 2024. The Medicare Health Insurance (HI) trust fund has not met the trustee's formal test of short-range financial adequacy since 2003. The Supplemental Medical Insurance (SMI) trust fund is considered adequately financed, however, this is a result of the SMI trust fund being reliant on general revenue transfers. By 2037, the Medicare trustees estimate general revenue transfers will account for 56 percent of Medicare outlays.

To address these and other concerns, the Obama Administration has identified several key policies to modify cost-sharing within the Medicare program. In the President's FY14 budget, the Administration focused on three key cost-sharing policies: (1) increasing income-related premiums for Medicare Parts B and D; (2) increasing the annual Medicare Part B deductible; and (3) establishing a home health copay. The President's FY14 budget estimates that these three policies will save $54 billion over 10 years. In addition to the President's budget, several other bipartisan policy organizations, such as the Bipartisan Policy Center, The Moment of Truth project, and the Medicare Payment Advisory Commission, have collectively made recommendations to alter Medicare's cost-sharing policies as a means of extending the longevity of the program.

In announcing the hearing, Chairman Brady stated, **"The current Medicare spending trajectory is unsustainable. There is bipartisan recognition that modifying seniors' cost-sharing is appropriate and can be done in a way that maintains access to critical healthcare services. Medicare is fast going broke and the time to act to save this program is now."**

FOCUS OF THE HEARING:

The hearing will review policies that modify beneficiary cost-sharing within the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, June 4, 2013**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman BRADY. Subcommittee will come to order. I want to welcome everyone to today's hearing on the President's budget and other bipartisan proposals to reform Medicare. This is the fourth hearing for our Subcommittee this Congress, and the second Ways and Means Committee hearing in a series focused on proposals to reform Medicare and Social Security. During our first hearing of Congress we focused on redesigning the Medicare benefit package to make it more rational, more responsive to seniors and Medicare patients. Today's discussion is an extension of that hearing discussing the details around these three specific policies:

One, increasing income-related premiums for Medicare Parts B and D; two, increasing annual Medicare Part B deductibles, and three, establishing a home health copay. We focused on these three policies because they are included in the President's 2014 budget and supported by several bipartisan organizations. All too often recently, discussions surrounding finding Medicare savings have come under the context of a "grand bargain" or a "super committee." As the committee of jurisdiction over these critical topics, we have an obligation to discuss them publicly and determine how best to craft policy in these areas. That is why we are holding this hearing today.

The President's budget estimates that these three policies will save $54 billion over 10 years. These are real savings for a program that is facing bankruptcy in 10 short years. Asking seniors to pay more when they have the means to do so is not a new concept. In 2003, Republicans led the charge with income-related premiums for Medicare Part B in the Medicare Modernization Act, which ensured that seniors have access to accessible, affordable, high-quality medicines through free market competition for their business.

In 2010, Democrats included income-related premiums in the Medicaid program, Health Exchanges, and increases for Medicare Part D in the Affordable Care Act, known as ObamaCare. Throughout Federal programs, there has been recognition that some seniors can contribute more and some seniors need additional assistance. The growth of the retiree population has been and will continue to be a tremendous source of stress on Medicare's finances.

When Medicare was enacted in 1965, the average life expectancy was 70.2 years. It was anticipated that Medicare would cover an average person's health expenditures for the last 5.2 years of their life. In 2010, the average American lived to the age of 78.4, which means Medicare covered the last 13.5 years of life, a 158 percent increase. Yet, we have not made changes to the Medicare benefit structure to address this increase.

Now, I know that some may want to reject these policies out of hand and may suggest that the overall Medicare spending for seniors has decreased. They may contend that this means there is less of a need to find Medicare savings. But I, too, am glad to see Medicare spending is down, but the program is headed toward bankruptcy in 10 short years. Burying our heads in the sand and waiting for the looming crisis to overwhelm us will only force future Congresses to take more drastic measures.

Even the Medicare trustees recognize the growing challenges of Medicare's financial future as the baby boomers enter Medicare. Even if per-senior spending decreases, that will not help the sustainability of the trust fund when the number of new seniors coming into the program begins to dramatically increase.

And simply cutting providers is not the answer. In fact, the Medicare trustees warn because of cuts already in law, 15 percent of our Part A providers will be unprofitable by the end of this decade. Roughly 40 percent would be unprofitable by 2050. The actuaries warn that these cuts will force providers to withdraw from providing services to our Medicare seniors and patients.

Finally, instead of simply focusing on how much money a policy might save Medicare or how many more beneficiaries will pay

more, I challenge this Committee and our witnesses today to think differently. The question we should be asking ourselves is, how can we act now, this year, to extend Medicare solvency? If not permanently, how about for an additional 10 years beyond 2023? Why not extend its life an additional 20 years? We owe it to current and future seniors to examine and pursue these critical goals. It will require hard decisions, yes. But making them now will ensure a vibrant Medicare for generations to come.

Before I recognize Ranking Member McDermott for the purposes of an opening statement, I ask unanimous consent that all Members' written statements be included in the record. Without objection, so ordered.

I now recognize Ranking Member McDermott for his opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

There was a time in the Congress when the procedure was that the President proposed and the Congress disposed. And so I would just put a caveat on anything that has been proposed by the White House that that is not holy writ brought down from the mountain by Moses. That is to be looked at by the Congress and we will make a decision.

The Majority keeps holding hearings on supposedly bipartisan reform ideas, but over and over it is the same song: Cut the benefits, shift the costs to the poor and the elderly. These reforms were offered by the President in a spirit of a grand, balanced bargain. That package has shared sacrifice and included some spending cuts and revenue increases, but when it is cherry picked, when you catch the low-hanging fruit, they are nothing more than partisan cuts. How many times and how many ways can we rehash the same old idea? We have been trying to get blood from a stone.

Fifty percent of the Medicare beneficiaries in this country have annual incomes at or below $22,500. Our seniors, our parents, our grandparents, 50 percent of them are living barely above the poverty line. They should not be our go-to source for savings.

We are long overdue on fixing the physician payment system and I sincerely hope we can work in a bipartisan way to do it. In particular, we need to address inequities in payment for primary care physicians, and we need to do it in a way that encourages the most efficient delivery of health care so we can be pushing more of the right kind of care, not just more care overall.

Now let me be clear, and I am speaking as a physician here: It is the physicians who are driving the healthcare utilization in the system, not the beneficiaries. The notion that beneficiaries have to have more skin in the game to encourage smart healthcare shopping is ridiculous. When your doctor tells you you need an extra test, or to come back in 2 weeks, how many of you poll other doctors to see if they agree? Of course not. There is a major information asymmetry between doctors and patients and a necessity to trust the physician's judgment. Few beneficiaries can distinguish between necessary and unnecessary care, and in the face of more cost-sharing, they may forego both.

I would like to submit for the record a recent letter from the National Association of Insurance Commissioners in which they state that they were unable to find evidence that cost-sharing encour-

aged appropriate use of healthcare services. In fact, they found that cost-sharing would result in delayed treatments that could increase costs and result in negative health outcomes.

As it is, Medicare households pay nearly 15 percent of their income on health care as compared to non-Medicare households, which pay 5 percent. As one of our witnesses, Joe Antos, points out in his testimony, higher income Medicare beneficiaries already pay more into the system, both through higher premiums and because they have paid more payroll taxes over the course of their working lives.

As for the notion of home healthcare deductible, these beneficiaries are some of the frailest individuals in Medicare. Why do Republicans insist on using this Committee to go after them rather than building on the ACA's tools to fight fraud in this section?

It is fundamentally untrue that we have to cut Medicare in order to save it. If we are looking for offsets, we could focus on pharmaceutical companies' windfall from the Republicans' Part D drug benefit. Creating a drug rebate to capture that windfall would save $141 billion, the entire cost of the SGR fix. We could look to the providers with higher Medicare margins. MedPAC tells us that those margins mean payment rates are too high. Or we could look to the savings from winding down the wars in Afghanistan and Iraq. There are plenty of other savings to be found that don't involve jeopardizing the health and security of some of our most vulnerable Americans.

I look forward to this hearing and the witnesses' testimony. I think that we are faced with a question that we are going to have to face at some point. That is, how do you control costs in the healthcare system? I yield back.

Chairman BRADY. Thank you.

And without objection, the document will be included in the record.

Today we will hear from three witnesses, Joseph Antos, the William H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute; Alice M. Rivlin, the Senior Fellow of Economic Studies at the Brookings Institution; and Joe Baker, President of the Medicare Rights Center.

I want to thank you all on behalf of Mr. McDermott and myself, thank you all for being here today. I look forward to your testimony. You will all be recognized for 5 minutes for the purposes of providing your oral remarks.

Mr. Antos, we will begin with you.

STATEMENT OF JOSEPH R. ANTOS, PH.D., WILSON H. TAYLOR SCHOLAR IN HEALTH CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE

Mr. ANTOS. Thank you, Mr. Chairman.

Medicare is on a fiscally unsustainable path. Seventy-six million members of the baby boom generation will turn 65 and enroll in Medicare over the next 2 decades. According to AARP, that is about 8,000 baby boomers every day. The resulting costs will place a heavy strain on the Federal budget, crowding out other spending priorities and burdening younger generations, and for that matter

burdening older generations who will have to pay the rising costs of the Medicare program.

Comprehensive reforms are needed to ensure that Medicare will be able to continue to meet the needs of its beneficiaries over the long term. Bipartisan commissions, including the Bowles-Simpson commission, the Bipartisan Policy Center, the Medicare Payment Advisory Commission, and the Engelberg Center's Bending the Curve project concur on several principles that should form the basis of Medicare reform. One of those principles is addressed today, and that is the need to reform cost-sharing responsibilities to promote cost awareness and improve equity in the program.

Today's hearing focuses on three proposals advanced by the President: raising the Part B deductible, adding a copayment for some home health episodes, and increasing premiums for higher income beneficiaries. These proposals, as the Chairman said, these proposals yield $54 billion in budget savings over the next decade. That is less than 1 percent of the $7.9 trillion that Medicare will spend over the same period.

These are modest changes, certainly financially, but they could lead to bipartisan discussions of broader reforms to protect Medicare for future generations. Medicare reform should create a benefit that is easy to understand and that protects seniors from catastrophic costs. That is a principle that I think is almost universally agreed, but the Medicare program is the way it is today for historical reasons.

The bipartisan commissions support proposals to simplify traditional Medicare's confusing benefit structure. If patients know what a health service will cost them, they will be more informed about their alternatives and will be better able to decide, with their physicians, about the best course of action. Replacing the multiple deductibles and complicated copayment structure in traditional Medicare with a simpler design typical of private insurance is one step in this reform. Limiting what Medigap plans cover so that beneficiaries pay some of the upfront costs themselves is another part of this reform.

The President's budget proposals are much narrower. The Part B deductible would be increased 75 years over 3 years. The new copayment would be levied on certain home health episodes that were not preceded by an inpatient stay. Both proposals would apply only to new Medicare enrollees as of 2017. Those proposals have been criticized as imposing a burden on beneficiaries. But in fact 90 percent of beneficiaries have supplementary coverage through Medigap, retiree plans, or Medicaid. Consequently, most beneficiaries have nearly complete coverage against out-of-pocket costs.

That fosters inefficiency in Medicare and adds to the costs of the program, which are borne by beneficiaries and taxpayers. I might add that for those who buy Medigap policies, they are simply paying it through another mechanism. They are still paying the cost.

So a more equitable phase-in than the President proposes would provide further protection for beneficiaries who do not already have supplementary coverage. The cost-sharing provision should be applied to all beneficiaries, not only to new enrollees, but exceptions

could be made based on a beneficiary's ability to pay or health status, rather than the year of their enrollment.

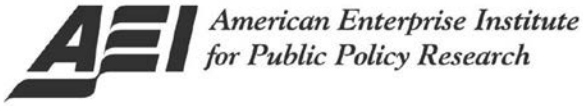
The third proposal increases income-related premiums under Part B and Part D. This extends the principle that those with greater means should provide more support for the program, a principle embraced by Republicans and Democrats alike. This principle was embodied in Medicare at its beginning in 1965. High earners pay more in payroll taxes, as Mr. McDermott pointed out, and income taxes throughout their work lives. That started in 1966, and we still have this principle today.

How much they should pay is an ethical judgment, but if the budget resources are not available to maintain an adequate level of Medicare benefits for every senior, then we should care first for those who cannot afford to cover the costs themselves.

Increasing premiums reduces the fiscal pressure faced by Medicare, but it does not address the fundamental defects that drive up program costs. Higher premiums do not change the financial incentives of fee-for-service Medicare. They do not change the way beneficiaries use services, or the way services are delivered. More fundamental reforms that address Medicare's cost drivers are needed.

Any significant Medicare reform will take time to develop and implement. It is better to start that process now rather than delay until the fiscal crisis is upon us. Abrupt actions forced by crisis harm seniors and risk the long-term stability of the program. Proposals advanced by the President, as well as proposals from the independent commissions, potentially provide a basis for bipartisan agreement and the start of a process that can preserve and improve Medicare for future generations. Thank you.

[The prepared statement of Mr. Antos follows:]



Statement before the House Committee on Ways and Means,
Subcommittee on Health
On the President's and Other Bipartisan Proposals to Reform Medicare

Medicare Cost-Sharing Requirements Should Be Restructured

Joseph R. Antos, Ph.D.
Wilson H. Taylor Scholar in Health Care and Retirement Policy
American Enterprise Institute

May 21, 2013

The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify today before the House Committee on Ways and Means, Subcommittee on Health.

The Medicare program is on a fiscally unsustainable path. Medicare spending will nearly double over the next decade, increasing from $586 billion this year to more than $1 trillion in 2023.[1] The oldest members of the baby boom generation have reached age 65 and are enrolled in Medicare. Over the next two decades, some 76 million people will move out of the workforce, into retirement, and into Medicare. That will place an increasing burden on the budget and on younger generations whose taxes support the program.

In their 2012 report, the Medicare trustees project that the Hospital Insurance (HI) trust fund, which finances hospital and other institutional services provided to Medicare beneficiaries, will become depleted in 2024.[2] Medicare has been liquidating the HI trust fund since 2008 to cover the excess of current expenses over income. The Supplementary Medical Insurance (SMI) trust fund, which finances physician and other outpatient services as well as prescription drug coverage, is considered adequately financed. However, that trust fund automatically receives funds from general tax revenue to cover any shortfall and would otherwise not be self-sustaining. This year's trustees' report, which will be released soon, may offer a somewhat more optimistic view of Medicare financing in the short run, but the long term picture remains bleak.

Policies must be adopted to moderate the growth of Medicare spending while ensuring that beneficiaries with greater needs continue to get the necessary help with their health care costs. Although there is considerable controversy over how best to reform Medicare, there are opportunities to make incremental changes in the program.

Today's hearing focuses on three proposals in the President's 2014 budget that would modestly reduce Medicare spending over the next decade. Beginning in 2017, new enrollees in Medicare would be required to pay a higher deductible for their Part B services. New enrollees would also be subject to a $100 per episode copayment for home health episodes lasting five or more visits. In addition, the President proposes to increase income-related premiums paid under Part B and Part D.

These proposals are estimated to yield $54 billion in budget savings over the next decade—less than 1 percent of the $7.9 trillion Medicare is likely to spend over the same time period. Although modest in scope, the proposals offer an opportunity for bipartisan agreement that could eventually lead to broader reforms to protect Medicare for future generations.

Reforming Medicare Cost Sharing

Traditional Medicare has long been criticized for its baffling set of cost-sharing requirements. Unlike modern insurance products, traditional Medicare requires its enrollees to

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[1] Congressional Budget Office, *Medicare—May 2013 Baseline*, http://www.cbo.gov/publication/44205.
[2] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report*, April 23, 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf.

pay greatly variable amounts in cost-sharing depending on which services are used. Because the required cost-sharing payments are difficult to know in advance, they do not provide a clear incentive to beneficiaries or their providers to select the lowest-cost approach to treatment.

Most comprehensive health insurance has a fairly simple benefit structure. A single deductible amount must be paid each year by the beneficiary before the insurer will pay its share of the cost of services. In addition, beneficiaries are responsible for either a coinsurance (a percentage of the negotiated price of each service, often 20 percent) or a copayment when they use health services.

Medicare imposes several different deductibles, requires varying amounts of coinsurance depending on the service, and places limits on coverage for certain services. In 2013, Medicare beneficiaries must pay a $147 Part B deductible before the program begins to cover the costs of physician and other services.[3] The separate hospital inpatient deductible of $1,184 must be paid for each benefit period—possibly more than once a year. In addition, traditional Medicare does not limit the amount that beneficiaries must pay out of pocket, exposing them to potentially catastrophic costs.

Few Medicare beneficiaries actually pay these amounts directly out of pocket. About 90 percent of beneficiaries in traditional Medicare receive supplemental coverage through Medigap, retiree plans, or Medicaid. That reduces beneficiary uncertainty about how much they might be required to pay in cost-sharing during the year. It also reduces the beneficiary's awareness of the cost of their care, which leads to higher use of services and higher program spending than would otherwise be the case.

Numerous experts and bipartisan commissions have recommended policies to reform and simplify Medicare's cost-sharing structure. The Bowles-Simpson commission proposed new cost-sharing rules and limitations on Medigap coverage that would reduce Medicare spending by $90 billion over the next decade.[4] Similar reforms have been proposed by the Bipartisan Policy Center (estimated program savings of $61.6 billion) and the Medicare Payment Advisory Commission (MedPAC).[5]

The President's 2014 budget proposals are much narrower in scope. The proposals increase the amount of the current Part B deductible and introduce a new cost-sharing requirement for certain home health episodes. Other cost-sharing rules would remain as they are today.

The new provisions would be phased in, and would apply only to new Medicare enrollees entering the program beginning January 2017. The Part B deductible would be increased $25 a

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[3] *Medicare 2013 costs at a glance*, http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html.

[4] The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, http://www.momentoftruthproject.org/sites/default/files/TheMomentofTruth12_1_2010.pdf.

[5] Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, April 2013, http://bipartisanpolicy.org/sites/default/files/BPC%20Cost%20Containment%20Report.PDF; Medicare Payment Advisory Commission, "Reforming Medicare's benefit design," chapter 1 in *Report to Congress: Medicare and the Health Care Delivery System*, June 2012.

year in 2017, 2019, and 2021, for a total increase of $75. The new $100 copayment would be levied on home health episodes with 5 or more visits, and would only apply if the episode was not preceded by an inpatient stay.

Because the provisions are not effective until 2017, the savings measured in the ten-year budget window are modest. The Part B deductible would yield $3.3 billion and the home health copayment would yield $730 million through 2023.

These are modest proposals, but at least they are a start. The increased deductible and the new copayment are intended to promote greater cost awareness among Medicare beneficiaries. It would be reasonable to apply the new requirements to all beneficiaries, and they could be applied before 2017. There is no obvious difference between someone entering Medicare in 2016 and someone entering in 2017. A more reasonable phase-in approach would account for differences in beneficiary ability to pay and health status rather than their year of enrollment.

Critics of these proposals argue that the new cost-sharing requirements could pose a burden on beneficiaries. Since the vast majority of beneficiaries have essentially complete protection against out-of-pocket costs through Medigap and other supplemental coverage, the financial impact on seniors would be minimized. Those who receive Medicaid benefits will not pay more, and those with retiree plans are also likely to have the extra cost paid by their plan. Medigap premiums would rise modestly since insurers will cover the additional $75 deductible (which everyone enrolling after January 2017 must pay) and the cost of the home health copayment (which will be incurred by a minority of patients). Beneficiaries without supplemental coverage risk paying higher amounts, but they already take that risk now.

The President also proposes to add a surcharge to the Part B premium paid by beneficiaries who have near-first dollar Medigap coverage. It is expected to yield $2.9 billion in program savings through 2023. This provision would increase the costs faced by beneficiaries with high-end Medigap plans, but would not significantly discourage the purchase of such plans and would do little to increase cost-awareness among seniors. Rather than adding to the tax burden of seniors, we should restructure Medicare to reflect the innovations that have occurred in benefit design over the past five decades.

Increasing Income-Related Premiums

Medicare provides generous subsidies to seniors at all income levels.[6] Imposing premiums that increase with the income of a beneficiary reduces those subsidies and makes the program more progressive. In that way, seniors who are better able to pay shoulder a larger share of the cost of the program.

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[6] The Medicare benefits that high earners can expect in their lifetimes more than make up for the additional Medicare taxes they pay during their working careers. A two-earner couple with a combined income of $116,000 who turn 65 in 2010 can expect an average of $387,000 in Medicare benefits but only paid $156,000 in Medicare payroll taxes, both measured in present value terms. See C. Eugene Steuerle and Caleb Quakenbush, *Social Security and Medicare Taxes and Benefits over a Lifetime: 2012 Update*, October 2012, http://www.urban.org/UploadedPDF/412660-Social-Security-and-Medicare-Taxes-and-Benefits-Over-a-Lifetime.pdf.

This is not a new policy principle for Medicare. The Medicare Modernization Act of 2003 established income-related premiums for Part B. The Affordable Care Act established income-related premiums for Part D. But even before those policies were enacted, higher wage earners have contributed more to Medicare than those with less income. During their working lives, high wage earners pay higher payroll and income taxes than low wage earners.

The President proposes to increase income-related premiums under Part B and Part D by five percentage points, beginning in 2017. In addition, the income threshold (currently $85,000 for an individual or $170,000 for a family filing a joint tax return) would be frozen until 25 percent of Medicare beneficiaries are subject to such premiums. This proposal is expected to yield $50 billion in program savings through 2023.

The Bowles-Simpson Commission supported a similar proposal, increasing premium levels and setting the income threshold to make 15 percent of seniors subject to income-related premiums ($65 billion in program savings). The Bipartisan Policy Center recommended setting the income threshold to make 17 percent of seniors subject to the premiums ($66.3 billion in program savings).

The Heritage Foundation took this policy to its logical conclusion. If the budget resources are not available to maintain an adequate level of Medicare benefits for every senior, then we should care first for those who cannot afford to cover the costs themselves. Under their proposal, Medicare subsidies would be phased out completely for individuals with income of $110,000 and couples with income of $165,000.[7] That was expected to save $514 billion over ten years.

Increasing premiums reduces the fiscal pressure Medicare places on the rest of the budget, but it does not address the fundamental defects that drive up program costs. Higher premiums do not change the financial incentives of fee-for-service Medicare. They do not change the way beneficiaries use services or the way those services are delivered. Although this policy may be a useful short-term measure, more fundamental reforms that address Medicare's cost drivers are needed.

Conclusion

The President's budget is one possible starting point for developing bipartisan legislation that can begin to slow Medicare spending while protecting the interests of seniors. Although it is far preferable to restructure Medicare's cost-sharing requirements, we can start with targeted changes such as raising the Part B deductible or introducing a new copayment for home health services. Raising premiums will not slow program spending, but could buy some time to implement effective measures to reform the program.

Any significant Medicare reform will take time to develop and implement. It is better to act now than to delay until the fiscal crisis is upon us. Abrupt actions forced by crisis harm

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[7] Robert E. Moffit and Rea S. Hederman Jr., *Medicare Savings: 5 Steps to a Downpayment on Structural Reform*, April 12, 2013, http://www.heritage.org/research/reports/2013/04/medicare-savings-5-steps-to-a-downpayment-on-structural-reform.

seniors and risk the long-term stability of the program. Proposals advanced by the President, as well as proposals from independent commissions, provide a basis for bipartisan agreement and the start of a process that can preserve and improve Medicare for future generations.

Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. He previously served as the Assistant Director for Health and Human Resources at the Congressional Budget Office, and he is currently a member of CBO's panel of health advisers.

Chairman BRADY. Thank you, Mr. Antos.

Ms. Rivlin.

STATEMENT OF ALICE M. RIVLIN, PH.D., CO-LEADER, BIPARTISAN POLICY CENTER HEALTH CARE COST CONTAINMENT INITIATIVE, SENIOR FELLOW, ECONOMIC STUDIES, BROOKINGS INSTITUTION

Ms. RIVLIN. Thank you, Chairman Brady and Ranking Member McDermott.

Let me start with a basic question: Why reform Medicare? The main reason for reforming Medicare is not that the program is the principal driver of future Federal spending increases, although it is. The main reason is not that Medicare beneficiaries could be receiving much better coordinated and more effective care, although they could. The most important reason is that Medicare is big enough to move the whole American health delivery system away from fee-for-service reimbursement, which rewards the volume of services, and toward new delivery structures which reward quality and value. Medicare can lead a revolution in healthcare delivery that will give all Americans better health care at sustainable cost.

This Committee knows very well that health care in the United States is expensive and getting more so. Moreover, quality is uneven, and much care is duplicative, wasteful, and uncoordinated. For decades, however, reformers have focused less on cost containment and quality improvement than on closing the gaps by widening healthcare insurance coverage. But now that the near universal coverage has been ensured by the Affordable Care Act, attention should shift to improving quality and value of healthcare delivery for all and containing cost growth.

I recently had the privilege of co-leading with former Senators Daschle, Domenici and Frist the Bipartisan Policy Center's report on the future—on cost containment in health care. We reached a consensus on a comprehensive package of reforms that span the entire healthcare system with a particular focus on Medicare and Federal health-related tax policy. We believe that if enacted together, and that is important, these reforms will improve healthcare quality for patients and families and lower overall spending throughout the healthcare system.

Budget savings were not our primary objective, but we believe that these reforms would achieve approximately $300 billion in net savings over the next 10 years and about a trillion in the following 10 years. These saving estimates are net of the cost of fixing the dysfunctional sustainable growth rate physician payment formula.

Now, as has been noted, our bipartisan foursome were not mavericks working in isolation. The Simpson-Bowles commission, the Bending the Curve project at Brookings, and indeed the President's budget have endorsed many of the same proposals. It seems that a bipartisan consensus is emerging on using Medicare and tax reform to lead the transition of the health system away from fee-for-service and toward quality and value-based care.

Briefly, our recommendations included preserving the guaranteed health coverage promised in traditional Medicare; modernizing the benefit package for Medicare to create a cap on beneficiary cost-sharing, a catastrophic cap which we don't now have; com-

bining the Part A and B deductibles; and exempting physician visits from the deductible and preventive care from all cost-sharing. We would limit Medicare supplemental coverage, and we would protect low-income beneficiaries by helping them with cost-sharing up to 150 percent of the poverty line. We would raise Part B premiums for higher-income beneficiaries in a slightly different way than the President does.

Most importantly, we would create Medicare networks, an improved version of the affordable care organization demonstrations in the Affordable Care Act. Medicare networks would be provider-led and enrollment-based, and would better provide coordinated care. Beneficiaries and providers would have incentives to join them, and reimbursement would be increasingly reflective of measures of quality and value.

We would replace the SGR with a better structure, and we would increase competition among health plans in Medicare Advantage by implementing a new competitive bidding structure that would result in lower payments and helping beneficiaries navigate plan choice on a user-friendly website.

We would also limit the tax-favored treatment of expensive health insurance products by capping the exclusion of employer-paid benefits. And we would have a cumulative limit on the increase in Medicare spending for each of the three categories that we propose.

This would not be an easy set of reforms to enact or implement, Mr. Chairman, but we believe it would improve the care delivery under Medicare and save money at the same time.

[The prepared statement of Ms. Rivlin follows:]

Written Testimony

Alice M. Rivlin
Co-Leader, Bipartisan Policy Center Health Care Cost Containment Initiative
Senior Fellow, Economic Studies, Brookings Institution

Before the United States House of Representatives Committee on Ways and Means
Subcommittee on Health
May 21, 2013

Chairman Brady, Ranking Member McDermott, thank you for this opportunity to discuss strategies to strengthen our nation's health care system and ensure that our Medicare dollars support high quality, cost effective health care.

Background and Overview of Health Care Cost Containment Initiative

Recently, the Bipartisan Policy Center (BPC) concluded a nearly year-long project which examined high and rising health care spending and made recommendations to improve the quality and sustainability of our nation's health care system. I, along with the other three leaders of BPC's Health Care Cost Containment Initiative, former Senate Majority Leaders Tom Daschle (D-SD) and Bill Frist (R-TN) and former Senator Pete Domenici (R-NM), came together around the common belief that our health care system can provide better care to patients at a lower overall cost by prioritizing high value, coordinated care delivery and payment.

We reached consensus on a comprehensive package of reforms that span the entire health care system, with a particular focus on the most powerful federal levers for incenting broad and systemic reforms – the Medicare program and federal health-related tax policy. Our report, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, released last month, describes all of these recommendations in detail. We believe that, if enacted together, these reforms will help improve health care quality for patients and families and lower overall spending growth across the entire health care system.

The work of the Health Care Cost Containment Initiative was informed by substantive, third party analytics and feedback from a broad group of experts and stakeholders. BPC commissioned Acumen, LLC (an organization that provides modeling support for CBO, CMS, MedPAC, and other similar organizations) and MIT economist Jonathan Gruber to estimate the spending and revenue impacts, respectively, of our proposed policies. Over the next 10 years, our proposals would result in approximately $560 billion in deficit reduction. Our Medicare reforms would achieve roughly $300 billion in net savings within that time frame, and over second decade (2024-2033), our proposals would result in another almost $1 trillion in budgetary savings to the Medicare program. These savings estimates are net of the cost of fixing the dysfunctional Sustainable Growth Rate (SGR) physician payment formula. Broadly, we propose the following:

- Preserve the guaranteed health coverage promised in traditional Medicare while adding more choices and protections for beneficiaries.

- Strengthen and modernize the traditional Medicare benefit.
- Reform the tax treatment of health insurance to limit the tax-favored treatment of overly expensive insurance products.
- Empower patients by promoting quality measures that are meaningful to consumers, families and businesses.
- Offer incentives to states to promote policies that will support better organized, value-driven health-care delivery and payment system, such as supporting medical liability reform and strengthening our primary-care workforce.
- Advance the nation's understanding of potential cost savings from prevention programs, through support for research and innovation on effective strategies to address costly chronic conditions.

Senator Domenici and I have long agreed on the urgent need to improve our nation's health care system and to get health care spending under control. Before joining with Senators Daschle and Frist on the Health Care Cost Containment Initiative, Senator Domenici and I co-chaired the BPC Debt Reduction Task Force. The Domenici-Rivlin Debt Reduction Task Force released a broad, balanced package of spending cuts and tax reforms to get our nation's debt on a more sustainable path, which focused heavily on improving our health care system.

The Domenici-Rivlin Task Force Medicare proposals emphasized beneficiary engagement; competition on the basis of quality and value that brings market forces to bear in Medicare; an improved, rationalized traditional Medicare benefit package; and more coordinated systems of health care delivery and payment. All of these elements are reflected in the BPC Health Care Cost Containment Initiative report, which emphasizes improving the quality of care and providing incentives to beneficiaries and providers that will increase coordination and measured effectiveness of care. Some proposals were refined as we acquired more knowledge and recognized the need to prioritize political and economic realities to develop a package around which both sides of the aisle can realistically coalesce.

In today's hearing, I will focus on the Medicare benefit and cost-sharing redesign recommendations Senators Daschle, Domenici, Frist and I released. However, I want to note that our recommendations are structured as an integrated package. We believe that a comprehensive approach, rather than breaking out individual recommendations for implementation, is critical to achieving successful health care system transformation. As was made clear by each of the leaders when the proposal was released, one cannot "cherry pick" a proposal from the report and assume that all leaders would endorse the provision in isolation.

Our Medicare reforms have three key policy foundations:

1. Structural reforms that will preserve traditional Medicare while improving Medicare payment and care delivery by encouraging coordination, competition, and beneficiary choice;
2. Redesign of the traditional Medicare benefit package and cost-sharing; and
3. A series of reforms that can be implemented in the near term that will achieve budgetary savings and support our longer term goals of system-wide health care transformation, such as

expanding competitive bidding for certain goods and services, ensuring that Graduate Medical Education payments support a workforce that can effectively and appropriately deliver care, and encouraging the use of high quality, low cost drugs.

Over the long-term, we envision a health care system where all patients are able to receive high quality, coordinated care. To achieve this goal, the dominant delivery and payment systems must be reformed to encourage providers to form and develop organized systems of care. As the largest payer, Medicare has the opportunity to lead the way. Our proposal calls for the creation of a new, permanent option in traditional Medicare called "Medicare Networks." Medicare Networks would be provider-led and similar to accountable care organizations (ACOs), but with key improvements. Most importantly, Medicare Networks would be enrollment-based, meaning that beneficiaries must make an active, informed choice to join a network—rather than being passively assigned to an ACO without their knowledge, as they are under current law.. Beneficiaries joining a network would receive a discounted monthly premium and lower in-network cost-sharing for participation. We would offer strong financial incentives for both providers to form and beneficiaries to join Medicare Networks, and allow both to share in savings that result from greater quality and efficiency of care. We would repeal the SGR, and physicians practicing within Medicare Networks would receive updated payments based on the Medicare Economic Index (MEI).

Ultimately, beneficiaries would be free to choose between improved fee-for-service Medicare, improved Medicare Advantage, or the new Medicare Networks. In Medicare Advantage, our recommendations would implement a new competitive-bidding structure. Competitively-bid payments to plans would only take effect in regions where such payments are lower than those under current law, therefore guaranteeing savings for the Medicare Trust Funds. Initially, a portion of the savings would be allocated to finance reduced enrollee premiums and cost-sharing. To help beneficiaries navigate plan selection, we propose a user-friendly, up-to-date Medicare Open Enrollment website. Our recommendations also call for continual improvements to Medicare Advantage risk adjustment and a new, budget-neutral reinsurance program to augment the risk adjusters in addressing risk selection issues.

We project these reforms to achieve substantial savings on their own, but we also include a fallback spending limit to take effect no earlier than 2020. This limit would be triggered by spending growth in excess of GDP per beneficiary growth (age-adjusted) + 0.5 percentage points and would apply separately to all three Medicare program options. Acumen's budget estimate includes no savings from this fallback spending limit.

Strengthen and Modernize the Medicare Benefit

Our recommendations improve, simplify and modernize the traditional Medicare benefit package. This redesign provides long overdue protections and preserves the same aggregate cost-sharing that beneficiaries experience today. Again, I would stress that these reforms are part of our integrated package of recommended Medicare reforms, which recognizes that changes in benefits and cost-sharing should protect low-income seniors.

Changing Traditional Medicare Cost-Sharing: Important Considerations

Any reform to the Medicare benefit design should ensure that beneficiary cost sharing provides incentives for appropriate utilization of services without imposing a financial burden on beneficiaries that would keep them from receiving medically necessary services.

Challenges in Traditional Medicare Cost-sharing

In addition to its lack of catastrophic protection, there are several unusual features of Medicare's cost-sharing design that are important to consider when proposing adjustments.

- **Two Deductibles.** Private health insurance typically has one deductible covering all hospital and physician services. Once the deductible is met, it does not apply for the rest of the year. The Medicare program has two deductibles, one for physician and related services ($147 per year in 2013) and one for hospital ($1,184 per episode in 2013). Moreover, the Part A hospital deductible applies to each episode of care. In this respect, the Medicare hospital deductible is more like a copayment, since it may apply multiple times per year.
- **Physician office visits are subject to the deductible.** In most private health insurance, policyholders can see a doctor for only the cost of a copayment, even if the deductible has not been met. This encourages patients to seek care early on, before conditions worsen. In Medicare, beneficiaries who have not met the deductible must pay the full cost of a physician visit.
- **No cost-sharing for some services, very high cost-sharing for others.** A beneficiary with a health condition that requires a very long hospital stay is expected to pay $296 in cost-sharing for days 61 through 90, and even more if more than 90 days are required (remember, Medicare has no out-of-pocket maximum). Clearly, this is not a realistic or affordable amount, and such high amounts are not necessary to provide incentives for appropriate utilization of care. Conversely, some Medicare-covered services, such as home health, laboratory services, and the first 20 days of a Skilled Nursing Facility stay, have no cost-sharing at all. Private health insurance usually includes some kind of cost-sharing for these services. Just as unrealistically high cost-sharing is counterproductive, the total absence of cost-sharing for some services encourages inappropriate utilization and can help fraud remain undetected. If services do not have cost-sharing, there should be a strong justification and the application should be limited. Examples of services that should not have cost-sharing include preventive care (already a strong feature of the Medicare benefit design), hospice care, and very inexpensive services, such as a $3 lab test.
- **Interaction with supplemental insurance.** Even well-designed changes to Medicare cost-sharing will have a limited effect in discouraging inappropriate utilization if supplemental insurance cancels their effect. . Beneficiaries who have and keep supplemental coverage that fills in the entire amount of the deductibles and all coinsurance, are not affected. This is another reason that changes to cost-sharing should be considered in the context of broader reforms.

Medicare Benefit Modernization: The BPC Approach

Currently, the Medicare benefit package provides no limit on annual beneficiary liability. Our proposal would set an annual, beneficiary cost-sharing limit for catastrophic medical costs at $5,315. We would streamline the Medicare Part A and B deductibles into a single, annual deductible of $500 and provide the Department of Health and Human Services (HHS) Secretary with authority to replace coinsurance and establish more predictable copayments for most covered services, similar to those suggested by the Medicare Payment Advisory Commission (MedPAC). Our proposal would also ensure that beneficiaries are able to see their doctor without facing high out-of-pocket costs, by exempting physician office visits from the new, combined deductible; beneficiaries would always be able to see a physician for the cost of a copayment ($20 for a primary care office visit, $40 to see a specialist). Furthermore, we would maintain current policies that eliminate cost-sharing for preventive care and provide for the annual Medicare wellness visit, as well as hospice.

As part of our payment and delivery system reform proposals for traditional Medicare, we seek to encourage organized systems of care that are accountable for quality and cost. One of our recommendations is to dramatically improve the existing ACOs by allowing for greater patient engagement. Traditional Medicare beneficiaries who enroll in our proposed Medicare Networks would receive lower in-network cost-sharing, but would also pay higher cost-sharing if they receive services from Medicare providers that are not part of the network. This would provide stronger incentives for beneficiaries to enroll and access care from high quality, efficient providers.

Reform Medicare Supplemental Insurance

The point of co-payments and deductible to engage patients in ensuring that health care dollars spent on services that actually improve patient health. Therefore, starting at the same time as our benefit redesign proposal, all supplemental coverage would be required to include a deductible of at least $250, an out-of-pocket maximum no lower than $2,500, and cover no more than half of beneficiary copayments and coinsurance. These restrictions would apply to both individually-purchased (medigap) and employer-provided plans, including TRICARE for Life and the Federal Employee Health Benefits Program.

Medigap insurance is expensive. The the market for medigap plans is highly concentrated—two issuers control three-quarters of it—raising concerns about adequacy of competition.[1] Modernizing and strengthening the Medicare benefit package, as we recommend—including a new beneficiary out-of-pocket limit, lower costs for early year physician visits, and other improvements—would make such supplemental policies less necessary and enable beneficiaries to save money by forgoing an expensive product.

[1] Starc, Amanda. Insurer pricing and consumer welfare: evidence from medigap. Feb. 22 2012. Available at: https://hcmg.wharton.upenn.edu/files/?whdmsaction=public:main.file&fileID=1858.

Increase and Improve Support for Low-Income Medicare Beneficiaries

Low-income beneficiaries cannot afford to pay the same cost-sharing as middle- and upper-income seniors. Currently, most seniors and people with disabilities with incomes below the federal poverty level (FPL) qualify for assistance that covers 100 percent of their non-drug cost-sharing liability—including deductibles, copayments, and coinsurance—but there is no physician or hospital cost-sharing help available for beneficiaries with incomes that are near-poverty. This is a significant gap in the safety-net—one that also complicates efforts to reform Medicare's benefit design and limit first-dollar supplemental coverage due to legitimate concerns about the potential impact on beneficiaries with incomes just above the poverty level who do not currently qualify for any cost-sharing assistance.

In tandem with our Medicare benefit modernization, therefore, we recommend expanding cost-sharing assistance to beneficiaries with incomes up to 150 percent of the poverty level. This proposal would help roughly eight million low-income seniors and people with disabilities, which in conjunction with the rest of our plan, would provide them each, on average, with $1,250 of support.

Under this new, federally funded assistance:

- 50 percent of cost-sharing (including deductibles, copayments, and coinsurance) would be covered for Medicare beneficiaries with incomes between 100 percent and 135 percent of the FPL; and
- 25 percent of cost-sharing would be covered for beneficiaries with incomes between 135 percent and 150 percent of the FPL.

Eligibility would be automatically determined by the Social Security Administration based on an individual's modified adjusted gross income (MAGI). There would be no asset tests for this new assistance, enabling automatic enrollment.

Reduce Subsidies to Higher-Income Medicare Beneficiaries

Importantly, because Parts B and D of Medicare are not pre-funded like Part A or Social Security, the federal government contribution through general tax revenue amounts to a subsidy for medical and prescription drug coverage. We believe that a generous government contribution is appropriate for low- and middle-income seniors and people with disabilities, but providing generous subsidies to high-income beneficiaries who do not need the assistance is unjustified given the perilous fiscal trajectory of the nation.

As part of comprehensive Medicare reform, BPC recommends reducing subsidies to higher-income Medicare beneficiaries. Specifically, the proposal would reduce premium subsidies for Medicare beneficiaries with income starting at $60,000 for single beneficiaries and $90,000 for couples. Because couples are typically more financially secure than single beneficiaries, our proposed thresholds feature a single/couple ratio of 1 to 1.5, as compared to a 1 to 2 ratio for the existing thresholds. The new thresholds would be implemented in 2016 and would be adjusted for inflation after 2018, at which point approximately 17 percent of Medicare beneficiaries would pay income-related premiums. In total, this reform would save taxpayers $66 billion over ten years.

*Proposed Thresholds		
Single	**Couple**	**Premium**
<$60,000	<$90,000	25%
$60,001-$82,000	$90,001-$123,000	35%
$82,001-$135,000	$123,001-$202,500	50%
$135,001-$189,000	$202,501-$283,500	65%
>$189,000	>$283,500	80%

Conclusion

All of these Medicare proposals fit together as an integrated package that seeks to improve quality, reduce waste and inefficiency, and lower costs. Senators Daschle, Domenici, Frist and I all agreed that we needed a sustainable and comprehensive plan for improving our health care system. Our recommendations are intended to support our vision of a more coordinated and efficient health care system that delivers high quality care to all Americans. Due to the inefficiency and waste that plague the current system, delivering better quality and higher value care will naturally lead to lower spending growth. Cost shifting is a short term expedient only, and cannot be sustained over the long term.

Changes to beneficiary cost-sharing should not be solely a budget-driven policy exercise; reform should focus on strengthening the Medicare benefit, blunting the harmful effects of first-dollar supplemental coverage, and expanding protections for low-income beneficiaries. These policies should be pursued in concert with broad, structural reform. Our proposed changes in beneficiary cost-sharing and benefit design were carefully constructed to complement our Medicare delivery system and payment reforms. In our proposal, Medicare beneficiaries share in the responsibility of building a better health care system with the whole spectrum of providers, industry leaders, stakeholders, and payers.

Thank you again for this opportunity to discuss BPC's approach to creating a higher quality, higher value health care system. I look forward to a continued dialogue with you on this very important topic.

Chairman BRADY. Thank you, Ms. Rivlin.
Mr. Baker.

STATEMENT OF JOE BAKER,
PRESIDENT, MEDICARE RIGHTS CENTER

Mr. BAKER. Thank you, Chairman Brady, Ranking Member McDermott, and distinguished Members of the Subcommittee on Health, for the opportunity to testify this morning about proposals to modify Medicare cost-sharing. Medicare Rights Center is a national nonprofit organization dedicated to making sure that people with Medicare get access to affordable health care. We counsel about 15,000 people a year and their families and through our education initiatives help about 700,000 others.

Proposals to increase the Medicare Part B deductible, introduce a home health copayment, and further income-relate Medicare premiums share a common pernicious theme: Each plan achieves savings by shifting cost to the very people Medicare was designed to protect.

Cost shifting to Medicare beneficiaries doesn't solve the underlying problem with our healthcare system: the long-term challenge of systemic healthcare inflation and costs, which threatens both the public and the private spheres. We believe that Congress should focus its attention on reforms that diminish wasteful Medicare spending and encourage the transformation of our healthcare system from one that rewards high-volume care to one that rewards high-value care.

To this extent, we support the proposals that would shift no costs, like advancing some of the delivery system reforms in the Affordable Care Act, restoring Medicare drug rebates, equalizing reimbursements to Medicare Advantage plans, and other proposals.

Today, as Ranking Member McDermott said, half of all people with Medicare, 25 million older adults and people with disabilities, are living on annual incomes of $22,500 or less and spending about 15 percent of their household income on healthcare costs as opposed to 5 percent for those under age 65 who are not on Medicare. These people with Medicare cannot afford to pay more for health care. Indeed, the most common call to our help line comes from a Medicare beneficiary having difficulty affording a treatment or a medicine. Further, forcing so-called wealthy beneficiaries to pay more for Medicare translates into a premium hike on middle-class retirees and people with disabilities while also fracturing one of our Nation's most successful social insurance programs.

Added cost-sharing leaves many beneficiaries with no choice but to self-ration care. Faced with higher upfront costs, beneficiaries living on fixed incomes are likely to forego doctor's visits, a decision made on affordability, not on healthcare needs. Almost 40 years of data consistently demonstrates that while higher out-of-pocket costs certainly deter healthcare utilization, it deters utilization of needed care as well as unneeded care indiscriminately. The equation is simple: Higher out-of-pocket costs will require many Medicare beneficiaries to go without, either going without heating or rent payments, or going without needed medical care. And in the long run, reduction in the use of medically necessary care can in-

crease healthcare spending through the increased likelihood of emergency room visits, ambulance rides, and hospital stays.

Increasing the Medicare Part B deductible, either alone or by combining the Part A and Part B deductible, is one of several proposals that adhere to the faulty logic that added cost-sharing is an appropriate tool to limit healthcare service use. Most alarming about this proposal is that these added costs would impose greater hardship on beneficiaries with low fixed income. And with regard to the point about supplemental insurance covering this, many who would also increase the deductible would also decrease the level of coverage in Medigap or other Medicare supplemental plans.

Similarly, introducing a home health copayment would be most damaging to the most vulnerable—the poorest, the oldest and the sickest. The typical home health user is an older, lower-income woman with one or more common or chronic conditions. Beneficiaries who need ongoing care to remain in their homes and not be institutionalized in nursing homes or other types of care are most at risk of skipping needed care if forced to pay this copayment.

Many policymakers suggest that wealthier beneficiaries can contribute more in Medicare costs, specifically through higher premiums. Yet higher-income beneficiaries already pay higher premiums, as we have heard. Achieving savings of any scope under these proposals requires reaching down the income spectrum. Recent analysis shows that individuals making $47,000 per year would pay more under current proposals. And that is a slippery slope. It could get lower and lower as this is looked at.

So we implore you to reject proposals that fail to build a better healthcare system, instead only achieve ephemeral savings by shifting costs to people with Medicare. Thank you for this opportunity to testify.

[The prepared statement of Mr. Baker follows:]

Testimony of Joe Baker
President, Medicare Rights Center

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

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

May 21, 2013

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Introduction:

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

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

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

Most people with Medicare cannot afford to pay more for health care, and the burden of added cost sharing falls heaviest on those with low- and fixed- incomes and those with significant health care needs. Further, forcing "wealthy" beneficiaries to pay more for Medicare translates to a premium hike on middle class retirees and people with disabilities, while also fracturing one of our nation's most successful social insurance programs.

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

People with Medicare – Income, Assets and Health Care Costs

We know firsthand the economic and health challenges facing people with Medicare and their families. The Medicare Rights Center provides answers 15,000 Medicare questions on our national helpline each year, serving older adults, people with disabilities, family caregivers, social workers, attorneys and other service providers. Through our educational initiatives,

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

including peer-to-peer learning networks, we touch the lives of an additional 65,000 people with Medicare and their families. In addition, our online learning tool, Medicare Interactive, receives approximately 650,000 visits annually.

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

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

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

Pat's story is commonplace. As such, any attempt to modify Medicare cost sharing must begin with a close examination of the financial and health realities facing our nation's older adults and people with disabilities. As noted before, most people with Medicare are living on low, fixed incomes. In 2012, half of all Medicare beneficiaries lived on annual incomes at or below $22,500—just under 200% of the federal poverty level. And half had $77,500 or less in personal savings.[2] The Baby Boomers, many of whom will retire within the next two decades, are not expected to fare much better. Among the next generation of retirees, one quarter are expected to have annual incomes below $15,000 and half are expected to have annual incomes below $27,000.[3]

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

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

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

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

average Medicare household spends three times on health care-related costs as the average non-Medicare household—15% vs. 5% as a share of total income.[5]

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

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

Most people with Medicare (90%) have coverage to supplement basic Medicare benefits. Some have retiree benefits through former employment (30%), Medicare Advantage plans (29%), Medicaid (14%) or Medigap coverage (18%), and others who have only Medicare (8%) may also be entitled to benefits through the Veterans Administration.[9] Many of these supplemental insurance plans allow Medicare beneficiaries to manage significant cost sharing.

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

Most Medicare beneficiaries, people like Pat, cannot endure added costs without facing significant hardship. The stark financial reality facing most people with Medicare makes clear

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

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

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

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

[9] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), "Variations and Trends in Medigap Premiums" (December 2011), available at: http://aspe.hhs.gov/health/reports/2011/medigappremiums/index.pdf

[10] Genworth, "2013 Cost of Care Survey: Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes," (March 2013), available at: https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032213_Cost%20of%20Care_Final_nonsecure.pdf

that added cost sharing would impose a harsh burden on the older adults, people with disabilities, and families who rely on Medicare.

Effects of Cost Shifting to People with Medicare

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

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

The equation is simple: higher out-of-pocket costs will require the majority of Medicare beneficiaries to go without: either going without heating or rent payments, or going without needed medical care. In the long run, reductions in the use of medically necessary care can, in fact, increase health care spending through the increased likelihood of emergency room visits, ambulance rides and hospital stays.[12]

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

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

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

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

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

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

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

The subgroup's research demonstrates that cost sharing has dubious utility in holding down health care spending and can actually lead to increased total spending on health care if people forgo medically necessary services. In a letter to Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services, the NAIC concluded:

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

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

While some proposals seek savings by way of increased Medicare cost sharing as a vehicle for limiting utilization of care, others find savings merely by charging people with Medicare more. Proposals to increase Medicare Part B and D premiums achieve federal savings by forcing people with Medicare to contribute more for their benefits, the very same taxpayers who paid

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

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

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

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

into the program over the course of their working lives. Similarly, proposals that would add a surcharge or tax to supplemental Medicare coverage, like Medigap plans, aim to accomplish one of two related goals: (1) to deter beneficiaries from opting for coverage that shields them from sporadic and high cost sharing; or (2) to collect revenue from people who choose these plans.

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

Advancing Value-Driven Care

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

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

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

Despite what some claim, Medicare is *not* in crisis. Cost saving measures taken in the ACA extended the solvency of the Medicare Hospital Insurance (Part A) Trust Fund for eight years,

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

until 2024.[20] This represents one of the longer periods of projected solvency throughout the program's history.[21] For this reason, we reject the notion that we must cut Medicare benefits or shift costs to current retirees and people with disabilities to preserve the program for future generations.

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

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

Increasing the Medicare Part B Deductible

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

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

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

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

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

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

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

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

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

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

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

A second iteration of the Bowles-Simpson plan made attempts to mitigate the known harms of this significant cost shift by, for example, suggesting a lower deductible for individuals living

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

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

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

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

Introducing a Home Health Copayment

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

It is worth noting that home health copayments existed in the Medicare program until 1972, when Congress acted to remove them. This action was prompted by the finding that copayments deterred the appropriate use of home health services and contributed to over-utilization of more costly institutional care. In eliminating home health copayments in 1972, Congress presaged the findings of the studies cited above about the negative effects cost shifting has on access to care.[31]

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

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

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

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

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

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

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

Further Income-Relating Medicare Part B and Part D Premiums

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

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

In contrast, beneficiaries who fall into the current highest income tier, those with an annual income at or above $214,000, pay a Part B premium of $336 per month (calculated as 80% of projected annual Part B costs per person aged 65+) and an additional $67 per month on top of his or her selected Part D premium.[34] Couples in the highest income tier pay twice this amount, with

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

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

Part B premiums reaching nearly $700 per month. An estimated 5% of Medicare beneficiaries (2.4 million) pay an income-related Part B and Part D premium. This share is expected to increase to 9.7% by 2019 as income thresholds were frozen through the ACA. In addition, because there is no cap on Medicare payroll tax deductions, higher income individuals and couples pay higher taxes towards Medicare benefits during their working lives.

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

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

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

As proposed, added income-relating in Medicare premiums constitutes little more than a cost shift to middle class retirees and people with disabilities. This slippery slope has broader consequences for the Medicare program, eroding popular support for one of society's most successful pillars of retirement security. Further means-testing Medicare would undermine the social insurance model inherent to the historical, quantifiable success of the program.

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

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

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

Though taxes paid over a lifetime of work, Americans jointly bear the responsibility of ensuring that our nation's older adults and people with disabilities have access to health care when they need it the most—this is the social insurance value of Medicare. The financing of Medicare Part A, Part B, Part C and Part D, whether paid for through payroll taxes, income taxes or premiums, have no bearing on this social contract. To qualify for the Medicare program, a person must have paid these taxes. Arbitrarily determining that some share of people with Medicare should be forced to pay more chips away at what makes Medicare a success.

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

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

Conclusion

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

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

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

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

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

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

Risk scoring—the formula Medicare uses to determine MA plan payments based on estimated costs per beneficiary adjusted for health status—could also be adjusted to eliminate overpayments caused by differences in diagnostic coding between people with MA plans and people with traditional Medicare—saving $8.6 billion over 10 years as reflected in the President's FY2014 budget.[41]

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

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

Thank you for the opportunity to testify.

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

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

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

Chairman BRADY. Thank you, Mr. Baker.

First to Mr. Antos, Ms. Rivlin. Medicare is so important. It is in deep trouble. Lawmakers like to bury their heads in the sand on these tough issues. How important is it that we act this year to either save Medicare for the long-term or to take meaningful steps to extending its life, for example, another 20 years or more? Mr. Antos. Ms. Rivlin.

Mr. ANTOS. Well——

Chairman BRADY. Act now.

Mr. ANTOS. Acting now is a critical matter. Congress has had plenty of opportunity to take appropriate actions over many, many years. But in fact we still face the fiscal problems and the risk to the Medicare program.

Chairman BRADY. I have a couple more questions for you, so your point is act now?

Mr. ANTOS. Act now, but act responsibly.

Chairman BRADY. Got it.

Ms. Rivlin.

Ms. RIVLIN. I would say act now, but for the principal reason that you can use Medicare to reform the whole system.

Chairman BRADY. Yeah. Yeah. Do you see, as you look at these issues and the President's policies in his budget, income-related premiums for Medicare Parts B and D, the Part D deductible establishing a home health copay? The President has suggested this begin 4 years from now, 2017. Ms. Rivlin, do you see any reason we should wait that long?

Ms. RIVLIN. I don't think you need to wait until 2017. You need a little time to get them in place and——

Chairman BRADY. Yeah. Set them up.

Ms. RIVLIN. Set them up. So it can't be 2014. I think we suggested 2016 as a reasonable year. But again, I wouldn't do these in isolation. Do them as a package.

Chairman BRADY. Got it, makes sense.

Mr. Antos, you emphasized broad reforms of combining Medicare Parts A and B. This important topic, the Subcommittee has been looking at and will continue to explore. Would you consider the policies we are discussing today to be smaller reforms on the pathway to perhaps bigger ones?

Mr. ANTOS. Well, they could be on the pathway to a discussion about combining A and B and more sensible reforms of Medicare. But these specific proposals I don't think take us in that direction. They are simply budget cuts.

Chairman BRADY. Got it.

Ms. Rivlin, you—and Mr. Antos, you both recommended establishing a home health copay so that patients determine the value of those services that are being provided to them. Some critics have warned it would deter many vulnerable Medicare beneficiaries from accessing needed care, maybe increase returning to hospitals. Can you respond to those criticisms?

Mr. ANTOS. Well, certainly, the President's proposal follows the Medicare Payment Advisory Commission's precaution and restricts this to episodes that have at least five visits and are not preceded by an inpatient stay.

Chairman BRADY. So you are not coming from the hospital.

Mr. ANTOS. You are not coming from the hospital. Nonetheless, this is a serious matter. And the problem with a lot of Medicare policy is that it is very heavy-handed. We need to have a more subtle policy or we need to have a better management of patient care.

Chairman BRADY. Should we adjust it to the income of the Medicare senior?

Mr. ANTOS. We certainly should recognize the extra burden that this is going to cause on the minority of patients who don't have the money.

Chairman BRADY. Ms. Rivlin, your thoughts?

Ms. RIVLIN. Home health care is liable to abuse, and I think that some cost-sharing is appropriate. In our plan, we actually help the lower-income beneficiaries cope with total cost-sharing, including any new cost-sharing, so it wouldn't be subject to that criticism.

Chairman BRADY. Yeah. And your belief is we are looking at value over volume. Is Washington the best one to determine what that value of service is, or are patients actually using them, you know, who have some role in some cost-sharing, small or large, according to ability to pay? Is that where we see value more likely to be determined?

Ms. RIVLIN. Well, when we talk about value and quality, we envision a set of measures that will eventually govern the reimbursement as we get more experience with them. I don't think you entirely rely on patients, as Dr. McDermott has suggested, to sort out what is quality. The point of cost-sharing is to give patients some reason to stop and think, unless they are very low income, about whether they need to go.

Chairman BRADY. That makes sense.

Mr. Baker, I just want to understand: You absolutely reject the President's proposals to begin some of these reforms in Medicare?

Mr. BAKER. Yes, we think that the cost-sharing as set is a blunt instrument and one that would visit some harm on beneficiaries.

Chairman BRADY. Okay. Thank you.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I didn't take economics and so I am always pleased with the chance to learn from economists how they think. You take the average person is 78 years old, and he or she is living on $22,000 and spending about $3,000 on average, 15 percent, on their medical expenses, okay. So they are already spending a big chunk out of it.

Now, we are going to impose a tax on them. We are going to tax them—we are going to call it a premium increase, but it is a tax. It is a tax on the seniors that we are putting on here. And I want to understand from the economist's point of view how imposing that tax on a 78-year-old senior who is living on $22,000 and spending $3,000 already on health care, how is that going to change the delivery of the healthcare system to deliver quality instead of quantity?

I mean, I am trying to think of Mr. Johnson sitting there and saying, well, the doctor said I should come back and have my blood pressure checked, and it is going to cost me X number of dollars and so forth, and so I am not going to go. Or I am going to go because the doctor told me to. How does this change the cost of over-

all Medicare by putting a tax on seniors of another 50 bucks a month?

Ms. RIVLIN. That proposal is not what I—tax on seniors of 50 bucks a month is not what I am advocating.

Mr. MCDERMOTT. You are not talking about the melding of the Part A and Part B?

Ms. RIVLIN. We are.

Mr. MCDERMOTT. You are. So that means that the money that they pay will be more per month, right?

Ms. RIVLIN. Let me finish. We do not propose a net increase in beneficiary cost-sharing. The package that we would have, and it is a package, would reduce the cost-sharing for low-income beneficiaries, increase it at the top. It would also make some very important changes in the benefit package that would say no deductible for going to the doctor ever, and no cost-sharing at all for preventive care, and a cap on out-of-pocket spending. All of that is helpful to your average and below beneficiary.

Mr. MCDERMOTT. So then you are going to put it all on the richer people, that is the idea. Since it is not going to cost the poor people more, it has to cost the richer people more, is that it? So you are putting the tax on the people above——

Ms. RIVLIN. Well, we are increasing the Part B premium, yes, for higher-income people. There is already an income relation, and we would lower the thresholds for that, but not to levels where people are in need.

Mr. MCDERMOTT. When does it tip over into being a welfare system? If you are poor you get it for free; if you are rich, you have to pay for it. I mean, that is what we have now in the healthcare system in this country. If you are poor, you go to Medicaid, right? Or you just walk into the emergency room and get taken care of. The rest of us pay for it, and we are paying 1,000 bucks a year for the cost of the uncompensated care, presently. What you are doing is just shifting it to the top, is that what you are saying?

Ms. RIVLIN. That is part of what I am saying, but remember, we don't pay for Part B. Right now the premiums cover only 25 percent of the cost of Part B. We would like the premiums to cover a somewhat higher share, and we would do that by raising the premiums for people like me. I am a beneficiary of Medicare who can afford to pay it.

Mr. MCDERMOTT. Mr. Baker, your view of this whole process?

Mr. BAKER. Well, I think whenever you are talking about shifting the benefit, especially in the context of deficit reduction or for paying for other things, you are looking for savings. And in that context, even if you are protecting lower-income people——

Mr. MCDERMOTT. You are looking for savings or you are looking for more revenue?

Mr. BAKER. Well, you are looking for revenue for the Federal budget, of course.

Mr. MCDERMOTT. So it is basically a tax.

Mr. BAKER. It is a tax.

Mr. MCDERMOTT. You are taxing somebody to get more revenue into the system.

Mr. BAKER. It gets more revenue into the system, and I think that the problem is, it doesn't solve the underlying problem, as I

said, which is the healthcare costs themselves and inflation in that market, and it is kind of a slippery slope. So once you start charging, say, people at $60,000 or $85,000 a year or more, and you can argue whether that is a wealthy individual when you look at our Tax Code, not necessarily as wealthy, of course, as someone at 450 or a million dollars where tax rates start to go up. But even for folks that are in that middle-income range, they do not qualify for low-income protection. They are strapped.

So, you know, you are looking at folks that are the most vulnerable, that have the least control over their utilization of health care, because as you had mentioned, once they get to the doctor and they are in the healthcare system, they are moving through that system. They are following doctor's orders. And I think that is where the incentives need to be placed on controlling care, through accountable care organizations, some other mechanisms I think we all see as appropriate.

Mr. MCDERMOTT. Thank you.

Chairman BRADY. Thank you.

Mr. Roskam is recognized for 5 minutes.

Mr. ROSKAM. Thank you, Mr. Chairman.

You know, it is interesting to take a step back and look at the trend and the history of this discussion. So the trend would suggest that income-related premiums and the discussion around them are here to stay. If you look at 2003, the decision by House GOP at that point to move forward on Part D and Part B; the decision by the Democrat majority in 2010 to move forward with similar themes as it relates to Medicaid and health exchanges in Part D; the decision of the Obama Administration, even if it is de minimis, they are acknowledging in their budget that it is here to stay.

So, Mr. Baker, I think that you are making yesterday's argument. Yesterday's arguments, they are nostalgic, but I think that the entire question, these numbers are so big, they have really eclipsed. Mr. McDermott raised this question about the economics of this, and that is sort of the wonder of it all, isn't it? That if you give patients choices, and not cutting out the legs from underneath the vulnerable that he is defending today, as well he should, but you look at the success of Part D, for example, a lot of the themes that we have heard in terms of criticisms of income-related premiums, we have heard those echoes in the past, and that was the claim that Part B was going to sort of lead to a very difficult situation, when as we all know, the data suggests just the opposite. Incredibly high satisfaction rate among seniors, you know, savings that have come in well under, you know, by 45 percent under the expectations. So that is part of the power of giving people choices and the ability to move forward.

Mr. McDermott mentioned a minute ago the idea of a senior being told, well, chase this down, you know what I mean, and come back and double-check with your physician. Part of the other story, though, to complete the picture is, many times if you are told by a physician to get an MRI, or whatever it happens to be, right now the system doesn't create an environment where you have much interest in trying to figure out who is doing the most efficient MRI. Where is the best, cheapest, and easiest, as opposed to the one that you just end up in?

Dr. Rivlin, can I ask you a question? With that sort of predicate, you made an interesting statement, and you said that the driving opportunity right now take the debt—and it is a pretty provocative thing. You said the debt is a big question; set it aside. A more effective healthcare system is interesting; sort of set it aside. But you are telling this Committee and this Congress that you have such a big opportunity right now that you can have a transformational moment as it relates to Medicare. What did you mean by that?

Ms. RIVLIN. The rising costs are not just in Medicare. They are in the whole system. And one of the culprits is the fee-for-service reimbursement system, which does, not surprisingly, reward more services, more volume, rather than coordinating care and rewarding value and quality.

We think that the accountable care organizations, we all think that accountable care organizations should be strengthened, provider-led networks that will take care of the whole patient, coordinates the care, and we think do it on a better, a higher quality basis, and at a lower cost.

Now, time will tell whether that is right, but there is a strong feeling among health policy analysts that it is time to use Medicare to move the whole system off of fee-for-service.

Mr. ROSKAM. Thank you. I yield back.

Chairman BRADY. Thank you.

Mr. Pascrell is recognized for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman.

Ms. Rivlin, I think you have hit the nail on the head when you talk about Medicare and the whole system. Because I think one of the major problems we had in putting the ObamaCare together, in writing out the law, and it is voluminous pages, we have all heard, was that we often lose track that the person who is over 65 years of age many times has the same kinds of problems that a couple of 45 years of age have. And we have missed the point on this thing. When you shift costs, when you are shifting costs, as you laid out, you are not changing the cost, you are not lowering the cost. It is like the person who doesn't look at his hospital bill because it is covered, because I have insurance.

This moves the cost higher as well. I mean, many medical people don't want us to be knowledgeable of what is in the bill. And let's face it and let's say it like it is. I understand my colleagues on the other side continue to say that these proposed additional costs to beneficiaries are bipartisan proposals, I will have you know. But we must remember that the President offered the proposal in the context of a broad, large deficit-reduction package that requires both spending cuts and increased revenues.

We also need to remember that reform to the Medicare program is already underway. Why we will not admit to that, some on my side, and some on the other side, is beyond me. When we put the Affordable Care Act together, the purpose of that was to look at, one of the specifics was Medicare and to reduce the cost.

And already, already, what we have done is the following: We have had entitlement change. We won't admit it. If you have Medicare, you qualify for an annual wellness visit, mammograms, other screenings for cancer and diabetes, important preventive care. Medicare Advantage plans that give better quality care receive ad-

ditional bonus payments. Plans must use some of the bonus money to offer you added health benefits. Medicare Advantage plans cannot change—or charge people more than the original Medicare pays for certain services. These services include chemotherapy administration, renal dialysis, and skilled nursing care. The law cracks down on waste, on fraud and abuse, a major part of that ObamaCare. Nobody refers to this. We have selective memory about what we want to think about or talk about in this legislation. And we guard against medical identity theft, et cetera, et cetera. It improves long-term care services.

Why not target when you say that we have to move away from fee-for-service, not just for seniors, for everybody? For everybody? Can we say it enough times, Ms. Rivlin, for everybody? Because the costs are too high. And if we don't change those costs and find a way to do it without cost controls, then we are not going to have any system at all, not just we will reduce the propensity of Medicare and the strength of Medicare.

Overall health spending has been constrained. Per capita Medicare spending was 0.4 percent of GDP in 2012, last year. And CBO projects Medicare cost growth will remain low throughout the decade. There is a reason for this. Are there less people going into Medicare? Heck no. And overall health inflation has been at historic lows for 3 years in a row.

There is a report that came out this morning, I don't know if you saw it. Senior poverty is much worse than you think due in part to such burdens. The new Kaiser Family Foundation report finds that the SPM poverty rate for seniors is actually higher than the official rate, 15 percent versus 9 percent. And here we are talking about shifting costs, even if it is to the higher income. We better be darn careful about this, because if we don't understand the situation that seniors are in, we are in big trouble.

Mr. Baker, if I can get a quick question in. I think we are trying to go in a new direction here. I agree we should always be open to new ideas. I think my colleagues need to take a look at the work happening today that is moving Medicare; more important the quality than the quantity. Can you discuss the ways in which affordable health care has helped the solvency of the Medicare program directly? Can you answer the question?

Chairman BRADY. If I may, because time has expired, Mr. Baker, could you perhaps answer in another question or provide Mr. Pascrell an answer in writing. Thank you.

Mr. PASCRELL. Thank you for your consideration.

Chairman BRADY. Thank you, Mr. Pascrell.

Mr. Gerlach is recognized for 5 minutes.

Mr. GERLACH. Thank you, Mr. Chairman. Thank you for having this hearing today.

Today's hearing is focused on the reform of Medicare's benefit structure, so your suggestions are very welcome and very helpful. Thank you very much. But in addition to the benefit structure itself, success and cost-effectiveness of the program is also based on how it is administered every single day. Currently, the Medicare program has a pay-and-catch system for improper payments. A few years ago, the GAO put out a report that concluded that there is about $50 billion a year in improper payments made in the Medi-

care program, both unintentional payments, erroneous, mistaken, or intentional fraudulent-based payments due to stealing the identification numbers of physicians and other fraudulent activities.

So based on the fact that that $50 billion a year in improper payments in the Medicare program over 10 years would be half a trillion dollars, and based on the fact that that is about 10 percent of the total expenditure in the program each year, what do you each believe would be the single-most important step that Congress could take now to reduce and ultimately eliminate $50 billion a year in improper payments in the program in addition to all of the other suggestions you have given us about benefits restructuring? But specifically what could be done today to reduce and eliminate $50 billion in improper payments just because of the way the program is administered on a daily basis?

Start with Mr. Antos.

Mr. ANTOS. Well, certainly, the idea about Medicare verifying who the providers are would be the first step. Don't pay unless the provider is a legitimate provider. Don't pay unless the provider is providing appropriate services. The idea of having information about the quality of care should extend also to traditional Medicare. It doesn't exist there right now.

Mr. GERLACH. Thank you. Is there a specific kind of technology or system, programming that could be utilized to make that happen?

Mr. ANTOS. Well, so in terms of measuring quality, there are literally scores of different measures that measure very specific results or very specific activities in health care. They don't necessarily represent quality. They represent things we can measure. And so I think the first step is to do a better job of developing the kinds of measures that really reflect not what goes into the patient, but what comes out. In other words, patient outcomes.

Mr. GERLACH. Ms. Rivlin.

Ms. RIVLIN. I agree with that, and I think more money for more vigorous prosecution of fraud would actually help. That is happening, but probably not enough. And better information for the patient to enable a patient to say, wait a minute, I never saw that doctor. It is hard now for a patient to monitor that kind of thing.

Mr. GERLACH. Mr. Baker.

Mr. BAKER. I would agree with all that has been said. We get a lot of complaints on our help line saying I didn't see this particular doctor, and we do refer them to the fraud tip lines, et cetera, but sometimes it is the pathologist in the hospital that no one ever sees. That kind of education is important.

I think one of the things that we do have to guard against is one of the justifications for home health copayments is, oh, it will help combat fraud efforts. And I think putting financial cost-sharing on consumers to have them help identify fraud is not necessarily the best way to go, but rather, some of the ideas that we have been talking about here, and really providing administrative resources to not only our law enforcement personnel, but also to the Center for Medicare and Medicaid Services to really oversee this program. We always brag about Medicare having a low administrative cost, but maybe it should have a little bit of a higher level of administra-

tive cost so that it can pursue some of these initiatives against fraud.

Mr. GERLACH. Do either of you have a debit card on you today?

Mr. BAKER. Yeah.

Mr. GERLACH. And you pull that card out, is there an identification number on that?

Mr. BAKER. Yes, there is.

Mr. GERLACH. And if you took it downstairs to the credit union and you want to get money, you would type in a few numbers, would you not, that are unique to you and unique to that identification number, is that correct?

Mr. BAKER. Yes.

Mr. GERLACH. And so why don't we have that system in Medicare right now? Why don't we have a smart card technology in our system that identifies that provider and that patient at the same time before the service is undertaken? Has anybody considered that as part of your review of the program?

Ms. RIVLIN. Sounds like a good idea.

Mr. GERLACH. Okay.

Mr. BAKER. We certainly could consider that.

Mr. GERLACH. I know when to end my questioning. Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Stop when you get the answer you want.

Mr. Price is recognized for 5 minutes.

Mr. PRICE. Sounds like a bill is coming, Mr. Chairman. Thank you. Thank you so much. And I want to thank the panel members.

This is a remarkably important topic, but it is also just part of a hugely complex system. And I am struck most often when we have the topic of health care come up in this Committee, and appropriately so, we are talking about money, not about patients. And when you talk just about money and not about patients, then I think that we miss really the focus of where we ought to be. We ought to be talking about patients.

And as a physician taking care of patients for over 20 years, I know that the patients of this country, especially the Medicare patients of this country, are extremely frustrated with the current system. Access is being diminished to care. I have said this before, if you are a new Medicare patient, you turn 65, your physician that has been taking care of you isn't seeing Medicare patients, which is more and more frequent.

Even in large metropolitan areas, the opportunity or the ability that you have to find a doctor who is taking new Medicare patients is minimal. One in three physicians in this country has limited the number of Medicare patients that they are seeing. One in eight physicians who would normally see patients of Medicare age is not seeing any Medicare patients. And that is only getting worse. And the ACA is making that worse, not Dr. Price's, Tom Price's opinion. That is the opinion of the Medicare trustees, that access to care will be diminished because of the laws that we have already passed.

Mr. Antos, you talked about Medicare oftentimes instituting policies in a heavy-handed way, and it is that heavy-handedness that I believe harms patients.

So there is huge pressure within the system, and I want to touch on a couple specific areas. And I know that the fee-for-service system has been bashed, and, you know, it isn't worth a doggone thing, according to some folks. But one of the antiquated notions of the fee-for-service system is that a patient can choose a physician that he or she desires to take care of them and that that care can be delivered.

So I would ask you, Mr. Antos and Ms. Rivlin, do you believe that whatever system we come up with, should patients and doctors be able to practice outside of that system? Should they be free to take—the doctor take care of a patient outside of that system if voluntarily the patient and the doctor desire to do so?

Mr. ANTOS. Well, under the Medicare program right now physicians are allowed to opt out, in essence. There are potentially substantial financial losses associated with that.

Mr. PRICE. How about for an incident of care right now?

Mr. ANTOS. For an incident of care, that is not possible. You are either in——

Mr. PRICE. Should it be?

Mr. ANTOS. It runs certain risk. I believe that this——

Mr. PRICE. The freedom runs the risk.

Mr. ANTOS. Freedom runs the risk. That is right. The question is, will the physician have the patient's best interest at heart or will the physician——

Mr. PRICE. Have you ever read the Hippocratic Oath?

Mr. ANTOS. I have read it, but there are plenty of ways to interpret it. And the question is——

Mr. PRICE. Can one interpret the Hippocratic Oath to not be in the interest of the patient?

Mr. ANTOS. It needs to be in the interest of the patient, but the financial system that the physician is under in Medicare works across purposes oftentimes to the patient's——

Mr. PRICE. But coercion to the physician is not to provide the best care to the patient.

Mr. ANTOS. The financial system promotes oftentimes services that are not useful or not very useful to the patient.

Mr. PRICE. That is not the physician's design, that is the system's design.

Mr. ANTOS. That is the system's design, and so we need to reform the system in order to make that relationship between the doctor and patient much more productive.

Mr. PRICE. And maybe a little freer.

This is going in an interesting direction. So my time is about to run out and I want to get to this other issue. We seem to be having contradictory themes. We say that the government control will produce value, push value—that is what we want, we want value—yet some of the things like home health care that provide some of the highest value for patients or care in ambulatory surgery centers that provides some of the highest value for patients, this proposal and others dis-incentivizes the use of those. So you have to ask the question, whose value? Is it the patient's value or the government's value?

Ms. Rivlin, whose value should we be talking about here, is it the government's value or the patient's value?

Ms. RIVLIN. We should be trying to measure the value to the patient and rewarding that. It is not easy. And the question of home health care I think is a good example. Clearly it is valuable to many, many patients and you don't want to discourage it, but you don't want abuse either, and you have to weigh the advantages and disadvantages of a copay.

Mr. PRICE. Complex issue, Mr. Chairman. Thank you.

Chairman BRADY. Thank you.

Mr. Buchanan is recognized for 5 minutes.

Mr. BUCHANAN. Thank you, Mr. Chairman. I want to also thank our panelists today for taking your time to be with us.

I represent a community in Florida, Sarasota, but it is pretty much the demographics of Florida when you look across it, 700,000 people we all represent, 300,000 55 and older. But I went to, probably a month back, went to an assisted-living facility in our area, these were seniors, very capable, active and engaged, and I usually go there once a year to talk to this group, 300 residents. So on the way in they mentioned to me, Vern, I would like to have you come meet a few of the residents, and very coherent. But I would say of the four I met, one was 108, there were three or four others in the assisted-living facility over 100. Another assisted-living facility in Venice, Florida, the average age, the guy had been there 40 years, it is a Lutheran organization that runs that out of Wisconsin, I think Wisconsin or Minnesota. He said the average age there today is 90, and he said 20 years ago it was 72.

So maybe it is just the sunshine in the State of Florida, I don't know, but I can tell you I am very concerned just looking forward from the viability as people are living longer. I think the statistics, the numbers used to be, people lived, when they put the program in place, I think it was 5 years. Today they claim 13.4 years. Have we looked down the road the next 10 years or so at what the age is that people are expected to live to or how many more years that is and are we factoring in the idea that the program, Medicare, is going to go broke in 10 years, Mr. Antos?

Mr. ANTOS. Well, certainly, the Medicare actuaries take longevity into account. But longevity isn't the principal issue here, I don't think, it is the rising cost of health care, it is the rising use of services.

Mr. BUCHANAN. Well, you mentioned this, just real quick, how many people did you say come a day, are coming into the program at 65?

Mr. ANTOS. According to AARP it is about 8,000 a day.

Mr. BUCHANAN. Yeah, I have heard 8,000, 10,000, 12,000, somewhere in that range, every day for the next 30 years.

Mr. ANTOS. Well, for the next 20 anyway.

Mr. BUCHANAN. Yeah, for the next 20. But go ahead, continue, what were you going to say?

Mr. ANTOS. They are youngsters. When you turn 65 you are basically a healthy person. It is at the other end of life where the money is being spent. And I think the issue here is not so much, we are not going to have people stop turning 65 and joining the Medicare program. The issue is how do we get unnecessary spending under control? How do we get better treatment for these patients?

Mr. BUCHANAN. Ms. Rivlin, did you have any comments on those about longevity?

Ms. RIVLIN. No, I agree with that. It is certainly increasing. But as Mr. Antos said, it is the rising cost per patient combined with the longevity, but the rising cost per patient is really the driving force.

Mr. BUCHANAN. The other thing I think that a lot of seniors are concerned about is the fact that we are not doing much about it. There is a 10-year window ideally. What is your opinion of waiting and not dealing with this in a real way? I mean, we are talking about some adjustments and things that we might be able to do today, but in the scheme of things long term it doesn't seem like it is going to have a huge impact in terms of the overall dollars. By waiting, what happens from that standpoint? How long can we wait and not deal with it in a big way? Ms. Rivlin.

Ms. RIVLIN. Every year you wait makes it more difficult. We have waited too long already on many of these things and I would include Social Security. We need to put all of these programs on a firmer basis.

But with respect to the healthcare programs it is a question of moving to better, more effective, more cost-effective delivery systems that is the most important. And the faster we can do that the better, although it is going to take time to transition.

Mr. BUCHANAN. Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Thank you.

Mr. Smith, you are recognized for 5 minutes.

Mr. SMITH. Thank you, Mr. Chairman. And thanks to our witnesses for sharing your time today. I appreciate the testimony and your insight. And I think the urgency cannot be overstated. And yet we want to build on what we know works, and we want to do what we can to eliminate that which we know does not work.

I get a little concerned when the term "fraud" that we should all be concerned about is often used to describe what might have been an innocent mistake amidst a bureaucracy in piles and piles of paperwork, and we don't want the heavy hand of government to overreact. But I am curious to know what you might have to suggest about States coming up with innovative solutions. One thing we do know is that with our 50 States they are different among themselves. I know that, representing rural Nebraska, the definition of rural has a different application in different parts of the country. And so if you might, any of you, elaborate on perhaps how we could maybe rely on the States for innovation and incentives to increase the effectiveness of care and access. Not all at once, but go ahead.

Mr. ANTOS. States obviously have a very strong fiscal interest in this question because of course they are responsible for about 42 percent of the cost of the Medicaid program. The Medicaid program, many Medicaid people are essentially young, relatively healthy people. But the older Medicaid beneficiaries are among the sickest and among the most expensive patients that we have. Many of them are dual eligibles in Medicare.

So States are very concerned about improving delivery of health care. I think in terms of rural America the idea of being able to bring modern electronics out there where you if can't get a doctor,

let's get somebody who is trained at the local level and have communications back with a medical center.

In addition, States, I don't think States are rushing to do this, but increasingly we are going to need to look at the personnel who provide healthcare services. We are going to have a doctor shortage, there is no question about that. We are going to have a lot more people who will be demanding care, we are not going to be producing that many more physicians, because it takes so long to produce a physician, a good physician. So we are going to have to look at expanding the scope of practice for nurse practitioners, for example, physician's assistants. States control that, they need to take a look at that issue.

Mr. SMITH. Okay.

Ms. Rivlin.

Ms. RIVLIN. I would agree with that. It is the Medicaid program which you ought to look to for giving States the most flexibility. And the potential is there. The situation now with waivers is much too complex, and it would be important, I think, to provide a more uniform system where States can take the measures that they think are most cost effective and are rewarded for that, but don't have to go through a very complicated waiver process.

Mr. SMITH. Mr. Baker.

Mr. BAKER. I would agree. I think some of the experimentation that is happening under the ACA but also outside of it with regard to dual eligibles, people that are eligible for both Medicare and Medicaid, and there the States really are pushing the envelope in many instances in combining those funding streams and coming up with creative ways to manage their care. The typical statistic is these are the 20 percent of people that generate 80 percent of the costs. If we can control those costs better, much of it through better coordinated care, managing that care better, breaking down those silos. And States have been doing that. And I think we need to continue to encourage that.

It is less possible in true rural areas that are sparsely populated, but some of the other ideas around allied professionals getting involved with physicians and others to kind of bring that care to the areas. Many times folks don't need that intensive medical care, they need kind of social supports or other supports, kind of to live in their communities and stay healthy. And I think those are important initiatives that States are engaged in right now.

Mr. SMITH. And, Mr. Baker, I think you touched briefly on perhaps cost-sharing with emergency room or other areas. Could you elaborate on that?

Mr. BAKER. Well, my point there was that if we increase cost-sharing up front, many times people don't access the kind of primary care or preventative care that they need. In many of the proposals preventive care would be covered first dollar up front, but other primary care would still need a copayment or a deductible to get through. So what happens is people put off care, end up in emergency rooms, or higher, more expensive care settings.

Mr. SMITH. Okay. Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Kind is recognized for 5 minutes.

Mr. KIND. Thank you, Mr. Chairman. I want to thank our panelists for your testimony today. Mr. Chairman, I hope this is the first of many more hearings that we can do to explore avenues of bipartisan cooperation on reforming a healthcare system that is in desperate need of reform. And I guess one of the frustrating things sitting here and listening even to today's conversation, is that there are so many of those tools that are currently a part of the Affordable Care Act right now.

Ms. Rivlin, delivery system reform, getting to a more integrated, coordinated, patient-centered healthcare delivery system. There are tools in the Affordable Care Act right now to drive the system in that direction, including payment reform. Demanding value-based payments, quality reimbursements, as opposed to volume is already in the Affordable Care Act right now and vast experimentation taking place. Would you agree with that assessment?

Ms. RIVLIN. I agree with that, and I said that actually. And we want to strengthen and build on what is already going on and accelerate it.

Mr. KIND. And I applaud the work the Bipartisan Policy Center has come up with additional recommendations on reform. In fact, the New Democrat Coalition just had Bill Hoagland and Chris Jennings before us to walk us through a lot of the recommendations, and many of which we embrace.

If there is one concern or one criticism I might have about the Bipartisan Center is you do maintain fee-for-service in a hybrid type of form, but nevertheless it is still there out in future years. And I happen to believe that we are going to have to kill this thing, we are going to have to have a date certain on fee-for-service so there will be institutional pressure from all over to maintain a fee-for-service or volume-based payment system that we are never going to be able to slay and get rid of.

Ms. RIVLIN. I think we kill it with incentives to move away from it, but we do preserve a choice so that no one can say we are destroying Medicare as we know it.

Mr. KIND. Well, and again on the whole topic of Medicare fraud, and I look forward to working with my good friend from Pennsylvania because I think he has some good ideas to bring to the table how we can do a better job. But, Mr. Antos, I don't know if you are sure, if you looked at the Affordable Care Act, but pay-and-catch is no longer the law of the land, it is a system of verification. And regional offices now have stepped up enforcement and funding to crack down or Medicare fraud. In the first 2 years we were able to recapture over $15 billion in fraudulent payments made in the Medicare system because of what is in the Affordable Care Act already. And that is moving forward. And maybe we need more personnel on the ground and more resources to do it, but again, as part of the Affordable Care Act, there has been a stepped-up measure to crack down on Medicare fraud. And I don't know, your testimony made me believe that you weren't aware that pay-and-catch is no longer allowed under Medicare.

Mr. ANTOS. Oh, I didn't address it in my written statement. It is not allowed but it still happens. It is great that CMS has been able to take actions, but obviously the problem isn't solved. The problem will never be solved.

Mr. KIND. Well, again, I think we can continue working in a bipartisan fashion on what stepped-up enforcement are needed. There would be wide bipartisan support because no one is going to be here defending fraudulent practices, especially in the Medicare program.

But, Mr. Baker, I also notice that you have been one of the panelists on the second Institute of Medicine panel trying to change volume to value-based payments. My only encouragement to you and the panel, I know it is hard with peer review with IOM, you have high standards, but you have to go bold and you have to go courageous. And if you guys can't come up with a path to get to a fee-for-value-based reimbursement system it is going to be very hard for this institution to embrace something as well. So I don't know if you want to give us a quick update where IOM 2 is going right now, but soon you are going to be reporting out.

Mr. BAKER. Well, we are in the peer review process so I can't really talk specifically about it. But I think that, as you saw from our interim report, we are very concerned about the present system. And I think you will be seeing some ideas about moving forward some of the value-based reforms that are already in the ACA. I think we are all agreed that those kinds of things and the kind of delivery system reform that we have all been talking about is key.

I would point out that, and I do believe that we need to move away from fee-for-service, as we have been talking about, but we also have to recognize that within some of these hybrid or some of these even in classic managed care fee-for-service is still used and still might be appropriate to encourage the provision of some services. So I think it is a hybrid system and one that definitely needs to move away——

Mr. KIND. I will need to be educated on the value of doing that, but I also agree with Mr. McDermott, if at the end of the day all we are doing is talking about cost shifting, that is not the path forward because that is not the reform that we need to create the right incentives to get better value at a better price within the healthcare system. I think we are all in agreement on that. And my concern is with SGR fix and everything else that this cost—and time is of the essence. The Ryan bill does nothing to reform Medicare for 10 years because they exempt the first 10 years of entrants into the program. So if time is of the essence, I don't know why we are repealing the Affordable Care Act 37 times and then trying to move forward on a plan that does nothing for the next 10 years when 10,000 seniors are joining Medicare every single day in this country.

My time has expired, Mr. Chairman, thanks for your indulgence.

Chairman BRADY. Thank you.

Mr. Thompson is recognized for 5 minutes.

Mr. THOMPSON. Thank you, Mr. Chairman. I want to thank all the witnesses for being here today and for your longstanding commitment to making health care work in this country.

I want to pick up where Mr. Kind left off, where Mr. McDermott started, and that is with the whole issue of cost shifting. And one provision I would like to explore a little bit is found in the President's budget as it relates to a copay for home health care. And I,

too, am worried about the idea that we would be cost shifting. And while the President's program saves close to $800 million—I don't know if it does save that, but it is scored at saving $800 million—and I just want to be very, very careful that we do the scoring correctly, because my concern is if this copay discourages folks from doing what they should be doing in regard to health care, it could end up costing us a lot more.

Specifically, if people don't get the care and they become more ill or they become injured and have to go into the hospital, that is a direct cost to Medicare and the Federal Government, or it could even turn out to be a cost shift to the specific States.

And on that note I would like to ask unanimous consent that we put in the record two letters from two different States who share the same concern, one from Governor O'Malley, a Democrat from Maryland, and the other from Governor Deal, a Republican and former colleague of ours from Georgia.

Mr. Chairman.

Chairman BRADY. Without objection.

Mr. THOMPSON. And I think that is important to note that, and I would like to know what your thoughts are on that, and we can start with whomever. Mr. Baker.

Mr. BAKER. Okay. Yes, I think that is a potential. I mean, in 1972 Congress actually took out copayment amount for the home health benefit after finding that it had led to increased hospital usage and institutionalization in other kind of more expensive and restrictive care settings. And I do believe that most of the savings that are scored there in the President's proposal don't come from collecting the actual copayments, but come in from analysis about the utilization being tamped down and folks just not accessing the benefit at all.

And particularly the way this copayment is structured, as has been mentioned, is for people that have not had a hospitalization that need extended or longer-term care, even though Medicare doesn't cover long-term care per se. Some folks can get ongoing home health care needed in order to stay in their homes through the Medicare benefit. And those are the folks that are at risk of either hospitalization or of deterioration of their condition either leading to hospitalization or nursing home care.

So I think it is misguided, I think it is penny wise and pound foolish, as they say, and certainly to the extent it has the potential to lead to higher health costs, that was recognized in the early 1970s and I think that lesson should be relearned.

Mr. THOMPSON. Anyone else?

Ms. RIVLIN. I think it is a difficult balancing act to the extent that there are people using home health care that don't really need it because there is no copay and you might as well. We need to discourage that and be careful that it doesn't hurt people who have very low income or who really need the care.

Mr. THOMPSON. Ms. Rivlin, I am glad that you raised that issue, because I suspect a lot of that savings is directed at detecting fraud abuse and getting away from that. But MedPAC has noted that there are patterns of abuse in home health care, primarily found in 25 different counties in Texas and Florida. So it

seems to be a pretty focused issue or for the most part focused, and a pretty wide, sweeping way to deal with it. Is there a better way?

And I am glad that Mr. Gerlach raised the issue of going after the fraud because I am one who believes that we can accomplish a lot in fixing the system if we are able to nail the fraud stuff. Is there a better way to go after the fraud than the copay?

Ms. RIVLIN. Well, there may be, but I think the copay would probably help.

Chairman BRADY. Thank you, Mr. Thompson.

Mr. Blumenauer is recognized for 5 minutes.

Mr. BLUMENAUER. Thank you, Mr. Chairman. And I do appreciate an opportunity for a conversation like this, zeroing in on what actually can happen. And I want to follow up on comments from both my colleagues Mr. Thompson and Mr. Kind because I think we have embedded in the Affordable Care Act some opportunity to change the delivery mechanism. We are doing some experimentation in Oregon, and we are optimistic globally that it can have some significant effects. What Mr. Thompson said about being able to identify outliers, counties in a couple of States that are clearly having a pattern that screams abuse, the same way that we have had some pill mills where there are a handful of pharmacies that are responsible for certain narcotic drugs that find their way into the system. And I am a proud cosponsor of Mr. Gerlach's legislation for the secure card, which I think could help us get at that.

I am open to other systematic adjustments, some of which have been proposed, Mr. Chairman, by some of your colleagues, some from the Administration. But I am hopeful that we are able to focus on the big picture, things that we can do now that clearly attack problems of abuse and mismanagement that should share broad bipartisan support. And I am hopeful, Mr. Chairman, that our Subcommittee could zero in on a few of these proposals that have bipartisan support on the Committee, that aren't going to solve everything overnight, but will make a significant difference improving the system.

I am of the opinion that the more we can do on some of these smaller things that will make a difference, that are bipartisan, that are not particularly controversial except for some people who are taking advantage of the system, will help us establish a foundation for what we are going to have to do for the next half dozen years as the nature of healthcare changes in this country.

And I will wrap up, we have things to do. I don't want to debate particularly some of these modest points, although I would put on the table one other bipartisan proposal that will give people better health care, what they want, and will actually save money. And that deals with letting people know what they face at the end of life, that Medicare will pay untold billions to give hip replacements to 92-year-old people in the last months of life, it will hook them up to machines, it will do anything, but it won't pay to have a conversation with the medical professional of their choice about what they face.

There is a reason why doctors actually consume less health care in their final months of life, because they know what they are facing, they know what works, they know what doesn't, and they have

a way of making those decisions and making sure whatever the decisions are that they are respected.

And I would hope that there would be an opportunity for us to deal with legislation like that, that is bipartisan, that will make a difference, that surveys tell us over 90 percent of the American public wants, that will not just save money but will give people a better quality of care.

I appreciate your commitment to make the Subcommittee zero in on some of the big picture, some controversial, some not. But I hope that we can circle around to some of the stuff that doesn't have to be controversial which will save money and bring the Committee together while, above our pay grade, certain things are battled out. Thank you, Mr. Chairman.

Chairman BRADY. Thank you, Mr. Blumenauer.

Ms. Black for the final question.

Mrs. BLACK. Thank you, Mr. Chairman. And I appreciate being able to sit here on the Committee and for being given an opportunity to ask a question.

My question is going to go to two pieces here. One is the solvency and the other is the quality. And being a healthcare provider, as Dr. Price talked about, the quality is very important to me as well, but making sure that we have a system at the end of the day that is solvent, that we can actually have a system.

So the current Medicare spending trajectory is unsustainable and we know that. It has actually led the Medicare trustees to estimate the Part A trust fund will go bankrupt in 2023 and insolvent in 2024. So that has already been established. But recent data has showed that Medicare spending is actually lower and some have suggested that this means that we don't need to make any changes to the program. And so I ask the panelists, and starting with you particularly, Mr. Antos, and then working down the line, wouldn't you agree that this is the wrong way to look at this?

And then, second to that, instead of waiting should we be acting now to extend the solvency of this program? And if we make those changes now would you agree that the changes would be smaller now rather than waiting? And then the end piece of that, can you discuss how you think a well-designed Medicare program would benefit the outcomes for our beneficiaries? So, Mr. Antos, can you go to that?

Mr. ANTOS. Thank you. What is lower now is not Medicare spending, what is lower is the last 2 or 3 years of growth per beneficiary. But of course the number of beneficiaries is growing every year. So in fact Medicare spending is continuing to grow, just at a somewhat slower rate than in the past. But we only have evidence for the last 3 years of slower Medicare spending. So I think it is way premature to announce victory and to hang up our hats.

Clearly, the sooner we take responsible actions to shore up Medicare financing and to improve the program so that it actually does a good job for patients, the easier the transition will be to whatever the new Medicare program will be. I tend to agree with many of the suggestions of the Bipartisan Policy Center and the other groups, certainly in general terms, and they all imply changes in the way patients act, physicians act, health plans act, and the traditional Medicare program acts. That is a lot of change, and that

takes a lot of time. The sooner we start on that the more successful we will be without having what could be a disastrous experience for vulnerable people.

Mrs. BLACK. Thank you.

Ms. Rivlin.

Ms. RIVLIN. I agree with all of that. I don't think it is the bankruptcy of the Part A trust fund that should drive this primarily. You can always put more general revenues in the trust fund and you are doing that already in Part B. But the opportunity that you have now to change the way Medicare reimburses organizations and to incent more cost-effective delivery systems seems to me just major, and you ought to take it right away and push on that continuously.

There is no one thing you can do to fix the whole thing, we will all be back here again. But there is a big opportunity now to accelerate the reforms, many of which are already in the Affordable Care Act, to improve the delivery system for Medicare and the rest of the health system.

Mrs. BLACK. And might I add to that, because I think I heard you say earlier that one of the things you think is a benefit of this is that the quality of care is actually going to increase.

Ms. RIVLIN. Yes, absolutely.

Mrs. BLACK. Mr. Baker, in my little bit of time I have left.

Mr. BAKER. Of course. I think I agree with a lot of what has been said. I think the crisis isn't as acute a crisis as it has been because of the slowdown in growth in Medicare costs. And if you are looking 10 years ahead we do have this window now where, if this projection keeps up—and projections are projections, right—but we feel that there is some breathing room. That doesn't mean we should be complacent. Definitely, as we have all discussed, not only in our Medicare program, but also in our private health insurance and private coverage schemes we need to be looking at how to save money and, as you are saying, increase the level of quality of care and get higher value.

And so we think once again that some of the reforms in the Affordable Care Act, some of the things that are happening in the private sector that mirror that, and I agree with Ms. Rivlin that those things coming together and Medicare working shoulder to shoulder can drive a lot of good change. I mean, Medicare has had that role in the past and can have it now. I think my concern is that some of the cost-sharing that we see here isn't driving in that direction.

Mrs. BLACK. Thank you, Mr. Baker.

Yield back.

Chairman BRADY. Thank you. On behalf of Mr. McDermott and myself, I would like to thank all three of our witnesses for their testimony today on the President's budget proposals. Your experience and ideas on how to reform Medicare to keep it solvent for our Nation's seniors are constructive, and your continued thoughts and feedback will be very helpful as we move forward with these efforts in the coming months.

As a reminder, any Member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted,

I ask the witnesses respond in a timely manner, as I know you will.

With that, the Subcommittee is adjourned.

[Whereupon, at 11:35 a.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

May 21, 2013

The Honorable Kevin Brady
Chairman
Ways & Means Subcommittee on Health
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member
Ways & Means Subcommittee on Health
Washington, D.C. 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of AARP's over 37 million members and the millions of Americans with Medicare, thank you for holding a hearing to examine Medicare beneficiary cost-sharing. Medicare continues to play a vital role in the health and financial security of older Americans. We have long recognized the need to strengthen and improve the program and appreciate the Committee is considering ways to do so.

This hearing focuses on changes to three particular areas of cost-sharing: expanding income-relating of Part B and Part D premiums; increasing the Part B deductible; and adding copays to home health services. Modifying any part of the Medicare cost-sharing structure could have a significant impact on beneficiaries. We are concerned that a discussion of beneficiary cost-sharing focused on reducing Medicare expenditures ignores the underlying issue of high health care costs system-wide. As Congress considers various proposals, we urge you to examine all the potential ramifications on beneficiary out-of-pocket spending, access to needed care, and total costs to the health care system.

Background

Medicare is the major pillar of health security for older Americans and people with disabilities. Yet, the program provides fewer benefits than most employer-sponsored insurance plans and only covers about half of beneficiaries' total health care costs. There are notable gaps in current Medicare benefits, including the lack of a catastrophic cap and coverage for certain common health benefits, such as dental, vision, and hearing. In recent years, the creation of the Medicare Part D drug benefit in 2006 and the phasing out of the coverage gap, or "doughnut hole", in Part D – as required by the Affordable Care Act – have been major improvements. Yet, even with these improvements, out-of-pocket costs still remain a great burden for many Medicare beneficiaries. At least 50 percent of Medicare beneficiaries have incomes of less than $22,500 and spend nearly 17 percent of income on health care. Ten percent of beneficiaries spend over $7,800 on health care costs.[1] Additionally, out-of-pocket spending is higher for older and poorer beneficiaries: spending increases to over 20 percent of their income on health care.

Without an out-of-pocket cap, the traditional Medicare program currently leaves beneficiaries at risk for significant cost-sharing if they become seriously ill or need to manage chronic health

[1] C Noel-Miller, "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care", AARP Public Policy Institute, Washington, DC, May 2012. Includes spending for Medicare and supplemental premiums, and for medical services and some long-term services and supports. http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-beneficiaries-out-of-pocket-spending-AARP-ppi-health.pdf

conditions. No other public or private health insurance plan imposes the same level of risk on their participants: these plans generally limit the amount of cost-sharing that participants have to pay in a year or a lifetime. As a consequence, most Medicare beneficiaries rely upon other supplemental insurance to avoid the potential risk of significant out-of-pocket costs (e.g. employer-provided retiree health and Medigap) or rely on Medicaid. Not all beneficiaries have supplemental insurance coverage, however. About 4 million beneficiaries (8%) have no additional coverage, and potentially face significant health care expenses should they become seriously ill.

In exploring any changes to Medicare cost-sharing, AARP believes it is essential to look at any proposed changes from the perspective of beneficiaries, not just from the perspective of a budget score. Most beneficiaries already struggle to make ends meet, and they are particularly sensitive to the high cost of health care and prescription drugs. An examination of Medicare cost-sharing must take into account the economic status of seniors, as well as evaluate how benefit changes will interact with other potential changes to the Medicare program.

Income-Relating of Premiums

As you know, premiums for Part B & D are currently income-related, whereas individuals and couples earning more than $85,000 and $170,000, respectively, pay a higher rate. The premium amount is scaled higher over three subsequent income tiers. Approximately 5 percent of beneficiaries are subject to the higher-income premiums for Part B. Approximately 3 percent of beneficiaries are subject to the higher income premiums for Part D.

Various proposals have considered revising the existing income-relating structure. In general, proposals tend to increase the share of Medicare costs paid by the beneficiary, lower the threshold for those subject to income-relating, or some combination of the two. No matter how it is implemented, though, expanding income-relating directly shifts costs onto beneficiaries without addressing the high cost of health care.

Moreover, forcing higher-income beneficiaries to pay even greater premiums could drive people away from Medicare, which would be detrimental to the program. Higher income beneficiaries have already paid more into the system in the form of higher payroll taxes – all wage income is subject to the payroll tax – as well as higher income and Social Security taxes. Given higher income and payroll tax payments and current income related premiums, asking higher-income individuals to pay even more for their Medicare is both a work and saving disincentive. Also, when determining who is subject to the income-related premium, the Medicare program relies on the beneficiary's tax return from the prior year (which reports income made from the year before). Thus, new retirees (whose income is likely to have dropped precipitously from their working years) would be subject to a higher income-related premium based on their previous wages, not their current financial situation. On average, Medicare spending goes down as income goes up. If the beneficiaries in the highest income group are asked to pay an even greater share of their Medicare premium, they could decide not to enroll in Medicare and seek alternative sources of insurance. This would worsen the Medicare risk pool, leaving more costly beneficiaries in the Medicare program, raising costs for everyone else.

Part B Deductible

In 2013, the deductible for Part B (medical insurance, including physician visits) services is $147. As noted above, the typical Medicare beneficiary lives on a modest income and already spends a significant portion of it on health care expenses. Raising the deductible amount, either through periodic increases or combining it with the Part A deductible, would increase beneficiaries' out-of-pocket costs, even for those who could least afford it.

Increasing up-front costs for beneficiaries creates a barrier to seeking care – discouraging both necessary and unnecessary care. Asking beneficiaries to pay more out-of-pocket will lead to less access to the health care system. While it may lower utilization rates, delaying or neglecting preventative and routine care will result in even greater costs to the system later. Any discussion about changing Medicare deductibles must include an analysis of the impact on access to care, particularly for lower-income beneficiaries.

Home Health Copays

In 2011, approximately 3.4 million beneficiaries used Medicare home health services, for which there is no copay. Congress eliminated cost-sharing for Medicare home health care decades ago so that more beneficiaries who need care would get it at home and not have to turn to a more expensive hospital or skilled nursing facility.

Despite the financial burden many beneficiaries already face for health care costs, proposals to add home health copays or cost-sharing range from about $100 to $600 per 60 day episode (this includes proposals to establish a uniform 20 percent coinsurance in Medicare). Like other beneficiary cost-sharing proposals, adding copays can have the effect of discouraging necessary, as well as unnecessary, care. And as with other cost-sharing proposals, discouraging necessary care can have the effect of reducing health care outcomes and increasing total Medicare costs down the road.

Furthermore, Medicare beneficiaries receiving Medicare home health care are likely to be older and have lower–incomes, and thus least able to afford the added costs. Those asked to incur these higher proposed copays are also likely to already face high health costs, including costs from a recent hospitalization or nursing home stay.

Costs would also be shifted to other payers, such as States and private employers. State and federal Medicaid spending would increase, since Medicaid would pay in many cases for the copays of individuals dually eligible for Medicare and Medicaid. Some state officials have raised concerns about added copays, since these increased costs would increase cost burdens for states already under tight fiscal constraints. Similarly, employer costs for supplemental retiree coverage would also increase, as supplemental plans would pay the cost sharing amounts previously covered by Medicare. Indeed, the previous experience with a Medicare home health copay led Congress to ultimately repeal it, due to the burden it placed on seniors and the fact that services were shifted to more costly settings.

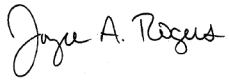
Conclusion

Any redesign of Medicare cost-sharing will have a significant impact on beneficiaries, and will affect various groups of Medicare beneficiaries differently. The impact will ultimately depend on the types of services they use, the intensity of their use, whether and what type of supplemental coverage they have, and their income. Those without supplemental coverage will be most directly impacted by increases in cost sharing. Research shows that individuals, particularly those who are sicker and poorer, react to higher cost sharing by avoiding or delaying use of health care services, including necessary care. In particular, this would apply to services that currently require no coinsurance or limited coinsurance, such as inpatient hospital services, home health, or hospice. The avoidance of needed care could lead to a faster or more serious decline in health, which not only has adverse consequences for the beneficiary, but potentially could end up costing the health care system more.

Finally, Congress must consider Medicare benefit redesign in the context of broader reforms to the health care system. If redesigning the Medicare benefit package simply results in more cost-shifting to beneficiaries and other payers, it will do little or nothing to reduce overall health care spending. Indeed, it may increase total health care costs. In fact, Medicare spending growth is already moderating. According to the Congressional Budget Office, from 2007 to 2012, Medicare spending growth has averaged only 1.9 percent per year. As a result, in May 2013, the CBO reduced its estimate of projected 2020 Medicare spending by $138 billion from its estimate in 2010. Moreover, Medicare spending increased only 0.4 percent per beneficiary in 2012, substantially below the growth in GDP of 3.4 percent per capita. With the rate of Medicare growth stabilizing, focusing solely on Medicare benefit cuts or cost-shifting to achieve budget savings misses the larger need to build on reducing health care costs throughout the health care system.

Again, we thank you for holding a hearing to explore Medicare cost-sharing. Medicare reform should be done cautiously and deliberatively, in an effort to avoid negatively impacting the beneficiaries who rely on the program for their health and financial security. If you have any questions, please feel free to call me, or have your staff contact Ariel Gonzalez of our Government Affairs staff at agonzalez@aarp.org or 202-434-3770.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

Statement for the Record
by the
American Federation of State, County and Municipal Employees (AFSCME)
For the Hearing on
the President's and Other Bipartisan Proposals to Reform Medicare
Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
May 21, 2013

This statement is submitted on behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME).

AFSCME is proud of labor's historic role in the creation Medicare, a federal social insurance program that is indispensable to our country. When President Johnson signed Medicare into law on July 30, 1965, he spoke of its profound promise:

> "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

For today's 50 million Medicare beneficiaries and the millions who will depend on this program in the future, the need for Medicare to remain a bulwark against financial ruin caused by the caprice of illness and disability rings as true in 2013 as it did nearly five decades ago.

Changes to Medicare Should be Aimed at Improving Coverage, Not Deficit Reduction

Half of all people with Medicare live on incomes of less than $22,000 per year. Medicare households spend 15% of income on health care costs compared to the just 5% spent by non-Medicare households. In short, Medicare beneficiaries are often forced to choose between making ends meet and getting the medical care they need. Increasing out-of-pocket health care costs for beneficiaries will jeopardize the health of seniors and individuals with disabilities who rely on Medicare.

As Congress looks at beneficiary cost sharing within the Medicare program, the focus must be on expanding benefits and reducing beneficiary costs. Medicare benefit design must not be a diversion to disguise shifting costs onto beneficiaries or employers who provide retiree coverage or making health care unaffordable for the majority of seniors and individuals with disabilities. While the details may vary, the underlying premise of many proposals is to increase out-of-pocket costs

for beneficiaries, all of which is under the pretense that Medicare beneficiaries are over-insured and increased cost sharing is an appropriate means of limiting unnecessary health care services.

Increasing beneficiary cost sharing (either directly or by constraining supplemental policies that cover Medicare cost sharing) is a misguided approach to benefit redesign because it will limit beneficiary access to necessary care. Building in extra costs and charges for beneficiaries is a blunt and inefficient tool for cutting costs. In reducing utilization, it will prevent beneficiaries from getting the appropriate care they need. This troubling implication is acknowledged by the Medical Payment Advisory Commission (MedPAC) in its June 2012 benefit redesign proposal. The National Association of Insurance Commissioners (NAIC) has strongly recommended against further cost sharing to Medicare supplemental insurance policies, known as Medigap plans, because of the harm to the health of beneficiaries and the Medicare program in the long run.[1]

The classic RAND Health Insurance Experiment, which did not include Medicare beneficiaries, found the reduced use of services resulted primarily from participants deciding not to initiate care. But it reduced both needed and unneeded health care services. Once patients entered the health care system, cost sharing had a limited effect on intensity or cost of an episode of care. The study also found that the absence of cost sharing (free care) improved the control of treatable chronic diseases, such as hypertension, improving the mortality of patients, especially for the poorest patients in the experiment. The implication from this study is that cost sharing is an unreliable tool for reducing health care use and that reducing costs for treatable conditions can save lives.

It seems dubious at best (and potentially cruel at worst) to ask beneficiaries with multiple conditions and illnesses to second-guess their doctor's recommendations or to shoulder the full responsibility of evaluating the extent to which they need medical care in the first place. Increasing cost sharing does more harm than good for the very sick, for the old and for the poor. While asking beneficiaries to pay higher co-pays or coinsurance may reduce federal expenditures in the short run, it simply moves these costs from the government onto beneficiaries.

Increasing cost sharing focuses on the wrong problem as a means of curbing overall health care costs and is not likely to remedy high costs. As compared with other industrialized nations, our high medical spending is driven by high prices, not high utilization.[2] Raising the out-of-pocket costs on beneficiaries will not reduce high medical prices. Indeed, providers may increase prices if utilization drops.

Medicare is an amazing success story – providing health and financial security to millions of Americans even during the worst economic crisis since the Great Depression. AFSCME urges Congress to reject proposals to redesign Medicare in a way that builds in extra cost sharing for beneficiaries. This would allow sick and older seniors and individuals with disabilities, who are on limited incomes, to be denied the needed health care because of additional out-of-pocket costs.

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[1] National Association of Insurance Commissioners, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011).

[2] Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's The Prices, Stupid: Why The United States Is So Different From Other Countries" Health Affairs, 22, no.3 (2003):89-105.

While we oppose achieving short-run federal savings through beneficiary cost savings because such savings are shortsighted, we do support eliminating sweetheart deals for the pharmaceutical industry that cost Medicare. For example, when Congress enacted the Medicare Part D drug benefit, it prohibited Medicare from negotiating lower drug prices with drug companies. Ending this prohibition could save Medicare more than $200 billion over ten years. In addition, the Medicare Part D law resulted in a substantial drug manufacturer windfall because it ended the then-existing requirement that manufacturers pay rebates for beneficiaries who are eligible for both Medicare and Medicaid (known as dual eligible) and low-income Part D enrollees. Reinstating the rebates that were required before 2006 would ensure that taxpayers and the Medicare program do not overpay for Part D drugs.

We would be remiss if we did not point out that Medicare excludes the vital services that many seniors and individuals with disabilities need to maintain their independence – such as long-term supports and services. Medicare provides limited post-acute care and few Americans can afford private long-term care insurance. Medicaid is by default the provider of long-term care services, but requires seniors and individuals with disabilities to impoverish themselves to get the services they need to complete life's daily activities. As America ages, the gaps in coverage for long-term care will further strain and challenge families, communities and our country. We urge Congress to support efforts by the Commission on Long-term Care to address this urgent and growing need for long-term supports and services.

In sum, Medicare has helped generations of Americans keep a toehold in the middle class. As Congress considers the adequacy of Medicare's benefit design, we urge the Congress to reject proposals that seek to shift costs from the government onto beneficiaries. The goal of benefit redesign should be to ensure that benefits are adequate, not to achieve deficit reduction.

STATEMENT FOR THE RECORD
SUBMITTED TO THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS & MEANS, SUBCOMMITTEE ON HEALTH

HEARING ON

MEDICARE REFORM PROPOSALS

May 21, 2013

ALLIANCE FOR RETIRED AMERICANS
815 16TH STREET, NW
WASHINGTON, DC 20006
www.retiredamericans.org

The Alliance for Retired Americans appreciates the opportunity to submit comments to the Committee on Ways and Means, Subcommittee on Health for the hearing on Medicare reform proposals. We are very concerned that the proposals to increase cost sharing will harm seniors and jeopardize their health.

Founded in 2001, the Alliance is a grassroots organization representing more than 4 million retirees and seniors nationwide. Headquartered in Washington, D.C., the Alliance and its 33 state chapters work to advance public policy that strengthens the health and economic security of older Americans by teaching seniors how to make a difference through activism.

Before considering any reform we must look at the population that will be affected by these policies. Half of all Medicare beneficiaries have annual incomes under $22,500 and one third of beneficiaries have annual incomes under $16,755. A typical Medicare household has a lower average budget than the average household ($30,818 versus $49,641 respectively) but spends three times (14.7 percent versus 4.9 percent respectively) as much on medical expenses than does the average household. To make matter worse seniors are already spending a larger share of their income on health spending then in the previous years. The costs of Medicare Part B and D premiums and cost sharing as a percentage of average Social Security benefits went from 7% in 1980, to 14% in 2000 and 26% in 2010. Given this sobering reality, it is difficult to comprehend how anyone can expect Medicare beneficiaries to pay more.

We are especially concerned over the proposal to further means test Medicare beneficiaries. While means testing may seem like a good sound bite, the devil is in the details. The proposal to freeze the income threshold and capture 25% of Medicare beneficiaries would result in individuals with incomes of $47,000 paying higher premiums if that policy were in effect today. That is not high income by any means and is a direct attack on the middle class.

The proposal to charge a copayment for home health care will hurt the most vulnerable – oldest, sickest and poorest Medicare beneficiaries. These individuals often suffer from chronic conditions and usually have limitations in one or more activities of daily living. Home health care help many of these individuals stay home rather than enter more costly institutional settings that will increase costs for Medicare down the road. According to an analysis by Avalere, home health copayments could increase Medicare hospital inpatient spending by $6-$13 billion over 10 years.

The proposals that would eliminate first dollar coverage or would impose a surcharge on Medigap proposals are especially troubling. They are based on the misguided notion that Medicare beneficiaries overutilize services and that they need to have more “skin in the game”. The surcharge is designed to impact beneficiaries’ medical spending habits. However, this type of thinking is flawed in many ways. First,

Medigap policies are expensive. In fact, two-thirds of the medical spending by Medicare households goes to premiums for Part B, Medicare Advantage, Part D, and/or supplemental coverage. The suggestion that Medigap policyholders are getting a free ride is absurd. Second, medical decisions are made by doctors and not beneficiaries, so spending decisions are driven by doctors not patients. Thus, the belief that beneficiaries can control health spending is a notion that needs to be dispelled. Beneficiaries do not have the expertise to make medical decisions. Furthermore, the current medical system is too complex. In order for consumers to be involved in the medical decisionmaking process, the system should be easier to navigate. There should be a one-stop shop where patients can compare prices. Third, while the surcharge may initially reduce demand for care and reduce government spending, it could come at a high cost to beneficiaries, many of whom may forgo treatment due to higher costs. In the long run, the government could end up spending more if such individuals experience complications or require more costly care later.

Another troubling aspect is that the surcharge as proposed by the MedPAC will affect beneficiaries with employer-sponsored supplemental plans. Those individuals often received health benefits in lieu of pay raises. They agreed to forfeit pay for health benefits, because it gave them peace of mind, knowing the benefits would be there for them when they needed it. It is unconscionable that Congress would now take that away from them.

Rather than focusing on increasing cost-sharing to those who can least afford it, Congress should look at other health savings. One example is requiring pharmaceutical companies to pay rebates for dual-eligibles – individuals who qualify for Medicare and Medicaid – and low-income Medicare beneficiaries. According to the Congressional Budget Office, this would save $147 billion over 10 years. We should also expand on the delivery system reforms included in the Affordable Care Act. These options would save the program billions of dollars and would not negatively affect Medicare beneficiaries or shift costs to them.

It is important to note that the growth in health spending has gone down over the last four years. It is estimated that if the current trends continue between 2013 and 2022, Medicare spending could go down by $770 billion. Given this new and more positive economic forecast, we should not be rushing to cut benefits or shift costs. Instead, we should have a more thorough discussion of the impact these policies would have on Medicare beneficiaries.

On behalf of our 4 million members, the Alliance for Retired Americans appreciates the opportunity to submit this testimony on this critically important issue.

June 4, 2013

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
Subcommittee on Health
United States House of Representatives
1135 Longworth House Office Building
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Committee on Ways and Means
Subcommittee on Health
United States House of Representatives
1035 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

The American Association of Bioanalysts (AAB) and the National Independent Laboratory Association (NILA) appreciate the opportunity to submit comments for the record in follow up to the Ways and Means Committee Subcommittee on Health's hearing on proposals to reform Medicare held on May 21, 2013. We appreciate that the Subcommittee is planning to hold a series of hearings on Medicare reform and that the focus of this hearing was mainly on proposals to change cost-sharing for services received under the Medicare program.

AAB and NILA represent the owners, directors, supervisors, and technologists of independent, regional and community clinical laboratories working with physician practices, hospitals, outpatient care settings, skilled nursing facilities, and home health care agencies. The majority of our members are community-based businesses that want to ensure access to laboratory services for Medicare beneficiaries by allowing competitiveness in the laboratory market, and as such, are significantly concerned about further cuts to the Part B Clinical Laboratory Fee Schedule (CLFS) either through direct reductions or through the imposition of cost-sharing requirements on all laboratory services.

AAB and NILA urge the Subcommittee to oppose Medicare Part B cost sharing (coinsurance or copays) for clinical laboratory services. Cost sharing—whether through a uniform coinsurance or direct copay across laboratory services—will result in deep cuts to clinical laboratory reimbursement, threatening Medicare beneficiaries' access to essential services. In addition, the cost of collecting the copay frequently exceeds the amount collected.

A 2000 Institute of Medicine report on Medicare laboratory payment policy recommended against beneficiary cost sharing, concluding that "cost sharing is unlikely to significantly reduce overuse or increase the detection of fraud and abuse; it could create barriers to access for the most vulnerable Medicare beneficiaries; and it would be financially and administratively burdensome for laboratories, patients, and the Medicare program." Additionally, in 2011, the Congressional Budget Office did not include laboratory coinsurance or co-pays in the savings options presented to Congress. In its report to Congress, the Medicare Payment Advisory Commission also did not include any recommendation for cost sharing on laboratory services.

AAB and NILA also want to express serious concern to the Subcommittee about further reducing the Medicare Part B CLFS as addressed in the President's 2014 budget. Such reductions would undoubtedly result in the closure of many small and mid-size community laboratory providers that are already struggling after receiving drastic Medicare cuts over the last few years, as follows:

- 1.75 percent reduction every year for five years (2010-2015) and a productivity adjustment every year through the Affordable Care Act;
- 2 percent reduction from the Middle Class Tax Relief and Job Creation Act of 2012 passed in February 2012 for the short-term Sustainable Growth Rate patch; and,
- 2 percent reduction in FY 2013 from sequestration.

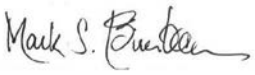
Additional reductions to the CLFS do nothing to meet Congress's goal of reducing overall health care spending and improving the quality of patient care. Such cuts do not modernize the fee schedule for laboratory services, as suggested in the President's proposal. Such cuts would only lead to a reduction in competition within the laboratory market and a limitation on access to laboratory services, particularly in rural communities and nursing home populations, both largely served by AAB and NILA members.

Independent clinical laboratories are being forced to make drastic economic decisions to ensure their viability in an already difficult market. As demonstrated in a 2012 survey conducted by the George Washington University, a significant number of small and mid-size independent clinical laboratories operate on very low margins, with profit margins that do not exceed 3 percent. Additional cuts are not an option if these laboratories are to continue to serve Medicare beneficiaries.

AAB and NILA have formed a new workgroup to look at issues concerning payment for clinical lab services and to establish new ideas to address the value of laboratory services. Over the coming months, as you address larger issues concerning Medicare payment reforms and associated health expenditures, we want to continue our dialogue with you. Additional cuts to clinical laboratory services would have severe consequences on community independent labs. Other policy reforms, i.e. cost-sharing or coinsurance could also fundamentally shift the lab market and have dire consequences on beneficiaries' access to services. We want to work with you to be part of the solution.

If we can provide additional information, please feel free to contact me directly at me at 314.241.1445 or birenbaumm@birenbaum.org; or Julie Allen, our Washington representative at 202.230.5126 or julie.allen@dbr.com.

Sincerely,



Mark S. Birenbaum, Ph.D.
Administrator
AAB and NILA

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS & MEANS, SUBCOMMITTEE ON HEALTH
HEARING ON "THE PRESIDENT'S AND OTHER BIPARTISAN PROPOSALS TO REFORM MEDICARE"

WRITTEN TESTIMONY SUBMITTED JOINTLY BY
CALIFORNIA HEALTH ADVOCATES,
CENTER FOR MEDICARE ADVOCACY,
AND MEDICARE RIGHTS CENTER

May 21, 2013

Introduction

Mr. Chairman and Members of the Committee:

California Health Advocates, the Center for Medicare Advocacy, Inc., and the Medicare Rights Center are all independent, non-profit organizations with extensive experience representing older adults and people with disabilities who rely on Medicare for basic health and economic security.

Our three organizations also served as consumer representatives to a subgroup of the Senior Issues Task Force (SITF) of the National Association of Insurance Commissioners (NAIC) tasked with reviewing a provision of the Affordable Care Act (ACA) relating to Medigap policies. We offer this testimony through our perspective as beneficiary advocates and members of this deliberative NAIC process that included a range of stakeholders.

In December 2012, as a result of the work of the NAIC subgroup, the NAIC strongly recommended against adding further cost-sharing to Medigap plans in a letter to the U.S. Department of Health and Human Services.[1] In short, the research conducted by the subgroup roundly rejects the basic assumption that limited cost-sharing afforded by Medigap plans leads to overutilization of health care services. The subgroup concluded:

> The proposals [to add cost-sharing to Medigap plans] focus on overutilization by beneficiaries but do not consider the potentially serious and unintended impacts for beneficiaries and the Medicare 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. In addition, research indicates that once beneficiaries seek care, doctors and other medical providers, not patients, generally drive the number and types of services delivered to beneficiaries. Further, the proposals do not address the fact that Medicare

[1] National Association of Insurance Commissioners letter to Secretary Sebelius (December 2012), available at: http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf.

> determines which services are reimbursed and therefore, by law, covered by Medigap insurance policies.[2]

The NAIC determined that increased cost-sharing in Medigap plans was likely to prohibit the use of both necessary and unnecessary health care services. Both the Medicare Payment Advisory Commission (MedPAC) and the Congressional Budget Office (CBO) have acknowledged this same concern in reference to proposals that increase beneficiary out-of-pocket costs.[3] By way of the subgroup's conclusion, the NAIC rebuffed the notion that increased cost-sharing is an appropriate tool to limit unnecessary use of health care services.

Although this NAIC subgroup focused on potential changes to Medigap plans, the research reviewed and the resulting conclusions are applicable to a range of Medicare reform proposals, including the subject of this testimony—proposals to modify Medicare costs sharing by introducing home health copayments, increasing the Part B deductible, and further income-relating Part B and D premiums.

Our testimony focuses on how the three enumerated types of proposed cost sharing would impact the lives of people with Medicare.[4] While taking a measured look at the program outside of the context of deficit reduction would be a welcome exercise, we believe that the Medicare reform proposals which are the subject of this hearing would have harmful, unintended consequences for beneficiaries. Each of these proposals might save federal dollars in the short run, but would do so through significant cost-shifting to beneficiaries. At the same time, none of these proposals address the long-term challenge of systemic health care inflation that threatens our nation's ability to provide affordable health care, both in public and private markets.

Current Expenses and Coverage for Medicare Beneficiaries

Before considering proposals that would alter what Medicare beneficiaries pay for their health care, it is necessary to understand the current fiscal challenges faced by this population. The vast majority of Medicare beneficiaries have low or moderate incomes. In 2012, half of all Medicare beneficiaries had annual incomes below $22,500, or below 200% of the federal poverty level

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[2] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental 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.

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

[4] Note that our three organizations previously submitted joint testimony to this subcommittee regarding its February 26, 2013 hearing entitled "Examining Traditional Medicare's Benefit Design." This testimony is available at each of our websites, including: http://cahealthadvocates.org/_pdf/advocacy/2013/Medicare_Redesign_Testimony_CHA_CMA_MR_20022513.pdf.

(FPL).[5] Half of beneficiaries had just $77,500 in personal savings.[6]To put this in context, the average annual cost of care in a semi-private nursing room in was $130,000 in 2011. In 2010, an estimated one-third of Medicare beneficiaries have annual incomes below $16,755—150% of the FPL for a single person.[7] [8]

Contrary to general belief, Medicare beneficiaries already pay more than other groups for their health care. Medicare households have a lower average budget than the average household (about $30,800 vs. $49,600 respectively) but devote a substantially larger share of their income to medical expenses than does the average household (15% vs. 5% respectively). Two-thirds of the medical spending by Medicare households goes to premiums for Part B, Medicare Advantage, Part D, and/or supplemental coverage.[9]

Medicare beneficiaries also tend to have greater health needs than other groups. Nearly half (40%) of older adults covered by Medicare have three or more chronic conditions, and nearly one-fourth (27%) are in fair or poor health.[10] Typical out-of-pocket health spending for someone in fair or poor health without any supplemental benefits is about $4,500 per year.[11]

Because the current Medicare benefit is not overly generous and requires considerable out-of-pocket costs, approximately 90% of Medicare beneficiaries have some type of coverage that supplements Medicare. Some have retiree benefits through former employment (30%), Medicare Advantage plans (29%), Medicaid (14%) and Medigap (18%), and others who have only Medicare (8%) are also entitled to benefits through the Veteran's Administration.[12] Many of these supplemental types of insurance, in effect, limit out-of-pocket expenses. Even with these supplemental coverage options, people with Medicare lack coverage for particular services, including most long-term care services and supports and dental care.

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[5] Kaiser Family Foundation, "Policy Options to Sustain Medicare for the Future" (January 2013), available at: http://www.kff.org/medicare/upload/8402.pdf

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

[7] General Accounting Office (GAO), "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment" (September 2012), available at: http://www.gao.gov/assets/650/648370.pdf .

[8] Note that public assistance to help pay for Medicare cost sharing is made available through Medicare Savings Programs (MSPs) and the Part D Low-Income Subsidy or Extra Help. Currently, though, full Part A, B and D subsidy protection is provided only for those with incomes up to 100% of FPL, about $11,500 in 2013.

[9] Kaiser Family Foundation, "Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare Households. An Updated Analysis of Health Care Spending as a Share of Total Household Spending" (March 2012), available at http://www.kff.org/medicare/upload/8171-02.pdf.

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

[11] MedPAC, "A Data Book: Health Care Spending and the Medicare Program" charts 5-6 (June 2012), available at: http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf.

[12] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), "Variations and Trends in Medigap Premiums" (December 2011), available at: http://aspe.hhs.gov/health/reports/2011/medigappremiums/index.pdf.

Most Medicare beneficiaries cannot absorb more costs without facing significant hardship. To borrow a crude metaphor, Medicare beneficiaries already have too much "skin in the game," and as a group, are very aware of the high cost of health care services based on the bills they receive and Medicare's summary notice of payment.

Economic and Health Risks Posed by Increasing Medicare Cost Sharing

Cost-Shifting to Beneficiaries Limits Access to Necessary Care

While increased cost-sharing poses significant financial risks for beneficiaries, particularly for those living on low- and moderate-incomes, it is also shown to limit access to necessary health care services. This was a primary finding of the NAIC subgroup convened to explore adding cost-sharing to specific Medigap plans on which our organizations served.

Pursuant to the ACA, the NAIC was directed to "review and revise the standards for benefits in Medigap Plan C and Plan F" and to update those standards to include cost-sharing, if practicable, so as to "encourage the use of appropriate physicians' services…"[13] Toward this end, the NAIC convened the Medigap PPACA (B) Subgroup that included state insurance regulators, insurers and trade associations, consumer advocates and other Medicare experts. This subgroup spent almost two years reviewing available literature on cost-sharing and patient behaviors.[14] In addition, mid-way through its deliberations, the NAIC subgroup issued a discussion paper on more expansive proposals to diminish Medigap coverage and increase Medicare cost-sharing.[15]

The subgroup's research demonstrates that cost-sharing has dubious utility in holding down health care spending and can actually lead to increased total spending on health care when people forego medically necessary services. For example, a major Harvard School of Public Health review of the research on cost-sharing made several conclusions about its utility in controlling health care costs, including: "We do not know if increased patient cost-sharing would reduce the growth in total national health care spending;" "Increased cost-sharing disproportionately shifts financial risk to the very sick;" "Low-income older adults with chronic conditions are at increased risk for poor health outcomes due to increased cost-sharing."[16]

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

[14] National Association of Insurance Commissioners, "Medigap PPACA (B) Subgroup" webpage, available at: http://www.naic.org/committees_b_sitf_medigap_ppaca_sg.htm; See under heading "Cost-sharing Research and Literature" for summary of much of this literature (as of June 2011) available at: http://www.naic.org/documents/committees_b_senior_issues_110628_summary_dist_research.pdf.

[15] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental 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.

[16] Katherine Swartz, "Cost-Sharing: Effects on Spending and Outcomes" (December 2010), Robert Wood Johnson Foundation Research Synthesis Report No. 20, available at: http://www.naic.org/documents/committees_b_senior_issues_110628_rwjf_brief.pdf

In 2008, the CBO similarly determined that a proposal to restrict Medigap coverage of Medicare cost-sharing would lead beneficiaries to face "uncertainty about their out-of-pocket costs." Given this, the CBO further acknowledged that the corresponding "…decline in the use of services by Medigap policyholders (which would generate the federal savings under this option) might lead beneficiaries to forego needed health services and so might adversely affect their health."[17]

Due in large part to these findings, in a letter to Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services, the NAIC concluded, "We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost-sharing designed to encourage the use of appropriate physicians' services. Therefore, our recommendation is that no nominal cost-sharing be introduced to Plans C and F."[18]

Our organizations strongly support the NAIC's determination. The conclusions drawn by this subgroup are applicable not only to Medigap reform proposals, but also to proposals that would increase beneficiary out-of-pocket costs, such as those under consideration by this committee.

Specific Proposals to Modify Beneficiary Cost-Sharing

Our organizations have been critical of many proposals that would shift costs onto Medicare beneficiaries, including several provisions in the President's FY2014 budget.[19] In its hearing notice, the committee also references other Medicare reform proposals offered by the Bipartisan Policy Center, The Moment of Truth project and the Medicare Payment Advisory Commission (MedPAC).[20] In previous testimony submitted to this committee, our organizations identified the potential consequences to beneficiaries if some of these efforts to redesign Medicare's benefit structure were realized.[21] As outlined below, we are also opposed to the three proposals currently under consideration by this Committee.

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[17] Congressional Budget Office, "Budget Options Volume 1: Health Care" (December 2008), page 155, available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf.

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

[19] See, e.g., the Center for Medicare Advocacy's Weekly Alert "The Impact of the President's Budget on People Who Depend on Medicare and Social Security" (April 11, 2013), available at: http://www.medicareadvocacy.org/the-impact-of-the-presidents-budget-on-people-who-depend-on-medicare-and-social-security/, and the Medicare Rights Center Press Release, "Statement by Medicare Rights Center President Joe Baker on President Obama's FY2014 Budget" (April 10, 2013), available at: http://www.medicarerights.org/newsroom/pressreleases/2013_11.html.

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

[21] See our previously submitted joint testimony to this subcommittee regarding its February 26, 2013 hearing entitled "Examining Traditional Medicare's Benefit Design." This testimony is available at each of our websites,

- Adding a Copay to the Home Health Benefit

Several Medicare reform proposals include adding cost-sharing or coinsurance to the Medicare home health benefit, which currently is not subject to beneficiary cost-sharing. Starting in 2017, the President's FY2014 Proposed Budget would create a home health co-payment of $100 per 60-day home health episode, applicable for episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay.

Imposing such co-pays would have a staggering impact on individuals with long-term and chronic conditions, who, under the President's proposal, would essentially incur $600 in new out-of-pocket costs annually. Additionally, adding copayments to the home health benefit would likely lead to higher hospitalizations (and thus higher costs) as a result of beneficiaries forgoing needed care when they cannot afford the co-payments.[22]

Both the President's and MedPAC's proposals would implement a co-pay only for those who receive home health care that is **not** preceded by a hospital or nursing home stay. While this limitation might seem like an attempt to mitigate the harm of home health copays, instead it would create a perverse incentive toward hospitalization or nursing home care, and would harm people with long-term or chronic conditions. In our experience serving Medicare beneficiaries, we find that many home health agencies are already reluctant to take on patients who need home health for the long haul; further segmenting out the home health population by only charging copays from those who more likely need care due to chronic conditions, rather than those who have short-term post-acute needs, will significantly exacerbate this problem given the reluctance on the part of home health providers to collect copayments (or take on patients who are required to pay them).

In short, we are opposed to imposing home health copays. The Congressional Budget Office estimates that this home health copay would save only $730 million over ten years. This minor savings simply does not justify the great harm it would cause to vulnerable older, disabled people, and their families.

We also oppose efforts to cap Medicare payment based upon episodes of care, either by individual beneficiary or by an individual home health agency's aggregate episodes of care,

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including:
http://cahealthadvocates.org/_pdf/advocacy/2013/Medicare_Redesign_Testimony_CHA_CMA_MR_20022513.pdf.

[22] See, e.g., a study in the *New England Journal of Medicine* which found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes and greater expense. Trivedi, Amal N., Husein Moloo and Vincent Mor, "Increased Ambulatory Copayments and Hospitalizations among the Elderly," *New England Journal of Medicine*, January 2010. Also see, e.g., the Urban Institute's Health Policy Center finding 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." Urban Institute Health Policy Center, "A Preliminary Examination of Key Differences in Medicare Savings Bills," July 13, 1997.

which would effectively limit the duration of time individuals could access home health services.[23]

- Increasing the Annual Part B Deductible

Several Medicare reform or deficit reduction proposals include provisions that would either increase the Medicare Part B deductible alone or in combination with altering the Part A deductible.[24] Combining the A and B deductible by effectively increasing the Part B deductible ($147 in 2013) and lowering the Part A deductible ($1,184 in 2013) to form a combined deductible somewhere in between these figures would arguably have some benefit for a relatively small number of Medicare beneficiaries who use inpatient services.[25] Merely increasing the Part B deductible for everyone without lowering any other expenses, however, simply amounts to an unwarranted shift of additional costs onto Medicare beneficiaries.

The President's FY 2014 Budget proposes to increase the Part B deductible for newly eligible beneficiaries by $25 dollars in the years 2017, 2019 and 2021, raising the deductible for each cohort of beneficiaries entering the program each of those years. Since individuals currently entering the Medicare program would not face these increased amounts, the result would be four different cohorts of Medicare beneficiaries paying four different deductible amounts. This proposal would increase Medicare's complexity by drawing an arbitrary line between current beneficiaries and near retirees who would be unaffected and those who will join Medicare in the future and will permanently pay more.

Even more worrisome, however, is the impact that an increased deductible would likely have on Medicare beneficiaries, particularly those who are lower income and unable to afford additional health costs. Additional upfront costs in the form of a higher deductible would lead to self-rationing of care as many individuals would postpone needed care which, in turn, could result in increased costs when an untreated illness becomes more complicated and more costly to treat.

- Further Income-Relating Premiums for Parts B and D

The President's FY 2014 Budget proposes to increase income-related premiums for Parts B and D. Medicare beneficiaries with incomes above $85,000 ($170,000 for a couple) already pay higher Part B premiums due to a provision in the Medicare Modernization Act of 2003 (in 2013, adding between $146.90 and $335.70 to premium costs per month, depending upon income). The

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[23] Such episodic payment caps would disproportionately harm individuals with chronic conditions, including people with conditions such as traumatic brain and spinal cord injuries, Alzheimer's, Parkinson's disease, MS, and other such illnesses and disabilities. This is contrary to the recently settled national class action lawsuit, *Jimmo vs. Sebelius*. No. 5:11-CV-17 (D. VT, October 16, 2012). Further, such payment caps would thwart current broad efforts aimed at favoring community-based living as opposed to institutionalization of individuals.

[24] For an analysis of the potential impact of a combined Part A/B deductible, see, e.g., our previously submitted joint testimony to this subcommittee regarding its February 26, 2013 hearing entitled "Examining Traditional Medicare's Benefit Design." This testimony is available at each of our websites, including: http://cahealthadvocates.org/_pdf/advocacy/2013/Medicare_Redesign_Testimony_CHA_CMA_MR_20022513.pdf.

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

Affordable Care Act of 2010 required higher-income individuals to also start paying higher Part D premiums in 2011 (in 2013, adding between $11.60 and $66.60 per month, depending upon income) and froze the income limits ($85,000 individual/$170,000 couple) through 2019 so that each year more people will be subject to higher premiums for Parts B and D.

Today, income-related premiums affect roughly 5% of Medicare beneficiaries.[26] 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.[27] If higher premiums were applied to Medicare beneficiaries with the top 10% of income today, it would affect people earning approximately $63,000.[28]

The President's proposal would increase the share of Part B expenses paid in premiums by higher income beneficiaries to between 40% and 90% of such expense, depending upon an individual's income bracket. There currently are four different income brackets with respect to means testing; under the President's proposal, there would be nine income brackets[29], further complicating, rather than simplifying, the payment of premiums specifically and the Medicare program more generally.

The President's proposal would also freeze income-related premium thresholds under Parts B and D until 25% of beneficiaries are subject to these premiums. According to 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.[30] In other words, individuals earning only about half of the current income threshold of $85,000 would be impacted by such a proposal. This is an income level, we note, that is substantially lower than the thresholds often used to define higher-income individuals in other policy discussions, including discussions about tax policy.

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[26] According to the Kaiser Family Foundation, in 2012, 5.1% of Part B enrollees (2.4 million beneficiaries) to pay the income-related Part B premiums were estimated to pay the income-related 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://kaiserfamilyfoundation.files.wordpress.com/2013/01/8276.pdf.

[27] 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://kaiserfamilyfoundation.files.wordpress.com/2013/01/8276.pdf .

[28] According to Urban Institute/Kaiser Family Foundation analysis in 2011, the 90th 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://kaiserfamilyfoundation.files.wordpress.com/2013/01/8172.pdf.

[29] "AP Newsbreak: Medicare Means Test Plan Detailed" by Ricardo Alonso-Zaldivar, Associated Press, April 12, 2013.

[30] "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://kaiserfamilyfoundation.files.wordpress.com/2013/01/8276.pdf .

Our organizations are opposed to further income-relating (means testing) Medicare premiums. Further means testing would undermine the integrity and universality of the Medicare program. Medicare remains an immensely popular program. However, 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 …"[31]

Conclusion

Our organizations recognize the need to bring down the nation's deficit and reduce health care spending system-wide. We support Medicare savings mechanisms that eliminate wasteful spending and build on the efficiencies of the Affordable Care Act (ACA). At a time when Medicare spending is growing at historically low rates, and innovations through the ACA hold considerable promise of continuing to keep costs down, we oppose implementing unwise policies that seek federal savings by way of cost-shifting on the backs of Medicare beneficiaries.

Under the proposed cost-sharing reforms being considered by this committee, too many Medicare beneficiaries would lose access to affordable coverage, and too many would be discouraged from seeking needed health care services. In short, these proposals threaten the health and economic security of people with Medicare.

Instead of shifting additional costs onto beneficiaries, we support prudent cost containment designed to solve the true threat to our nation's fiscal health: rising health care costs system-wide. To realize this goal, we endorse cost-saving solutions that eliminate wasteful spending and promote the delivery of high value care—meaning better quality at a lower price. Proposals our organizations support include:

Reduction of wasteful spending on drugs, medical equipment and private health plans: Significant cost savings can be achieved by allowing the Medicare program to secure lower prices on pharmaceutical drugs. Congress should expand the tools available to the federal government to achieve this end, including restoring Medicare drug rebates, allowing the federal government to directly negotiate with pharmaceutical companies and introducing a public drug benefit in Medicare.

In addition, Congress should expand the cost savings already achieved by the Centers for Medicare & Medicaid Services (CMS) through the successful competitive bidding demonstration for durable medical equipment. Expansion of the competitive bidding on a national scale should be accelerated and extended to other types of medical equipment, such as lab tests and advanced imaging services.

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[31] "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://kaiserfamilyfoundation.files.wordpress.com/2013/01/8276.pdf .

The ACA took major strides to reduce sizable overpayments to Medicare Advantage. More should be done to equalize payments between Traditional Medicare and private Medicare plans. Private plans should be reimbursed no more than Traditional Medicare.

Advance Medicare delivery system reforms made possible by health reform:
The ACA includes many opportunities to test delivery system reforms designed to enhance health care quality while simultaneously driving down the cost of care. These reforms are meant to improve care quality by promoting better coordination among providers, patients and caregivers to prevent harmful drug interactions, unnecessary hospitalizations and more.

Congress should maximize the Administration's authority to test these reforms in a timely manner. At the same time, Congress should avoid dramatically altering Medicare benefits, so as to allow time for these advancements to yield results, meaning both improved care coordination and better cost-effectiveness.

We look forward to working with the Committee and members of Congress to examine additional cost-saving options in the Medicare program that simultaneously address the systemic issue of rising health care costs that concern not only Medicare, but also to the private health insurance market. We implore you to reject proposals that fail to address this systemic issue and instead achieve only short-term savings by shifting costs to people with Medicare. As such, we ask that you carefully weigh the significant risks posed to Medicare beneficiaries by the proposals discussed above and we urge you to steer clear of these models.

We appreciate this opportunity to submit these comments.

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TO THE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

MAY 21, 2013

The National Association for Home Care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

As the House Ways and Means Subcommittee on Health reviews proposals to change cost-sharing for services received under the Medicare program, NAHC appreciates this opportunity to provide our views. Some proposals have suggested adding copayments for Medicare home health and hospice services as a means of both reducing the deficit and preventing overutilization of home health and hospice services.

Congress eliminated the home health copayment in 1972 for the very reasons it should not be resurrected now. The home health copayment in the 1960s and 1970s created an incentive for Medicare beneficiaries to receive costly institutional care by deterring them from accessing more cost-effective home health care services. Reinstating the home health copay today would undo the progress made in reducing unnecessary hospitalizations and nursing home stays.

Moreover, home health services and hospice care already have the highest cost-sharing in Medicare. On a daily basis, millions of spouses, family, friends, and community groups

contribute the equivalent of billions of dollars worth of care and support to keep their loved ones at home. Further, care in the home means that the Medicare beneficiary provides all the financial support in terms of room and board that are otherwise paid for by Medicare and Medicaid in an institutional setting.

Numerous studies have concluded that a copay would discourage use of necessary and beneficial care, resulting in the deterioration of a patient's condition and ultimately leading to higher costs for the Medicare program through acute care interventions in higher cost settings. With hospice patients, barriers to comfort at the end of life add both avoidable costs and avoidable pain.

We respectfully submit that Congress should oppose any copay proposal for Medicare home health and hospice services.

HOME HEALTH CARE

Proposals to impose a home health copay should be rejected for the following reasons:

- **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."[i] 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.[ii] A home health copay would cause the same adverse health consequences and increased use of more costly acute care and hospitalizations. The National Association of Insurance Commissioners concluded that beneficiaries, in response to increased cost sharing, "may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs for Medicare in the long run."[iii] Studies have shown that Medicaid copays can backfire with beneficiaries avoiding care leading to higher overall Medicaid costs.[iv] The Veterans Administration recently eliminated copays for in-home video telehealth care to prevent avoidable hospitalizations of veterans.[v] According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by $6-13 billion over ten years.[vi] A recent Economic Policy Institute analysis concluded that the imposition of increased cost sharing would have a "penny-wise, pound-foolish result."[vii]

- **The burden of a home health copayment would disproportionately impact 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.[viii] 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.[ix] 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."[x]

- **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.[xi] Medicare households already spend on average 15 percent of their income on health care costs, three times as much as the non-Medicare population.[xii]

- **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 percent 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 percent of poverty, with no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third actually have it.[xiii]

- **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,[xiv] and too frequently having to cut their work hours or quit their jobs. If beneficiaries cannot access home health services and are forced into institutional settings, Medicare will bear the costs of these services that are currently funded by patients and their families.

- **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 and that beneficiaries are homebound and meet other stringent standards. There is no evidence of systemic overutilization of home health care. 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.[xv]

- **Home health copayments would shift costs to the states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by the Medicare Payment Advisory Commission (MedPAC)) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are already struggling to pay for their 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.[xvi] 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. Also, unlike hospitals, there is no provision for bad debt from uncollected copays built into the base payment for home health care. Home health agencies cannot absorb these costs, as nearly 50 percent of home health agencies are projected to be paid less than their costs in 2014 by Medicare. Overall home health agency margins from a combination of Medicare, Medicaid, Medicare Advantage and other payment sources average less than zero.[xvii]

HOSPICE

The Medicare hospice benefit was created under the Tax Equity and Fiscal Responsibility Act of 1982 to expand the availability of compassionate and supportive care to Medicare's many beneficiaries suffering from terminal illness at the end of life. Eligibility for hospice is based upon a physician's certification that the patient has a terminal illness with a life expectancy of six months or less if the illness runs its normal course. When a patient elects hospice under Medicare, he or she agrees to forgo other "curative" treatment for the terminal illness. While the cost of most hospice care is covered by Medicare, the patient may be responsible for copayments related to drugs for symptom control or management and facility-based respite care. The patient is also responsible for copayments related to any regular Medicare services unrelated to the terminal diagnosis.

Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit. The average Medicare hospice beneficiary receives care at a cost of approximately $11,500. With the cost sharing changes that have been proposed, a 20 percent copay would impose a charge of approximately $2,300 on terminally ill individuals in the last days of their lives. Given the requirement that a patient be determined to be terminally ill with a plan of care developed by an interdisciplinary team, there is no need for an additional check on utilization of care. Implementing a Medicare copayment for these services would cause many terminally ill patients to second guess their physician and care team in the last days of their life.

Historically, copayments have been imposed on health care services to reduce overutilization of services. While use of hospice services has grown significantly through the years, many Medicare beneficiaries are referred to hospice too late to reap its full benefit, and many more lack sufficient knowledge or understanding of hospice to consider it a viable option at the end of their lives. This is particularly the case for minority and low-income Medicare populations – who are the least likely to be able to afford additional cost-sharing burdens.

Beneficiaries who elect Medicare hospice services must agree to forego curative care for their terminal illness. Given that many "curative" interventions for terminal illnesses can involve administration of costly new medications and treatments, it is not surprising that numerous studies have documented that appropriate use of hospice services can actually reduce overall Medicare outlays while at the same time extending length and quality of life for enrolled beneficiaries.[xviii]

While valid concerns have been raised about the length of time some Medicare beneficiaries are on hospice service, the median length of stay under the hospice benefit is about 17 days, and 95 percent of hospice care is provided in the home. Congress has already addressed concerns relative to extended length of stays in hospice care by requiring a face-to-face encounter prior to the start of the third and later benefit periods. Through that change, ineligible individuals are screened out and improper Medicare payments are avoided. In lieu of imposing additional beneficiary cost-sharing that could discourage appropriate, desirable, and cost effective use of the hospice benefit, Congress and other policymakers should explore additional ways to ensure that hospice services are being ordered for patients that are truly eligible, such as through physician education.

PROPOSALS TO ADDRESS CONCERNS ABOUT PROGRAM INTEGRITY

Rather than applying a copay to address concerns that have been raised about possible overutilization and wasteful spending on home health services in certain parts of the country, NAHC suggests targeted approaches that do not restrict access to care and penalize Medicare beneficiaries and ethical home health providers. It is essential that Medicare operate with integrity and compliance as millions of Americans depend on this program every day to meet their health care needs. Eliminating wasteful spending should be the highest priority in that regard. For too long, honest and compliant providers and beneficiaries have had to pay through increased costs, reduced benefits, and payment rate reductions for the misdeeds and criminal conduct of bad actors that seek to take advantage of systemic weaknesses in Medicare. NAHC fully supports efforts to address these weaknesses with constructive and well-focused action. The home care and hospice community recognizes that they must be responsible stewards of the limited resources available to Medicare. We also recognize that it is a privilege to be a participating provider in these programs and that we can be effective partners with government in combatting fraud, waste, and abuse.

In recent years, new policies and administrative practices have been instituted to address care overutilization concerns. For example, Medicare has added oversight and "real-time" predictive modeling to target aberrant providers, using its contractors such as the Zone Program Integrity Contractors (ZPICs) and Recovery Audit Contractors (RACs) in addition to its longtime claims reviews by the everyday Medicare Administrative Contractors (MACs). Also, an industry-developed restriction on home health outlier episodes in home health services eliminated abusive claims, reducing unnecessary Medicare spending by $1 billion in in its first year, 2010.

Other measures have been instituted by Medicare, including more stringent provider participation standards, a periodic professional therapist assessment requirement prior to continued care, and a physician face-to-face encounter requirement to initiate covered home health services. These and other changes have led to an actual reduction in Medicare home health spending, a phenomenon unique in the Medicare program in recent years. In fact, home health spending and utilization is less today than in 1997. In today's dollars, Medicare home health spending is about 40 percent lower than in 1997 while all other sectors have significantly increased. Still, home care and hospice wish to lead rather than follow in program integrity innovations.

In that spirit, we offer ten recommendations that we believe can further reduce wasteful spending and prevent fraudulent conduct. These recommendations include a combination of steps that are directed to the primary reason that concerns about fraud and abuse exist – the system permits bad actors and parties without adequate competencies to enter Medicare program. In addition, these recommendations also offer a series of improvements focused on existing providers of care designed to ensure ongoing and continuous compliance. These recommendations are designed to address both deliberate fraud and abuse as well as harm caused by ignorance, lack of competence, or confusion.

1) **Implement a targeted, temporary moratorium on new home health agencies.** CMS has expressed growing concerns about the entry of fraudulent providers into the Medicare program. With respect to Medicare home health services, there is strong evidence that much of the fraud, waste, and abuse stems from the entry of new providers in areas of the country already saturated with existing home health agencies. CMS has not exercised its authority to impose targeted moratoria on new home health agencies in spite of the evidence that certain areas of the country already have too many providers. Congress should mandate the implementation of a temporary, targeted moratorium on new home health agencies in geographic areas where there is a highly disproportionate number of providers relative to the number of beneficiaries in an area. It should apply certain standard exceptions to a moratorium such as where the state has a Certificate of Need program and the state determines that there is a need for additional providers; the provider is establishing a branch office or multiple locations within its geographic service area; or the provider has submitted the appropriate CMS Form 855A prior to the public notice of any moratorium.

2) **Require credentialing of home health agency executives.** Congress should strengthen Medicare program participation standards to include experience, credentialing, and competency testing of home health agency owners, managers, and personnel responsible for maintaining compliance with Medicare standards. Competency credentialing should be made part of the Medicare provider screening model and applied to both new and existing providers of home health services. The credentialing should include minimum training and competency testing of owners and managers in all areas of Medicare/Medicaid operations including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions.

3) **Expedite refinements to the Medicare home health payment system to eliminate incentives to over-utilize care.** The current home health prospective payment system (HHPPS) includes higher reimbursement for episodes with more therapy visits. Reimbursement for episodes increases incrementally as the number of therapy visits increases. Any episodic prospective payment system that relies on the volume of services to determine payment amounts raises the risk of service overutilization. The current case mix adjustment model for home health services payment should be modified to eliminate the use of a payment modifier based on the volume of therapy visits. Sufficient Medicare resources should be invested to expedite refinements to the Medicare home health payment system so that the provision of services is better aligned with patient characteristics and costs of providing care, rather than the number of visits provided per episode for any service.

4) **Require all Medicare participating home health agencies to implement a comprehensive corporate compliance plan.** Congress should require expedited implementation of corporate compliance plans by home health agencies to ensure adherence to all federal and state laws with proper funding support. Compliance program implementation, development and maintenance should include the following: corporate compliance plan frameworks based on the elements put forth in the Sentencing Guidelines; tailored to address specific risk areas; periodically re-evaluated; taken into consideration by CMS when making payment rate changes; outreach and education activities by CMS for providers to implement a compliance plan; and 12 months to fully implement a compliance plan following the publication of any rule.

5) **Strengthen admission standards for new Medicare home health agencies through probationary initial enrollment, prepayment claims review, increased initial capitalization requirements, and early-intervention oversight by Medicare surveyors.** CMS has implemented provider screening, including fingerprinting. However, participation standards should be established to further reduce the risk that unscrupulous, as well as inexperienced providers continue to manage to obtain Medicare participation agreements on the front-end. Congress should increase the initial capitalization requirements to the equivalent of one year operation; establish a "probationary enrollment" for new providers during which all new home health agencies are subject to 100 percent medical review for at least 30 days, followed by a minimum of 10 percent medical review for the first year in the program; establish a mandatory in-service training requirement during the probationary period on regulations and policies including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions; conduct State Agency full resurveys of all new home health agencies at 6 months of operation; and require training for all State surveyors in coverage standards, with reporting of questionable billing practices to the MACs.

6) **Create a joint Home Health Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries.** Congress should establish a Medicare Home Health Benefit Program Integrity Advisory Council appointed by the Secretary of HHS

with representation from Medicare beneficiaries, home health agencies, organizations representing beneficiaries and home health agencies, the Centers for Medicare and Medicaid Services, the Office of Inspector General of the US Department of Health and Human Services, and the US Department of Justice. Its purpose would be to: evaluate and assess existing compliance oversight systems and system performance within the Department of Health and Human Services and its contractors regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; recommend compliance oversight system improvements that should be developed and implemented by the Secretary; evaluate and assess existing compliance oversight systems within home health agencies and system performance regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; and recommend compliance oversight system improvements that should be developed and implemented by home health agencies.

7) **Require criminal background checks on home health agency owners, significant financial investors, and management.** A key to program integrity in Medicare and Medicaid home care starts at the top. Congress should require criminal background check requirements on all individuals seeking to open and operate an agency and those who finance the creation of the agency. Medicare participation should be denied to any prospective owner where that owner or party providing the financial capital to open the home health agency has a criminal background that involves patient abuse, neglect, or misappropriation of patient property or involves a financial related crime that indicates a risk to the integrity of Medicare.

8) **Establish authority for a self-policing compliance entity to supplement and complement federal and state oversight.** Government enforcement entities do not have sufficient resources to address all concerns regarding fraud, waste and abuse in federal health care programs. Congress should authorize the establishment of private enforcement and sanction power by an industry-sponsored entity as an adjunct and complement to existing federal enforcement powers. The entity would be industry-financed, subject to operational standards developed by HHS, and open and transparent in a manner equivalent to a federal agency. The private enforcement entities would be authorized to impose monetary and operational sanctions on Medicare/Medicaid participating providers of care, including suspension of the provider participation agreement, institution of corporate integrity agreements, and fines for noncompliance. The entities would have audit authority in order to engage in an investigation of alleged noncompliance.

9) **Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of program standards.** The Medicare home health benefit is governed by complex laws and regulations that lead to misinterpretation of coverage, payment, and program integrity rules. In addition, providers frequently receive conflicting information from various sources involved in enforcing program integrity. Congress should ensure that education and training of the Medicare program is a joint effort among home health providers, regulators, state surveyors, and Medicare contractors by taking the following

steps: develop education sessions to be conducted nationally and open to all stakeholders; provide educational resources that are accessible and that provide clear interpretations to CMS regulations and policies; require greater transparency on instructions provided to the Medicare contractors on payment, coverage, and program integrity policies; and abandon use of local coverage decisions (LCD) and require that only national coverage decisions be used for coverage and payment guidelines.

10) **Utilize targeted provider edits for application of claims reviews and oversight activities. In Medicare home health services, the variation in utilization warrants careful attention**. While the benefit may offer a wide range of services to be covered and permit coverage of extended periods of care, extreme instances of high levels of utilization should be subject to increased scrutiny. For example, MedPAC has highlighted the 25 counties with the highest level of utilization. In some instances, providers have twice the national average in the number of episodes per beneficiary per year. Although beneficiaries can qualify for an unlimited number of 60 day episodes in a calendar year, the extraordinary difference between national average utilization and these providers should trigger claims reviews, including a prepayment authorization process. Such an episode volume process edit will require providers to prove that their claims meet coverage standards.

In relationship to hospice care, NAHC's affiliated Hospice Association of America (HAA) has developed a similar list of program integrity recommendations that we would be happy to supply to the Committee.

MEDICARE INNOVATIONS TO PROMOTE HIGH QUALITY CARE AT LOWER COST

NAHC suggests the following reforms in the Medicare benefit structure that would incentivize high quality care while saving Medicare dollars:

1) **Ensure home care and hospice participation in transitions in care, accountable care organizations, chronic care management, health information exchanges, and other health care delivery reforms.** Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS's implementation of the health care delivery reform provisions in the Patient Protection and Affordable Care Act (PPACA) to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

2) **Allow nurse practitioners and physician assistants to sign home health plans of care.** Congress should enact the bipartisan Home Health Care Planning Improvement Act that

would allow Nurse Practitioners (NP) and Physician Assistants (PA) to certify and make changes to home health plans of treatment. NPs and PAs are playing an increasing role in the delivery of our nation's health care, especially in rural and other underserved areas. Medicare reimburses NPs and PAs for providing physician services to Medicare patients. NPs and PAs can certify Medicare eligibility for skilled nursing facility services, but not more cost effective care in the home.

3) **Recognize telehomecare interactions as bona fide Medicare services.** Congress should: 1) establish telehomecare services as distinct benefits within the scope of Medicare coverage guided by the concepts embodied in the Fostering Independence Through Technology (FITT) Act, which should include all present forms of telehealth services and allow for sufficient flexibility to include emerging technologies; 2) clarify that telehomecare qualifies as a covered service under the Medicare home health services and hospice benefits and provide appropriate reimbursement for technology costs; 3) expand the list of authorized originating sites for telehealth services by physicians under section §1834(m)(3)(C) to include an individual's home; and 4) ensure that all health care providers, including HHAs and hospices, have access to appropriate bandwidth so that they can take full advantage of advances in technology appropriate for care of homebound patients.

4) **Ensure appropriate development of performance-based payment for Medicare home health services.** MedPAC has recommended application of a "pay for performance" (P4P) system for home health and other Medicare provider payments. Starting in 2008, Medicare began a P4P demonstration project operating in seven states. Under that demo, home health agencies qualify for incentive payments based on high quality of care performance or improvement in performance from the previous year. The incentive payments are based upon the impact that the performance has had on reducing Medicare costs in other health care sectors, including hospital care. This approach recognizes the dynamic value that high quality home health services can have in reducing overall health care spending. Congress should monitor the progress of the ongoing P4P demonstration and use the findings to guide its consideration of a full-fledged value-based payment system for Medicare home health services.

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Statement

Of

The National Association of Chain Drug Stores

For

U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health

Hearing on:

The President's and Other Bipartisan
Proposals to Reform Medicare

May 21, 2013
10:00 A.M
1100 Longworth House Office Building

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The National Association of Chain Drug Stores (NACDS) thanks the Members of the Subcommittee on Health for consideration of our statement for the hearing on "The President's and Other Bipartisan Proposals to reform Medicare." NACDS and the chain pharmacy industry are committed to partnering with Congress, the Centers for Medicare & Medicaid Services, patients, and other healthcare providers to improve the quality and affordability of the Medicare program.

NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate more than 41,000 pharmacies and employ more than 3.8 million employees, including 132,000 pharmacists. They fill over 2.7 billion prescriptions annually, which is more than 72 percent of annual prescriptions in the United States. The majority of Medicare Part D prescriptions are dispensed by chain pharmacies.

As the face of neighborhood healthcare, community pharmacies and pharmacists provide access to prescription medications and over the counter products, as well as cost-effective health services such as immunizations and disease screenings. Through personal interactions with patients, face-to-face consultations and convenient access to preventive care services, local pharmacists are helping to shape the healthcare delivery system of tomorrow – in partnership with doctors, nurses and others.

In recent years retail community pharmacies have played an increasingly important role in providing patient care. Activities such as the increased number of health screenings provided by pharmacists help educate patients and give them a better understanding of their health status and potential needs. Pharmacists also provide vital patient care through services such as medication therapy management (MTM) and their expanded role in providing immunizations.

Congress recognized the importance of MTM, including it as a required offering in the Medicare Part D program. The experiences of Part D beneficiaries, as well as public and private studies, have confirmed the effectiveness of pharmacist-provided MTM.

A recent report by CMS found that Medicare Part D beneficiaries with congestive heart failure and COPD who were newly enrolled in the Part D MTM program experienced increased medication adherence and discontinuation of high-risk medications. The report also found that monthly prescription drug costs for these beneficiaries were lowered by approximately $4 to $6 per month and that they had nearly $400 to $500 lower overall hospitalization costs than those who did not participate in the Part D MTM program.

How and where MTM services are provided also impacts effectiveness. A study published in the January 2012 edition of *Health Affairs* identified the key role of retail pharmacies in providing MTM services. The study found that a pharmacy-based intervention program increased patient adherence for patients with diabetes and that the benefits were greater for those who received counseling in a retail, face-to-face setting as opposed to a phone call from a mail order pharmacist. The study suggested that interventions such as in-person, face-to-face interaction between the retail pharmacist and the patient contributed to improved behavior with a return on investment of 3 to 1.

Similarly, policymakers have begun to recognize the vital role that local pharmacists can play in improving medication adherence. The role of appropriate medication use in lowering healthcare costs was recently acknowledged by the Congressional Budget Office (CBO). The CBO revised its methodology for scoring proposals related to Medicare Part D and found that for each one percent increase in the number of prescriptions filled by beneficiaries there is a corresponding decrease in overall Medicare medical spending. When projected to the entire population, this translates into a savings of $1.7 billion in overall healthcare costs, or a savings of $5.76 for every person in the U.S. for every one percent increase in the number of prescriptions filled.

Congress recognized the importance of MTM on a bipartisan basis, including it as a required offering in the Medicare Part D program. We urge Congress to build on this earlier action, and strengthen the MTM benefit in Medicare Part D through support of *the Medication Therapy Management Empowerment Act of 2013,* H.R. 1024 sponsored by Representative Cathy McMorris Rodgers (R-WA) (Senate companion legislation S. 557). This important legislation

would improve access to MTM services for Medicare Part D beneficiaries leading to increased healthcare quality and reduced overall healthcare costs. Under the legislation, Medicare Part D beneficiaries who suffer from one, rather than multiple, chronic diseases that account for high spending in the Medicare program would be eligible for MTM services. We urge members to co-sponsor H.R. 1024.

Additionally, NACDS believes the choice of where to obtain prescription drugs and pharmacy services should be left to Medicare beneficiaries. In order to make an informed choice, it is important for beneficiaries to have clear information. According to a Medicare Payment Advisory Committee (MedPAC) report, approximately 12.5 percent of Medicare beneficiaries were enrolled in a Prescription Drug Plan (PDP), and three percent in a Medicare Advantage Plan with a preferred network design. Participation in preferred networks is increasing.

We applaud efforts by CMS to ensure beneficiaries are fully educated when making plan selections and do not make selections based on ambiguous information. NACDS recommends that all beneficiaries be given clear instructions that, regardless of plan selection, they still retain the right to have a prescription filled at the pharmacy of their choosing and are not required to obtain their prescriptions at a preferred network. Ensuring beneficiary awareness of this policy will lead to less confusion and will allow beneficiaries to continue to utilize the pharmacy of their choice.

While beneficiary cost sharing may encourage the use of a preferred pharmacy, it should not be so significant as to disadvantage Medicare beneficiaries who rely on a pharmacy not in the preferred network. This may be particularly important in rural and urban areas, where beneficiaries would have to travel long distances to access preferred network pharmacies.

Despite the proven effectiveness of pharmacists in delivering preventive services such as immunizations and MTM, limitations remain in place that prevent pharmacists from practicing to the maximum of their capabilities. These limitations have prevented local retail pharmacists from participating in the various new innovative programs, such as those being supported by the Center for Medicare and Medication Innovation (Innovation Center). These include the new

Accountable Care Organization Models, community-based transitions of care, and bundled payment initiatives.

Permitting pharmacists to practice to their maximum capabilities within these new delivery models would help increase medication adherence and coordination between healthcare settings, result in higher rates of vaccinations, and reduce the burden of the physician shortage, particularly with the influx of new patients in 2014 through the Healthcare Marketplaces and the expansion of Medicaid eligibility. As we move forward with the reform of the healthcare delivery system and improving Medicare, it is imperative for all healthcare providers to practice to their maximum capabilities, working in partnership to provide accessible, high quality care to patients.

Thank you for the opportunity to share our views. We look forward to continuing to work with the committee to advance policies that improve care for Medicare beneficiaries.

United States House of Representatives
Committee on Ways and Means, Subcommittee on Health
Hearing on the President's and Other Bipartisan Proposals
to Reform Medicare
Tuesday, May 21, 2013

Mr. Chairman and Members of the Subcommittee:

I am Max Richtman, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare (NCPSSM), and I appreciate the opportunity to submit this statement for the record. With millions of members and supporters across America, the National Committee is a grassroots advocacy and education organization devoted to preserving, strengthening and promoting Social Security, Medicare and Medicaid. As you know, these programs are the foundation of financial and health security for older Americans. Today, I will address our concerns about proposals that would increase out-of-pocket costs for Medicare beneficiaries.

Medicare beneficiaries already have high out-of-pocket costs, and because over half of beneficiaries are living on incomes of $22,500 or less, they cannot afford to pay more. Premiums and cost sharing for Medicare Parts B and D already consume 26 percent of the average Social Security check. Many Medicare beneficiaries are paying for supplemental Medigap insurance to ensure some predictability of their health costs. And they are paying for services not covered by Medicare including most hearing aids, routine eye care and eye glasses, dental care and dentures, and foot care. Because of their lower average household budgets and higher average health care spending, families on Medicare spend 15 percent of their household budgets on health care, which is three times more than what non-Medicare households spend on health care.

Proposals in the President's Fiscal Year 2014 budget and various other deficit reduction plans would save money for the federal government by shifting costs to Medicare beneficiaries. Specific proposals in the President's budget that would increase costs for future beneficiaries include a $25 increase in the Part B deductible in 2017, 2019, and 2021 for new beneficiaries; a home health copayment for new beneficiaries beginning in 2017; and a Part B Premium surcharge for new beneficiaries who purchase so-called near first-dollar Medigap coverage. The surcharge would be equivalent to about 15 percent of the average Medigap premium (or about 30 percent of the Part B premium) for new beneficiaries who purchase Medigap policies with particularly low cost-sharing requirements, starting in 2017.

Supporters of proposals that shift costs to beneficiaries believe people will make wiser choices about using health care services, or will seek more high-value services, if they have to pay more of the cost. We oppose these proposals and agree with research which shows that these additional costs could lead many seniors to forego necessary care, which, in turn, could lead to more serious health conditions and higher costs. In addition, once a person seeks care, it is

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physicians and other health care providers who make the decisions about the care, tests and other services they receive.

The National Committee is also opposed to further increasing income-related premiums under Medicare Parts B and D. Medicare beneficiaries with annual incomes over $85,000 for individuals and $170,000 for couples are already paying higher income-related premiums. The President's budget proposes, beginning in 2017, to increase the amount of income-related premiums, and to maintain the income thresholds associated with income-related premiums until 25 percent of beneficiaries under Parts B and D are subject to these premiums. A study from the Kaiser Family Foundation found that this would affect individuals with incomes equivalent to $47,000 for an individual and $94,000 for a couple if fully implemented in 2014 – meaning it would reach many middle-income Americans.

Additional means testing would undermine the social insurance nature of Medicare and ultimately raise costs for middle and lower-income seniors who depend on it. If mean-testing results in Medicare becoming increasingly unfair to higher-income beneficiaries - who already pay more during their working years because there is no cap on the payroll tax for Medicare - they may opt out and purchase their own policy on the private market. The departure of higher-income beneficiaries, who tend to be younger and healthier, would increase overall costs and reduce public support for the program.

The President's budget includes numerous proposals that would strengthen Medicare's financing and improve the quality of care provided without adversely affecting beneficiaries. We support many of these proposals, including:

- Building on the Affordable Care Act (ACA). Savings in the ACA are slowing Medicare's per capita growth and have extended the solvency of the Medicare Part A Trust Fund. The ACA also includes provisions leading to changes in the way care is delivered and paid for that improve quality and reduce costs. We support efforts to expand these improvements, including better care coordination, reforms to fee-for-service payments, and enhanced support for primary care providers.

- Requiring Part D drug rebates and allowing the federal government to negotiate prescription drug prices. The Congressional Budget Office (CBO) has estimated savings of $141 billion over 10 years if drug manufacturers were required to provide rebates for drugs used by beneficiaries who are dually eligible for Medicare and Medicaid as they were required to do before passage of the Medicare Modernization Act.

- Improving initiatives to prevent, detect and recover improper payments, including fraud, waste and abuse.

Thank you again for this opportunity to submit our views on proposals to increase costs for Medicare beneficiaries, which we oppose. The combined impact of proposals to increase seniors' heath care costs would seriously erode the economic and health security of current and future older Americans.

United States House of Representatives
Committee on Ways and Means Subcommittee on Health
Hearing on the President's and Other Bipartisan Proposals to Reform Medicare

June 4, 2013

Mr. Chairman and Members of the Committee:

My name is Pamela Casper. I am a Medicare beneficiary, an advocate for persons with disabilities, and I previously worked as a registered nurse. Thank you for the opportunity to comment on the Medicare reform cost-sharing proposals that your committee is reviewing. As you consider possible cost-sharing changes to Medicare, it's vital that you ensure Medicare beneficiaries have access to affordable and appropriate health care!

I will be addressing the proposal to increase the Medicare Part B deductible. Medicare Part B covers physicians services, outpatient care, etc.

A significant increase in the Part B deductible will be especially detrimental for Medicare beneficiaries who don't have a Medicare supplemental policy and for those with low incomes who don't have Medicaid. If these populations are required to pay upfront costs beyond their means, they are likely to put off needed medical care. This could lead to more serious conditions that are more expensive to treat and result in poorer medical outcomes. Significantly increasing the Medicare Part B deductible will limit access to healthcare for these beneficiaries. Additionally, it may result in higher costs for individuals and the Medicare program.

In 2013, there are approximately 4.1 million Medicare beneficiaries who *do not* have Medicare supplemental policies (commonly referred to as Medigap" policies) ["Policy Options to Sustain Medicare for the Future" January 2013, page 136 http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8402-section-four.pdf] Individuals who have received Social Security Disability Insurance (SSDI) benefits for 24 months are eligible for Medicare. However, Federal law doesn't require insurance companies to sell Medigap policies to Medicare beneficiaries less than 65 years old. In some states, people under age 65 with disabilities can't buy a Medigap policy. Furthermore, companies that sell Medigap policies to persons under the age of 65 are allowed to charge those individuals more for the coverage. ["Medigap Policies For People Under Age 65 With A Disability or End-Stage Renal Disease (ESRD)", page Last Updated: May 7, 2012 www.medicare.gov/medigap/under65.asp]

Many low income Medicare beneficiaries can't afford to buy a Medigap policy. Particularly, SSDI beneficiaries such as myself. My income is currently $1,094 per month. I'm not eligible for Medicaid because my income is approximately 114% of the Federal Poverty Level (FPL).

I am very concerned about the recommendation by the National Commission on Fiscal Responsibility and Reform (Bowles-Simpson) to establish a single combined deductible of $550 for Medicare Part A (hospital) and Medicare Part B (physician and related services).
[www.ncpssm.org/PressRoom/NewsReleases/Release/ArticleID/1157/Hearing-on-the-President%E2%80%99s-and-Other-Bipartisan-Proposals-to-Reform-Medicare]

For individuals who have not used Medicare Part A, the single combined deductible results in raising the Part B deductible by more than $400.
This prohibitive up front cost will limit access to necessary health care for low income Medicare beneficiaries who don't have Medicaid or a Medigap policy.

It is important to keep in mind, that the majority of Medicare beneficiaries have low or moderate incomes. In 2012 the distribution of Medicare beneficiaries by income level was:

- 25% had incomes below $14,000
- 50% had incomes below $22,500

["Distribution of Medicare Beneficiaries by Income Level, 2012"; May 01, 2013; http://kff.org/medicare/slide/distribution-of-medicare-beneficiaries-by-income-level-2012]

The Medicare Part B deductible is $147 in 2013. Currently, Medicare beneficiaries whose incomes are below 100% of the FPL have assistance with the Part B deductible. Poor Medicare beneficiaries can't budget for a $550 Medicare deductible. The prohibitive upfront costs will make health care unaffordable for me and other low income Medicare beneficiaries who don't have Medicaid or a Medigap policy.

Thus, if a $550 single combined deductible is established, stronger beneficiary protections will be needed to ensure poor beneficiaries have access to affordable and appropriate health care. To achieve this, the Medicare Part B deductible would need to be subsidized similar to the "Extra Help" low income subsidy for Medicare Part D.

Thank you for the opportunity to comment on the proposal to increase the Medicare Part B deductible. When you consider possible cost-sharing changes to Medicare, it's vital that you ensure Medicare beneficiaries have access to affordable and appropriate health care!

Sincerely,
Pamela Casper

Committee on Ways and Means Subcommittee on Health
Partnership for Quality Home Healthcare
May 21, 2013

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Hearing on the President's and Other Bipartisan Proposals to Reform Medicare

May 21, 2013

Chairman Brady, Ranking Member McDermott, and distinguished Members of the House Ways and Means Subcommittee on Health, on behalf of the Partnership for Quality Home Healthcare ("Partnership"), I would like to thank you for the Committee's commitment to strengthening the Medicare program and for this opportunity to offer the following points and testimony:

- **The Partnership urges Congress to exercise caution in changing Medicare cost sharing rules and believes that the re-imposition of costs on clinically and financially vulnerable Medicare home health beneficiaries should be avoided in favor targeted program integrity reforms;**

- **Medicare home health beneficiaries are older, poorer and sicker than average beneficiaries and are less likely to have supplemental insurance, making them more vulnerable to directly bearing the costs associated with home health copayment and uniform cost sharing policies;**

- **Both a home health copayment and uniform cost sharing structure run the risk of dislocating seniors from their homes into higher-cost institutional settings, creating hardship for seniors and their families, for State Medicaid programs, and for taxpayers; and**

- **The Partnership urges Congress to review and consider the factors that led Congress to repealing the home health copayment in 1972, including the financial burden it imposed on seniors and the dislocation of many of them to more costly institutional settings.**

EXECUTIVE SUMMARY

The Partnership is a coalition of skilled home healthcare providers who are dedicated to developing innovative reforms to improve the program integrity, quality, and efficiency of the Medicare home health benefit. The Partnership believes any proposal that would re-impose out of pocket costs on Medicare home health beneficiaries is of concern and that savings should instead be achieved by enacting targeted program integrity reforms that effectively address the isolated instances of aberrant behavior that have occurred in the Medicare home health benefit.

Our concerns relate to proposals that would specifically impact seniors' access to home health care, as well as to broader proposals affecting the full scope of Medicare benefits, such as uniform cost sharing. The re-imposition of a home health copayment poses many risks to beneficiaries, providers and taxpayers alike, and the establishment of uniform cost sharing without adequate protections could

compel low-income seniors to fund as much as half the cost of home health episodes occurring early in the year. In brief, we are concerned that these changes would expose seniors to unsustainable out of pocket costs and lead to the dislocation of seniors from care in their homes to more costly settings.

For these reasons, the Partnership is concerned that proposals to re-impose a home health copay or establish uniform cost-sharing without adequate protections: (1) are problematic to the disproportionately poor Medicare beneficiaries who are homebound, who already have significant financial resources of their own at stake when it comes to the cost of their health care, and who would have difficulty absorbing new financial obligations; (2) are likely to once again cause seniors who today receive clinically advanced treatment in their homes to instead obtain that care in higher cost institutional settings; and (3) should be given very careful consideration in light of Congress' repeal of the home health copayment in 1972.

In order to fully assess this issue, the Partnership commissioned Avalere Health to determine the anticipated impact of the re-imposition of a home health copayment. We hope this analysis, which is discussed more fully below, will be of value to the Committee.

In sum, the Partnership urges the Subcommittee not to re-impose out of pocket costs on Medicare home health beneficiaries and to instead authorize targeted program integrity reforms that have already been proven effective in curtailing fraud and abuse. The Partnership believes such a targeted approach constitutes a fairer and more effective policy solution than the across-the-board re-imposition of out of pocket costs on all seniors nationwide. By delivering substantial savings and preventing further losses to fraud and abuse without harming senior citizens or the vast majority of providers who are honest and compliant, we respectfully submit that targeted program integrity reform would be in the best interest of seniors, caregivers, and taxpayers.

DISCUSSION

I. Demographic and Impact Analysis of a Home Health Copayment

In light of the findings of the Avalere Health analysis detailed below, the Partnership is concerned about the re-imposition of out of pocket costs on homebound Medicare beneficiaries, especially since these seniors are disproportionately older, poorer, and sicker than the Medicare beneficiary population as a whole.[1]

[1] The data used to assemble this submission come from Avalere Health's Analysis of Home Health Beneficiaries. The data were generated using the 2011 Medicare Current Beneficiary Survey (MCBS) Access to Care file, which includes the "always enrolled" Medicare population, or beneficiaries who were enrolled for the full calendar year.[1] To create a demographic profile of home health users who would be subject to a copayment, Avalere limited its analysis to home health users. Avalere excluded: Medicare Advantage Enrollees, Dual-eligible beneficiaries, beneficiaries residing in a facility, such as a nursing home, and beneficiaries reporting that they are enrolled in a supplemental insurance plan. As noted above, some supplemental insurance plans are limited to particular services or otherwise would not cover a home health co-pay.

A. Impact: Seniors' Clinical Complexity

Assuming a $150 per episode copayment, Avalere found that thirty eight percent of home health users who are not dual eligibles do not have supplemental insurance coverage and would therefore likely have to pay the full co-payment out of pocket. Seventy three percent of these home health users have incomes below 200% of the poverty line.

Not only are these individuals financially vulnerable to copays, they are sicker and more likely to be disabled than other Medicare beneficiaries. Eighty six percent of home health users who would pay the co-payment out of pocket have three or more chronic conditions, and twenty nine percent have disabilities severe enough to qualify for a nursing home level of care.

Per the table below, Medicare home health beneficiaries without supplemental insurance are older and in poorer health than the Medicare beneficiary population as a whole:

	Medicare Home Health Beneficiaries	All Medicare Beneficiaries
Over Age 85	25.5%	11.8%
3 or More Chronic Conditions	86.0%	69.8%
2 or more ADL Limitations	29.1%	4.8%
Requiring ADL Assistance	39.0%	9.0%

Indeed, Medicare home health beneficiaries without supplemental insurance are more likely to have five or more chronic conditions. Of home health users without supplemental insurance, about 15 percent have between 0 and 2 chronic conditions, just under 30 percent have 3 or 4 chronic conditions, and about 58 percent have 5 or more chronic conditions – whereas, of all Medicare beneficiaries, about 30 percent have between 0 and 2 chronic conditions, about 35 percent have 3 or 4 chronic conditions, and about 35 percent have 5 or more chronic conditions.

These seniors are also more likely to have a disability. Of all home health beneficiaries without supplemental insurance, nearly 40 percent require assistance with one or more Activity of Daily Living (ADL), such as bathing, dressing, transferring, using the toilet, eating, and continence. By contrast, fewer than 10 percent of all Medicare beneficiaries receive any ADL assistance.

As the Committee knows, people requiring assistance with two or more ADLs are considered in most states to have an "institutional level of need," meaning they are sufficiently disabled as to potentially need placement in a nursing home or other long-term care facility.[2] In light of these data, the services needed by Medicare home health beneficiaries is commonly recognized as due to their generally significantly poorer health rather the lack of a co-payment.

B. Impact: Seniors' Financial Vulnerability

[2] Kaye, Stephen, Charlene Harrington and Mitchell P. LaPlante. *Long-Term care: Who Gets It, Who Provides It, Who Pays, and How Much?* HEALTH AFFAIRS 29(1) 2010: 11- 21.

Assuming a $150 per episode copayment, Avalere Health found that thirty eight percent of home health users who are not dual eligibles do not have supplemental insurance coverage and would likely have to pay the full co-payment out of pocket. This group of home health users is predominantly lower-income – 73 percent are below 200 percent of the Federal Poverty Line (FPL), compared to 38 percent of all Medicare beneficiaries (dual eligibles are excluded from both groups).

New cost sharing obligations for home health care use would therefore consume a significant share of the annual income for a beneficiary at 150 percent of the FPL, after accounting for living expenses and premiums.

Consistent with these findings, other studies suggest that low-income beneficiaries often perceive co-payments to be a significant financial burden.[3] [4]

Many low-income beneficiaries are not enrolled in programs that would cover the co-payment, and even those with supplemental insurance might not be protected. In Medicaid, for example, more than half of eligible community-dwelling beneficiaries are not enrolled.[5] In Medicare, one third of eligible Medicare beneficiaries are not enrolled in the Qualified Medicare Beneficiary (QMB) program, which covers Medicare cost-sharing requirements.[6]

Also, because the Medicaid home health benefit differs from Medicare's skilled home health benefit, it is unlikely that states, facing financial pressures nationwide, will coordinate with a new Medicare cost sharing requirement and pay their share of this new cost, which could even further restrict seniors' access to services.

As Governors, including Governor Martin O'Malley (D-MD) and Governor Nathan Deal (R-GA) have pointed out, if patients cannot afford home health care because of a new copayment, those patients may need to stay in the hospital or nursing home, settings that cost far more than his or her home and which makes an individual who does not need to be there susceptible to additional complications. Furthermore, the result would impose significant new dollars in additional Medicaid costs onto states for such institutional care.

Even for those with supplemental insurance, in some cases supplemental coverage is limited to particular services such as dental care; even broader employer-sponsored insurance might not cover a new home health co-payment. The non-dual eligible home health users without supplemental coverage would likely be subject to the full co-payment; these beneficiaries are disproportionately low-income, in poor health, and living alone, putting them at risk of health decline. If beneficiaries with low

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[3] Ku, Leighton, Elaine Deschamps and Judi Hilman. *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program.* CENTER ON BUDGET AND POLICY PRIORITIES, November 2004.
[4] Individuals over 65 years old devote 4.1 percent of annual expenditures to car payments and 3 percent to apparel. *Consumer Expenditures in 2011.* BUREAU OF LABOR STATISTICS. U.S. DEPARTMENT OF LABOR. April 2013.
[5] Pezzin, Lilianna E. and Judith D. Kasper. *Medicaid Enrollment among Elderly Medicare Beneficiaries: Individual Determinants, Effects of State Policy, and Impact on Services Use.* HEALTH SERVICES RESEARCH 37(4)(2002)
[6] Haber, Susan G., Walter Adamache, Edith G. Walsh, Sonja Hoover and Anupa Bir. *Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs.* RTI, 2003.

income and/or in poor health forgo needed care, both adverse health events and inpatient costs would increase.

Finally and just as importantly, these seniors already have significant financial resources of their own at stake in their heath care, since they personally bear costs like housing, utilities, food, and laundry that taxpayers would bear if the seniors received treatment in facilities rather than in their own home.

C. Impact: Higher System Costs

Additionally, re-institution of repealed co-payments may result in higher costs to the system. Studies show that co-payment policies that reduce utilization of services (such as outpatient visits) can lead to higher inpatient costs.[7] Trivedi et al., in The *New England Journal of Medicine*, analyzed a nationally representative sample of elderly Medicare managed care enrollees[8] and found that Medicare Advantage plans that raised co-payments for outpatient care had 19.8 fewer annual outpatient visits per 100 enrollees. However, those plans saw 2.2 more annual hospital admissions and 13.4 more inpatient days per 100 enrollees. Importantly, the authors estimate that the total cost of the additional hospitalizations exceeded the savings from the decrease in outpatient visits.

Research also shows that the adverse effects of co-payments are greater for people with chronic disease and/or low incomes. For example, a study of the impact of co-payments in Utah's Medicaid program found that individuals in poor health suffered adverse effects, especially if they were low income.[9] Between 2001 and 2002, Utah instituted co-payments for most services. Co-payments were modest: $2 per physician/outpatient hospital visit or prescription. Nevertheless, 39 percent of beneficiaries stated that the co-payments caused serious financial difficulties.

Similarly, an analysis of California's public retirement system found that when drug and office co-payments were raised, beneficiaries with the greatest chronic disease comorbidities (Charlson Index 4 or more) experienced increased inpatient costs, which exceeded savings from decreased physician and drug use by 78 percent.[10] If beneficiaries with low income and/or in poor health forgo needed care, both adverse health events and inpatient costs could increase

Finally, in their analysis of the President's copayment proposal, former CBO Director Douglas Holtz Eakin and health economist Robert Book wrote: "One might think the goal is to save tax dollars by replacing government spending with patient spending. But that's not the case, as the average spending in a home health episode is $3,000, so the co-payment would represent only about 3 percent of total spending….In other words, the President's budget doesn't target the 3 percent that would become the patient's copayment; it's targeting the 97 percent that won't be spent if patients can't, or won't, come up with the copayment." The authors also concluded that a new copayment may result in

[7] Trivedi, Amal N., Husein Moloo and Vincent Mor. *Increased Ambulatory Care Copayments and Increased Hospitalization among the Elderly.* NEW ENGLAND JOURNAL OF MEDICINE 362 (2010): 320-328.
[8] *Id*.
[9] *See supra* note 3.
[10] *Id.*

the deterioration of patients' clinical conditions, causing many of them to "end up requiring hospital care to fix a problem that could have been prevented in the first place."[11]

II. Home Health Copayments Were Tried – and Repealed

The Medicare home health benefit originally included a 20 percent copayment to seniors who accessed it. In 1972, Congress passed an amendment repealing coinsurance payments for home health services citing copayments as a "financial burden to many elderly patients living on marginal incomes." Congress also recognized the inefficiencies associated with copayments for home health services, which often caused patients to forgo physician prescribed home health to avoid costs and instead wound up receiving care in more expensive institutional settings.

The cost of providing skilled home health services was then – and remains now –significantly lower than treatment provided in traditional care settings. For instance, the average Medicare payment for a hospital stay of a few days is $10,000. By contrast, a typical home health episode, which spans 60 days, costs approximately $3,000.

For all the same reasons that drove Congress to eliminate the home health copayment in 1972 – including its financial burden on seniors and the adverse cost consequences that resulted when care shifted to more expensive settings – Congress should avoid re-instituting a policy that was affirmatively repealed.

III. A Better Alternative: Program Integrity Reform

If one goal of a copayment is to curb utilization in Medicare's home health benefit and/or reduce instances of fraud and abuse in the sector, re-imposing an out of pocket cost on innocent seniors would seem to be a poor solution. Instead, we urge Congress to instead pass targeted reforms that would strengthen the integrity of the Medicare program.

We note that such an approach has already been proven effective in curtailing fraud and abuse: Since 2010, CMS has been using a payment safeguard that the home health community proposed to prevent payment of aberrant outlier claims. This single reform is already on track to save more than $11 billion over the next decade – all without harming innocent seniors or the vast majority of providers who are honest and compliant.

Similar safeguards can be built to prevent payment of aberrant excessive and low-utilization payment adjustment (LUPA), which would prove similarly targeted and effective. Our preliminary scoring estimates suggest that these two payment safeguards can generate more than $15 billion over

[11] Robert A. Book and Douglas Holtz-Eakin, *Home Health Medicare Co-Pay: A Study In Unintended Consequences,* FORBES (April 19, 2013) available at http://www.forbes.com/sites/aroy/2013/04/19/home-health-medicare-co-pay-a-study-in-unintended-consequences/

10 years, far surpassing the $700 million in savings projected in the President's budget for the re-institution of the repealed home health copayment.

CONCLUSION

For all the reasons stated above, the Partnership urges the Committee not to resurrect the failed and repealed copayment policy. Furthermore, it urges the Committee to not to establish uniform cost sharing that impose new costs on already economically and clinically compromised seniors. Instead, the Partnership believes targeted program integrity reform constitutes a fairer and more effective policy solution than the across-the-board re-imposition of out of pocket costs on all seniors nationwide.

By delivering substantial savings and preventing further losses to fraud and abuse without harming innocent senior citizens or the vast majority of providers who are honest and compliant, we respectfully submit that targeted program integrity reform would be in the best interest of seniors, caregivers, and taxpayers.

Respectfully Submitted,

Eric Berger
CEO, Partnership for Quality Home Healthcare

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June 4, 2013

The Honorable Kevin Brady
Chairman
House Ways & Means Health Subcommittee
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
House Ways & Means Health Subcommittee
1102 Longworth House Office Building
Washington, DC 20515

submitted electronically

Dear Representatives Brady and McDermott and Members of the Subcommittee:

The Partnership for the Future of Medicare (PFM) submits for the record the following statement on comprehensive Medicare reform as part of the Committee's May 21, 2013, hearing on Medicare proposals that modify beneficiary cost-sharing. We would like to thank the Committee for holding this series of hearings to explore bi-partisan Medicare reform proposals, and we appreciate the opportunity to share our thoughts on how to move the Medicare program forward to encourage high-quality, cost-effective care. We would be happy to discuss our ideas with you or come before the Committee to do so.

PFM is a bi-partisan organization focused on ensuring the long-term security of Medicare. By examining key challenges, highlighting best practices and evaluating innovations in Medicare health care delivery, we seek to foster innovation and support approaches that positively shape the future of Medicare.

We thank the Committee for holding this important hearing to examine Medicare proposals included in the President's 2014 budget, as well as those put forward by other stakeholders. We are encouraged by the number of bi-partisan Medicare reform proposals released in recent months and are pleased that Medicare reform has risen to the top of our national health care conversation.

As you know, as it stands today, Medicare is unsustainable. The Medicare population has transformed dramatically since 1965, yet the program has not adapted to these new developments – changes that include an aging population and a rapidly rising chronic disease rate. No matter how we shift costs or cut reimbursement rates, nothing will change the fact that the Medicare program is going to see millions of new beneficiaries, which equates to program costs growing exponentially over the coming decades. High costs in the health care system heavily outweigh the quality of services provided, and these expenses continue to grow. Our health care system is changing and requires us to rethink how we deliver care. The idea of focusing on value-based rather than volume-based health care has garnered strong bi-partisan support and has the potential to set the stage for an innovative, high-quality Medicare system.

Our current Medicare delivery system is fundamentally flawed – it pays for volume, rather than high-quality care. Medicare as we know it today is built on a fee-for-service (FFS) system, in which Medicare pays doctors individual fees for each service they perform – such as diagnostic tests and procedures or exams. By paying providers for each service they deliver, the program provides financial incentives to physicians to perform more tests and procedures, or to take on more office visits, because each service is paid for separately. Though Medicare beneficiaries have some input on their health care coverage, 75 percent of beneficiaries currently receive at least part of their coverage through original FFS Medicare. It's clear that there is great need for coordinated care that rewards quality, rather than quantity. We believe that we must move away from the FFS model to facilitate better, high-quality care.

PFM believes that the FFS model should be phased out over the next five to seven years. Our entire system is currently built around FFS, and updating the Medicare delivery structure will pave the way for innovative, high-quality care. Moving away from FFS will not be easy and will not happen overnight, but advancing these objectives will pave the way for a more efficient and effective Medicare system. To move away from FFS, we recommend that policymakers look at three specific categories when considering changes to the current Medicare system: payments, incentives and scaling.

Payments. The way Medicare pays providers needs to be reformed to guarantee that each beneficiary receives the best care. FFS essentially operates as a one-size-fits-all model, and it is a challenge for providers to give each beneficiary individualized and effective treatment. To resolve this problem, we must move away from our current FFS model to pave the way for more care coordination and patient engagement. Because we know transitioning away from FFS will take time, we recommend transitional steps to help improve payments and, ultimately, quality of care, such as updating and enhancing the physician fee schedule and repealing and replacing the sustainable growth rate (SGR).

Incentives. To support any adjustments in physician payments, it is vital that we incentivize efforts that provide high-quality and cost-effective care to beneficiaries. Using patient engagement metrics, enhancing transparency and use of public data and expanding existing rating, bonus and incentive programs are some types of incentive tactics we encourage policymakers to adopt in any plan for Medicare overhaul. These types of incentive programs are vital to shift away from FFS toward more value-based care.

Scaling. Despite the significant barriers the Medicare program faces due to the longstanding structure of traditional FFS, there have been significant efforts within the private and public sector to develop and execute programs to test potential delivery and payment models. To expand successful integrated care models, we must support information-sharing and data transfer to share best practices. We encourage policymakers to implement policy options that provide comprehensive care management access to all Medicare beneficiaries, launch targeted demonstration pilots to specific subsets of the population, such as those with chronic disease, and retest successful programs on a larger scale. We believe encouraging scaling of successful payment models is the key to revolutionizing the Medicare program.

Once again, PFM is encouraged by the widespread bi-partisan agreement that we must take action and reform Medicare. Though moving the Medicare program away from FFS will be difficult, we are confident that by working together, we can move the system forward to guarantee better and more efficient care for all.

Thank you again for the opportunity to submit this statement for the record. Questions may be addressed to Douglas Holtz-Eakin at doug@futureofmedicare.org or 202-559-6420 or Kenneth Thorpe at ken@futureofmedicare.org.

Sincerely,

/s/

Douglas Holtz-Eakin, Ph.D.
Co-Chair
Partnership for the Future of Medicare

/s/

Kenneth Thorpe, Ph.D.
Co-Chair
Partnership for the Future of Medicare

May 22, 2013

To: Chair, House Ways and Means Health Committee:
From: Robert N. Young
Ref. Hearing on President's FY2014 Budget
CC: Congressman Eric Cantor
Subcommittee on Health Committee Members

Dear Chairman Brady,

Presidents come and go, as do those they place in high positions of power and responsibility, such as HHS Secretaries, and Attorney Generals; while Congress is elected from their states and districts. Our President is compared to Abraham Lincoln, but this must not include Health Care which 20 years ago Attorney General Reno said fraud in it was "the number two crime problem in America, second only to violent crime". A review of Department of Justice Fraud Statistics for over the past 27 years since the False Claims Act was amended, and Congressional testimony show Health Care Fraud to now be the number one crime problem. The Justice Department, HHS and CMS are doing little to stop it from driving our Nation into un-survivable deficits as our health care system has the highest cost in the World while producing poor results.

On February 25, 2010 at the White House Summit on Healthcare Reform, Senator Tom Coburn, referring to waste, fraud, and abuse said "And the facts we know is one out of every three dollars that gets spent doesn't help anybody get well and doesn't prevent anybody from getting sick." One out of every $3 dollars amounts to 6% of our GDP while health care spending now is around 20% of GDP. The extent of the problem has been known since a late Carter Administration GAO study **"Fraud in Government Programs: How Extensive Is It? How Can It Be Controlled?"** http://archive.gao.gov/f0102/115135.pdf Increasing costs to recipients only fuels waste, fraud and abuse which provides no care to anyone! We spend over $2.7 trillion of our GDP on health care, a third of which is $900 billion, the amount Sen. Coburn in a Wall Street Journal video entitled: Cut from Medicare to Reduce Deficit on May 27, 2011 said a $900 billion reduction every year for 10 years is needed to regain solvency. Is the amount the Presidents budget projects to increase Medicare recipient's costs around $1 trillion a year?

Senator Coburn testified at the Summit: "And when you look at, when it's studied, if you look at what Malcolm Sparrow from Harvard says, he says 20 percent of the cost of federal government health care is fraud. That's his number." Senator Coburn, a practicing Family Physician went on to say "But I just went through last night, if you add up what Thomson Reuters, which looked at all the studies that have been done and combined them in, they say between $625 billion and $850 billion a year of health care dollars are wasted. When taxpayer funding for Medicare and Medicaid is wasted or stolen by criminals, it means the cost of the program goes up and so does the pressure to cut back on benefits for the rest of us." President Obama ended his discussion by saying "Well, Tom, I appreciate what you said. I just want to make this quick point: Every good idea that we've heard about reducing fraud and abuse in the Medicare and Medicaid system, we've adopted in our legislation. So that's an example of where we agree. We want to eliminate fraud and abuse within the government systems". When will fraud elimination start and what "good ideas" are in the ACA? Or is the budget plans just increasing costs to Medicare recipients' like me, to subsidize fraud in Medicaid programs, as millions are added in a few months and as Medicare recipients increase 11 million a day? Past experience shows health care fraud grows with entitlements, so where will this end? Or will it end only in bankruptcy?

While campaigning in 2008, Presidential candidate Obama promised he "Would empower the HHS Inspector General to fight fraud, implement anti-fraud measures in CMS contracting, expand the scope of Medicare and Medicaid audits, strengthen the federal False Claims Act, encourage states to go after fraud, and increase funding for Justice Department prosecutors and FBI agents to fight fraud". At a September, 2007 rally he said "We should also stop spending $15 billion a year in overpayments to insurance companies for Medicare, go after tens of billions of dollars in Medicare and Medicaid fraud." Thousands of False Claim suits piled up over 10 years, not acted on when False Claims Act suits only require 60 days for Justice Department to intervene or decline. The history of Attorney General Holder in fraud matters under Clinton and Obama is strewn with broken promises. http://www.cov.com/files/Publication/fe370a33-8950-48aa-a7eb-33acc82e27af/Presentation/PublicationAttachment/b127b566-5725-435e-821f-3b462ee48282/oid6386.pdf He recently issued press releases on multi-city sweeps, which uses CMS, HHS and state employees while hundreds of False Claims Act cases projecting much larger amounts for recoveries are sealed in Federal Courts for up to 10 years, hidden away and ignored in the Justice system. The few billions recovered shown on the Justice.gov website http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Statistics.pdf. doesn't show the principle HHS spent, or show half are from Medicaid pharmaceutical fraud, the highest recovery segment, about a 2% recovery rate. Health care fraud is very well known for over 35 years to "cost" tens of billions of dollars every year, and the reason for not stopping fraud has always been "we don't have enough people and funding". If Medicare recipient costs are increased how much will go to "fraud fighters" who can't find much fraud in this highly computerized World.

Candidate Obama pointed out "The pharmaceutical industry wrote into the prescription drug plan that Medicare could not negotiate with drug companies. And you know what; the chairman of the committee, [Billy Tauzin, a longtime Democratic member of Congress who switched party affiliations after Republicans gained control of Congress in 1994 to maintain his influence and rose to Chairman of the House Committee on Energy & Commerce.] went to work for the pharmaceutical industry making $2 million a year." He continued "Imagine that. That's an example of the same old game playing in Washington. You know, I don't want to learn how to play the game better, I want to put an end to the game playing." I don't like his new game!

On March 5, 2010 President Obama hosted a Health Care discussion group at the White House where he announced several group attendees had promised to work for compromise with him. Among these were, the American Medical Association, the Health Insurance Industry and the Pharmaceutical Research Manufacturing Association representing only brand named drug manufacturers. At the time the "deal" with PhRMA's President Billy Tauzin was mentioned but not published until July 7, 2010, for $80 billion, over 10 years.

Candidate Obama pledged to rescind the Re-Importation Act which makes American brand drug prices twice those of most socialized medicine countries and the Federal Supply System. Prices available to U.S. citizens are twice as much! Why did the President change his principles? In opposing rebates in Medicare Part D he appeased brand drug manufactures to support ACA knowing he could have reduced Medicare drug costs by more, $80 billion for recipients and $19 for Medicare over 10 years. The largest segment of the deal [42%] was to be a $34 billion rebate increase in the Medicaid Drug rebates, from 15.1% to 23.1%. As this deal was being done, then Kaiser News reporter Christopher Weaver reported 2009 Medicaid rebate percentages averaged 38.5%, making the 23.1% deal a decrease of 15.4%, $15 billion over 10 years of the ACA, But soon most brand drugs will be generic, replaced by extremely costly brand only Biologics that the deal shows are projected to save $9 billion from Follow-on Biologics? The only positive

feature was a $25 billion decrease in the Medicaid "donut hole" that currently doesn't effect many: and since Biologics are now a third all prescription drug costs, projected to increase by 67% by the end of 2015 no commercial insurance plan or Medicare will be able to cover them, while these are also half the price in socialized health care countries and generic versions exist.

Medicare drug plans started in 2006, switched "poor" Medicaid Seniors whose drug use was 66% of Medicaid programs drug costs, from Medicaid to Medicare Part D. State Medicaid drug costs only dropped 31% from $43 billion to $28 billion Poor seniors, still poor and unable to pay, continued to received drugs free under Medicare which paid higher prices with no public rebates as our President agreed none would be imposed for 10 years. But Medicaid rebates as a percentage of funds spent didn't decline; they rose from 27.1% in 2005 to 37.7% in 2006. In 2011 the last year reported, averaged 45.5%. Medicaid and Medicare brand drug costs never decreased while Medicaid rebates increasing is impossible to explain; especially when cheap generics have risen to be over 80% of the prescriptions with a small rebate of 11.1% rebate rate. This shows brand drugs are being over prescribed, over dispensed and are over priced!

The past 23 years Medicaid drug prices and rebates have been held secret while Medicare recipients know all socialized Medicine countries pay much less, most half as much. "Donut hole" rules are meant only to prevent Medicare recipients from becoming poor and eligible for Medicaid lower prices. HHS OIG oei-03-10-00320 report of August 2011 showed taxpayers pay more for their drugs under Medicare than they do for Medicaid because Medicaid rebates are higher while Medicaid only has hidden PBM rebates. The only reports of rebates are in Medicaid Financial Managements reports which seem to have stopped now, making it impossible to find out how much was paid in rebate amounts, while government and the VA prices have 50% to over 60% discounts. So cash customers, privately insured ones and Medicare recipients are to pay more to subsidize Medicaid recipients, including Biologics costing twice more than other countries, and will double in price soon: so Medicaid can get higher kick backs on Biologics?

This summer will be hot in D.C. as leaders argue about how to reduce our deficits. Nobody has mentioned "the elephant fraud in the room", or if or when they will "eliminate fraud in government". The only discussions are how much to increase costs to seniors who elected officials must believe are the most gullible. Must we wait until 2014 when the results of the PPACA will be too well known, perhaps too late? Can Medicaid or Medicare or our economy continue without major reductions in waste, fraud and abuse caused by providers who Congress and the President want to increase payments to, by increasing Medicare recipient costs? The Justice Department Fraud records show no case details but information on settled cases are found at TAF.org [Taxpayers Against Fraud]. Laboratories, hospitals, nursing homes, physicians, and drug manufacturers account for 80% of all False Claims Act HHS recoveries. These only show Qui Tam cases which were intervened in, or settled most usually as no information is ever provided on the majority of Qui Tam cases. Can Medicare, Medicaid or our economy continue without major reductions in waste, fraud and abuse; caused by some providers; who Congress and the President want to increase payments, by increasing Medicare recipient costs? These Tin cans have been kicked down the road too long; and "lock Boxes", even this empty one, can't be much longer, without many Medicare recipients becoming poor and eligible for Medicaid too.

The Medicaid Drug Rebate chart below from the Medicaid Financial Management reports shows Medicaid drug spend and rebate percentages, from its' start in 1991 through 2011 at a minimum brand rebate of 15.1% and "extra rebates that show were collected only as Medicare Part D was starting.

Year	Medicaid FMR Drug Spend	Medicaid FMR CMS rebates	Medicaid FMR State "sidebar Rebates	Total CMS and State "sidebar" rebates	Total Rebate %
1991	$ 5,622,507,455	$ 113,434,555	$ -	$ 113,434,555	2.0%
1992	$ 7,120,988,280	$ 900,252,297	$ -	$ 900,252,297	12.6%
1993	$ 8,317,432,427	$ 1,375,672,255	$ 11,105,720	$ 1,386,777,975	16.7%
1994	$ 9,257,334,150	$ 1,699,669,808	$ 20,747,062	$ 1,720,416,870	18.6%
1995	$ 9,994,406,563	$ 1,703,122,819	$ 17,305,221	$ 1,720,428,040	17.2%
1996	$ 11,048,243,053	$ 1,911,703,307	$ 23,115,137	$ 1,934,818,444	17.5%
1997	$ 12,383,834,374	$ 2,164,840,801	$ 23,292,403	$ 2,188,133,204	17.7%
1998	$ 14,142,303,810	$ 2,415,198,263	$ 25,906,216	$ 2,441,104,479	17.3%
1999	$ 17,047,331,170	$ 3,260,442,474	$ 37,272,150	$ 3,297,714,624	19.3%
2000	$ 20,543,807,301	$ 3,758,307,497	$ 107,518,404	$ 3,865,825,901	18.8%
2001	$ 24,656,812,921	$ 4,726,543,516	$ 107,711,713	$ 4,834,255,229	19.6%
2002	$ 29,339,050,970	$ 5,613,257,675	$ 144,709,509	$ 5,757,967,184	19.6%
2003	$ 33,912,159,591	$ 6,837,717,863	$ 217,360,888	$ 7,055,078,751	20.8%
2004	$ 40,065,314,592	$ 8,801,203,598	$ 376,891,977	$ 9,178,095,575	22.9%
2005	$ 43,077,457,835	$ 11,102,151,403	$ 588,035,905	$ 11,690,187,308	27.1%
2006	$ 28,220,039,444	$ 10,022,745,838	$ 683,035,330	$ 10,705,781,168	37.9%
2007	$ 22,550,887,846	$ 6,348,804,744	$ 434,473,369	$ 6,783,278,113	30.1%
2008	$ 23,576,377,912	$ 7,498,962,804	$ 396,766,130	$ 7,895,728,934	33.5%
2009	$ 25,321,340,237	$ 8,773,712,466	$ 324,490,139	$ 9,098,202,605	35.9%
2010	$ 27,301,461,287	$ 10,393,298,036	$ 332,819,194	$ 10,726,117,230	39.3%
2011	$ 29,793,533,030	$ 13,230,809,600	$ 330,899,767	$ 13,561,709,367	45.5%
TOTAL/AVG.	$ 434,697,679,346	$112,651,851,619	$4,203,456,234	$ 116,855,307,853	24.2%

Shannon Dwyer
7358 W Kiowa Ln
Palos Heights, IL 60463
708-609-6385
shannonfagan@yahoo.com

Hearing on the President's and Other Bipartisan Entitlement Reform Proposals

I am asking that members consider supporting the Social Security Fairness Act of 2013 (H.R. 1795, also SB 896). There are many retirees who are receiving or are going to receive small pensions and are penalized for that in their social security benefits even though they fully paid into the program. These are fireman, police officers, teachers and other local government workers - they support our communities and deserve a fair retirement. This bi-partisan bill has been referred to the Ways and Means Committee – please consider moving the bill forward for a vote.

St.JosephHealth

Santa Rosa Memorial • Petaluma Valley

May 20, 2013

The Honorable Dave Camp, Chairman
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

The Honorable Fred Upton, Chairman
Committee on Energy Commerce
United States House of Representatives
Washington, D.C. 20515

RE: SGR Repeal and Reform Proposal: Medicare Payment Locality Update Needed in California

Dear Chairman Camp and Upton:

St. Joseph Health - Sonoma County, representing Santa Rosa Memorial and Petaluma Valley Hospitals, applauds your efforts to resolve the problems plaguing the Medicare payment program for physicians and urges you to include an update of the California Medicare payment localities in the Medicare SGR reform legislation. These Medicare payment localities are outdated and have created serious problems with access to care in Sonoma County.

The long outdated geographic locality designations used in the current payment formula for physicians designates 14 counties, including some as large as San Diego, Monterey, Sacramento and Sonoma, as "rural", thereby reducing payments and ignoring demographic and practice cost increases. The geographic regions used by Medicare for hospitals are updated regularly so that hospital reimbursement accurately reflects local costs to deliver care. Unfortunately, the physician regions have not been updated in 15 years. As hospitals and physicians work together to provide care in their local communities, it is only fair that they receive accurate payment for the services they provide.

Physicians practicing in these misclassified regions are paid as much as 14% below what Medicare would pay if they were in a correctly classified region. In Sonoma County, this misclassification equates to an underpayment to doctors of approximately $3,750,000 per year.

The root of the problem is that Medicare still designates Sonoma County as rural, even though the county is increasingly urbanized, with almost half a million residents. Urbanization has increased the cost of providing medical care, yet our physicians are still reimbursed at the old "rural" rates.

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St.JosephHealth

Santa Rosa Memorial • Petaluma Valley

This disconnect between costs and reimbursements has greatly affected access to care for Medicare patients in Sonoma County. A recent survey conducted by SCMA found that 27% of local physicians planned to limit or eliminate Medicare from their practices, and that nearly half planned to move or retire over the next five years. More than half cited low reimbursements and high costs as the main impetus for moving or retiring. In addition, local practices have encountered chronic difficulties in recruiting new physicians. Again, the most often cited reasons are low reimbursements and high costs. This poses a serious challenge for patients trying to access the services they need as physicians are not available to care for our patients needs. As a health provider this lack of access to care is a great concern to Santa Rosa Memorial and Petaluma Valley Hospitals.

St. Joseph Health – Sonoma County supports the solution proposed by Representatives Darrel Issa and Sam Farr to redistribute physician payments within California in a way that would have no fiscal impact on the federal government. Their plan is a California financed solution to a California problem. We acknowledge that the outdated Medicare payment localities are a national problem that needs reform, but we urge you to start by addressing the most pressing concerns in California where the payment discrepancies are the largest.

We urge your support for this important effort to address more equitable payments for physicians in California and preserving access to care for all Californians.

Sincerely,

Todd Salvas
President

cc: The Honorable Mike Thompson, United States House of Representatives
The Honorable Jared Huffman, United States House of Representatives
Ronald R. DiLuigi, V.P. Advocacy & Government Relations, St. Joseph Health

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STATEMENT SUBMITTED BY
RACHEL HAMMON, EXECUTIVE DIRECTOR,
TEXAS ASSOCIATION FOR HOME CARE & HOSPICE
TO THE
HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
MAY 21, 2013

The Texas Association for Home Care and Hospice ("TAHC&H") respectfully submits the following written testimony for consideration by the U.S. House of Representatives Ways and Means, Subcommittee on Health hearing to consider proposals to reform Medicare.

TAHC&H represents over 1,300 licensed home and community supports services agencies across Texas that provide both long-term care and acute care services to seniors and patients with disabilities.

Our members fully understand the importance of employing sustainable solutions to the nation's Medicare spending. Home health plays a significant role in reducing overall costs to the health care system through preventing re-hospitalizations and supporting doctor/patient plans of care. As the Committee considers proposals to reduce Medicare spending please take into account the potentially devastating consequences of proposals that limit access to home health and hospice.

According to a recent report by the American Medical Association (AMA), "Careful use of appropriate home care services can prevent unnecessary re-hospitalizations, emergency department visits and poorer than expected health outcomes". As MedPAC asserts, preventable readmissions cost Medicare upwards of $12 billion a year. Home care is critical to physician objectives and alternative payment models that incentivize reductions in unnecessary hospitalizations and that utilize best practices to improve health outcomes.

We respectfully submit that the Committee and Congress oppose any copay proposal for Medicare home health and hospice services. A copayment will have the most devastating consequences on some of Medicare's most vulnerable patients. Congress instituted a copayment in the past for home health and it was overturned in 1972 after Congress realized the negative impact this had on patients and the healthcare system. Instituting another copayment now will have the same result: to drain the resources that seniors and people with disabilities need to continue living independently in their homes.

Recipients of home health and hospice already participate in significant cost-sharing with Medicare. They do this by paying for their own housing, food, utilities and in most cases by relying heavily on the support of family and friends, providing billions of dollars in savings in the form of uncompensated care to U.S. taxpayers. Because of these vast financial contributions we should promote the use of home health services. The alternative to home health is institutional care – nursing facilities and hospitals – where costs run up to three times more per day.

3737 Executive Center Drive, Ste. 268, Austin, Texas 78731 ★ (512) 338-9293 ★ fax (512) 338-9496 ★ www.tahch.org

Lastly, it is important to recognize that home care has already sustained damaging cuts in the form of reduced reimbursement rates and stiff regulations. Since 2009 when home care was a $17 billion industry, our providers have received disproportionate cuts to the tune of $77 billion (including $39.7 billion in the PPACA) to take effect over the subsequent10 year period. It has been very damaging to home health agencies and their patients; about 50 percent of agencies will be paid less than their costs by Medicare.

As you review proposals to reduce spending in the Medicare program in Tuesday's hearing, we urge you to consider how the use of home care and hospice can save the system money by keeping patients at home, contributing to quality-driven and cost-effective care. Thank you for the opportunity to participate in the process and please do not hesitate to contact me with any questions you may have.

Sincerely,

Rachel Hammon RN

Rachel Hammon, R.N.
Executive Director

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Written Comments of Stephen W. Still on behalf of Torchmark Corporation submitted to the House Committee on Ways and Means Subcommittee on Health addressing the Subcommittee's hearing May 21, 2013 "On the President's and Other Bipartisan Proposals to Reform Medicare"

These comments are submitted by Stephen W. Still, a shareholder in the law firm of Maynard Cooper & Gale, PC, on behalf of Torchmark Corporation to the House Ways and Means homepage before the deadline of June 4, 2013. Through its insurance subsidiaries, Torchmark is among the largest writers of Medicare supplement insurance (Medigap). Torchmark is a member of the Coalition to Promote Choice for Seniors, which represents the vast majority of Medigap insurers. Torchmark has previously submitted written comments to the Committee in connection with its February 26, 2013 hearing, a copy of which is included herewith, and incorporated by reference.

The Committee and Congress are currently hearing testimony and considering proposals that would have the effect of imposing a surcharge on Medigap insurance, or dramatically restricting the benefits covered by Medigap insurance. Such policy proposals are premised upon the misleading assumption that Medigap insurance leads to significant overutilization of the Medicare program. Torchmark, the Coalition mentioned above, and many other witnesses have testified and submitted comments to the Committee, Secretary Sebelius and to other interested parties that persistently and convincingly refute this assumption.

The assumption that Medigap insurance leads to significant overutilization of the Medicare program is completely unsubstantiated by any study or analysis of the effects of Medigap insurance on the utilization and costs incurred by the Medicare program. In fact, in a December 2012 letter to Secretary Sebelius, the National Association of Insurance Commissions (NAIC) reported that it "was unable to find evidence in peer-reviewed studies or managed care practices to support the introduction of nominal cost sharing designed to encourage the use of appropriate physician services" and that it "recommends against imposing nominal cost sharing on Plans C and F." This report has been entered into the records of this Committee by Representative McDermott, and notably, on Tuesday, May 28, 2013, Secretary Sebelius accepted the NAIC's recommendation.

To support further our position that the overutilization assumption is unfounded and as an example, we need look no further than the testimony submitted by Joseph R. Antos at the May 21, 2013 hearing. In the last sentence of the third full paragraph on page 2 of his testimony, Mr. Antos makes the following assertion; "It (Medigap) also reduces the beneficiary's awareness of the cost of their care, which leads to higher use of services and higher program spending than would otherwise be the case." While Mr. Antos's testimony appears to be well documented on major points of significance, as it includes a total of 7 footnotes for other

Written Comments of Stephen W. Still on behalf of Torchmark Corporation submitted to the House Committee on Ways and Means Subcommittee on Health addressing the Subcommittee's hearing May 21, 2013 "On the President's and Other Bipartisan Proposals to Reform Medicare"

various points, Mr. Antos's assumption quoted above is void of any documentation to this point and this statement is not footnoted in any way.

It is of critical importance that the Committee and the Congress understand that this contention is not supported or documented in any way, because what appears to be the driving force for policy changes that would impose a surcharge or drastically alter Medigap benefits and coverage is premised upon this inaccurate assumption; drastic policy change cannot be based on an inaccurate premise!

Any policy/legislative changes intended to discourage the use of Medigap insurance (through a surcharge or changes in benefits coverage) could essentially have
a chilling effect on seniors seeking physician-advised, medically necessary care.

For evidence, I need look no further than my own parents. Now in their mid-eighties, they paid their Medicare premiums, and Medigap premiums, for years with little utilization whatsoever of the Medicare program. Then, in his mid-seventies, my father required immediate heart valve replacement and by-pass surgery. Had my father not had this surgery, his cardiologist estimated he would have lived for only six months.

At the end of 2011, my mother fell and broke her hip. She required immediate hip surgery. Had she not had the surgery, she would have been an invalid and bed-ridden.

Did my parents over utilize the Medicare program? I think not! They appropriately utilized the Medicare program to avoid certain death and permanent disability.

Please keep in mind that older people, Medicare eligible seniors, do use the healthcare system more than younger people.[1] That is only common sense and, again, my parents provide good examples.

As Congressman Michael Burgess of Texas said so well at the Energy and Commerce Health Subcommittee on April 11, 2013, "I guess I'm having a hard time understanding – it seems like if someone buys a supplemental insurance policy as they enter into Medicare, they are doing the responsible thing by putting some of their own dollars into their future health care by covering against what would be excessive out-of-pocket costs if they get sick. So they are, it looks to me from a physician's standpoint, doing the prudent thing... but it looks to me like the

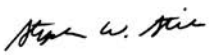
[1] "The Concentration of U.S. Health Care Spending," NIHCM Foundation Data Brief (July 2012); as discussed in the America's Health Insurance Plans "Myths & Facts" September 19, 2012 report.

Written Comments of Stephen W. Still on behalf of Torchmark Corporation submitted to the House Committee on Ways and Means Subcommittee on Health addressing the Subcommittee's hearing May 21, 2013 "On the President's and Other Bipartisan Proposals to Reform Medicare"

patient is doing the prudent thing by doing that…but you seem to articulate a different opinion."

We support Congress's effort to reform the Medicare program in a meaningful and effective manner. Medigap insurers have absolutely nothing to do with the Medicare approved costs that are imposed by the program; providers and the Medicare program make those determinations. Please don't throw the baby (Medigap insurance) out with the bathwater!

Sincerely,



Stephen W. Still

This submission has been prepared on behalf of
United American Insurance Company, an affiliate of Torchmark Corporation
3700 S Stonebridge Drive
McKinney, Texas 75070
(972) 569-4000

United American Insurance Company is the largest writer of Medicare Supplement insurance among Torchmark Corporation's affiliate companies. United American began selling individual Medicare Supplement coverage when Medicare first began in 1966, and has maintained its niche by focusing on serving the senior market with quality supplemental protection. The NAIC continues to rank United American in the Top 10 as a leading writer of individual Medicare Supplement insurance by direct premiums earned.

May 21, 2013

For the Record
House Ways and Means Health Subcommittee

Testimony submitted by Josh Nassar, Legislative Director, International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW

This testimony is submitted on behalf of the International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW) in connection with the hearing that will be held by the Subcommittee on Health of the House Ways & Means Committee on May 21, 2013 on "the President's and Other Bipartisan Proposals to Reform Medicare." This hearing will review proposals to change beneficiary cost-sharing for services under Medicare.

The UAW represents over 1.2 million active and retired workers in the auto, aerospace, education and public sectors across the United States. About two thirds of our retired members receive their primary health care coverage from Medicare. Many of these retirees also receive supplemental health care benefits from their former employers or from Voluntary Employee Beneficiary Associations (VEBAs) that have resulted from court-ordered settlement agreements.

The UAW recognizes the need to modernize and rationalize the benefit package provided under Medicare. In particular, it would be important to update and simplify the deductibles, co-insurance and other cost sharing requirements. This could make it easier for retirees to understand these cost sharing requirements. It also could ease the administrative burdens both on Medicare and on employers/VEBAs that provide supplemental coverage.

The UAW also strongly supports the addition of catastrophic coverage under Medicare. This has long been a glaring omission in Medicare. Providing protection against catastrophic medical expenses would help seniors who would otherwise face potentially devastating costs due to serious illnesses.

However, the UAW is concerned that proposals by the Medicare Payment Advisory Commission (MedPAC), the Bipartisan Policy Center (BPC) and Moment of Truth project (MTP) for changing the cost-sharing policies under Medicare would impose additional and substantial cost sharing onto most seniors. Even though the MedPAC proposal is intended to maintain **in the aggregate** the same level of cost sharing as the traditional Medicare benefit package, in order to pay for the catastrophic protection for a small number of seniors this proposal – like the BPC and MTP proposals - substantially increases the cost sharing that will have to be borne by most Medicare beneficiaries.

The UAW opposes this shifting of substantial new costs to most seniors. In 2010, half of all Medicare beneficiaries had annual incomes below $22,000 (200% of the federal

poverty level). Medicare households have a lower average budget than the typical household ($30,818 vs $49,641 respectively), but devote a substantially larger share of their income to medical expenses than the average household (14.7% vs 4.9% respectively). Thus, many seniors simply cannot afford the cost sharing implicit in the MedPAC and other proposals, and would experience significant hardship if they had to pay for these additional costs. Some UAW retirees could see their income reduced by up to a quarter if they had to pay the increased cost sharing in these proposals.

The UAW also is skeptical that this increase in cost sharing for most seniors would be effective in restraining the growth in health care spending. To begin with, most retirees already are paying significant health care costs, and thus have substantial "skin in the game." Furthermore, because most health care expenditures are incurred by a small percentage of the sickest individuals, increasing cost sharing for the majority of persons will not have any impact on the largest component of health care costs. In fact, increasing cost sharing for persons with chronic conditions may be counterproductive. This could potentially result in higher expenditures for costly hospitalizations and greater use of emergency department services. Instead of trying to control utilization by shifting costs to individuals, it makes more sense to focus on providing incentives for health care providers to deliver care based on quality rather than quantity. The reforms contained in the Affordable Care Act have already started to make progress in this direction. The UAW submits that we should be redoubling and accelerating those efforts, rather than shifting more costs to seniors.

The UAW is particularly troubled by the part of the MedPAC benefit proposal that would increase the cost sharing for inpatient hospital stays to $750 per stay. This would impose significant hardship on many seniors. And it would have little impact on utilization and health care costs, since providers rather than individuals normally make the decision to admit someone to a hospital.

The UAW also opposes the proposals by MedPAC, BPC and MTP to restrict supplemental "Medigap" coverage for seniors, as well as similar proposals made by other parties. Sometimes these proposals are designed as an outright prohibition on so-called "first dollar" coverage. Sometimes they are structured as a surcharge on the Part B premiums paid by seniors, or as a surcharge/excise tax on the supplemental policies themselves. Whatever the structure of the proposals, the net effect is to expose seniors to substantial additional health care costs. In our judgment, this would cause significant hardship for many seniors who simply cannot afford to bear these costs. In addition, as the National Association of Insurance Commissioners recently indicated in a December 19, 2012 letter to Secretary Sebelius, Medigap coverage is not a driver of unnecessary medical care by seniors. Peer reviewed studies do not indicate that increased cost sharing would promote a more "appropriate" use of physicians' services. Instead, this more likely would result in delayed treatments that could increase Medicare program costs.

The UAW believes it would be particularly problematic to apply surcharges or benefit prohibitions to supplemental health care benefits provided to retirees by employers, Taft

Hartley plans or VEBAs. With individual Medigap policies, the individual always has a choice about whether to prospectively purchase the supplemental coverage. But in the case of supplemental health care benefits provided to retirees by employers, Taft Hartley plans or VEBAs, the retirees have already given up wages during their active working years based on the promise that they would receive this additional health care protection during their retirement. In our view, it would be grossly unfair to now change the rules and deprive the retirees of the bargain that they negotiated many years ago and that they effectively paid for by foregoing part of their wages. For this reason, if there were going to be some type of surcharge or benefit prohibition, we believe it should be structured as proposed by the Obama administration, so that it would only apply to individual Medigap policies purchased by beneficiaries who enroll in Medicare after some future date.

In conclusion, the UAW appreciates the opportunity to submit our views to the Subcommittee on Health of the Ways and Means Committee regarding proposals to change the cost sharing policies in Medicare. We look forward to working with Members of the Subcommittee and the entire Congress as you consider these important issues.

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Submission for the Record

US House of Representatives
Committee on Ways and Means
Health Sub-Committee

"THE PRESIDENT'S AND OTHER BIPARTISAN PROPOSALS TO REFORM MEDICARE"

Tuesday, May 21, 2013

Respectfully submitted on behalf of,

UNITED STEEL, PAPER and FORESTRY, RUBBER, MANUFACTURING, ENERGY, ALLIED INDUSTRIAL and SERVICE WORKERS INTERNATIONAL UNION

By
United Steelworkers, Legislative Department
1150 17th Street, NW, Suite 300
Washington, DC 20036
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202-293-5308 (fax)

Submission for the Record

THE PRESIDENT'S AND OTHER BIPARTISAN PROPOSALS TO REFORM MEDICARE
Tuesday, May 21, 2013
US House of Representatives
Committee on Ways and Means
Health Sub-Committee

This testimony is submitted on behalf of the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (USW) in connection with the hearing that will be held by the Subcommittee on Health of the House Ways & Means Committee on May 21, 2013 on "the President's and Other Bipartisan Proposals to Reform Medicare." This hearing will review proposals to change beneficiary cost-sharing for services under Medicare.

The USW represents over 1.2 million active and retired workers in the steel, aluminum, rubber, paper, energy, mining, and health care sectors across the United States. About 65-70 percent of our retired members receive their primary health care coverage from Medicare. Many of these retirees also receive supplemental health care benefits from their former employers or from Voluntary Employee Beneficiary Associations (VEBAs) that have resulted from court-ordered settlement agreements.

The USW recognizes the need to modernize and rationalize the benefit package provided under Medicare. In particular, it would be important to update and simplify the deductibles, co-insurance and other cost sharing requirements. This could make it easier for retirees to understand these cost sharing requirements. It also could ease the administrative burdens both on Medicare and on employers/VEBAs that provide supplemental coverage.

The USW also strongly supports the addition of catastrophic coverage under Medicare. This has long been a glaring omission in Medicare. Providing protection against catastrophic medical expenses would help seniors who would otherwise face potentially devastating costs due to serious illnesses.

However, the USW is concerned that proposals by the Medicare Payment Advisory Commission (MedPAC), the Bipartisan Policy Center (BPC) and Moment of Truth project (MTP) for changing the cost-sharing policies under Medicare would impose substantial additional cost sharing on most seniors. Even though the MedPAC proposal is intended to maintain **in the aggregate** the same level of cost sharing as the traditional Medicare benefit package, in order to pay for the catastrophic protection for a small number of seniors this proposal – like the BPC and MTP

proposals - substantially increase the cost sharing that will have to be borne by most Medicare beneficiaries.

The USW opposes this shifting of substantial new costs to most seniors. In 2010, half of all Medicare beneficiaries had annual incomes below $22,000 (200% of the federal poverty level). Medicare households have a lower average budget than the typical household ($30,818 vs $49,641 respectively), but devote a substantially larger share of their income to medical expenses than does the average household (14.7% vs 4.9% respectively). Thus, many seniors simply cannot afford the cost sharing implicit in the MedPAC and other proposals, and would experience significant hardship if they had to pay for these additional costs. Some USW retirees could see their income reduced significantly if they had to pay the increased cost sharing in these proposals.

The USW also is skeptical that this increase in cost sharing for most seniors would be effective in restraining the growth in health care spending. To begin with, most retirees already are paying significant health care costs, and thus have substantial "skin in the game." Furthermore, because most health care expenditures are incurred by a small percentage of the sickest individuals, increasing cost sharing for the majority of persons will not have any impact on the largest component of health care costs. In fact, increasing cost sharing for persons with chronic conditions may be counterproductive, as it may result in higher expenditures for costly hospitalizations and greater use of emergency department services. Instead of trying to control utilization by shifting costs to individuals, it makes more sense to focus on providing incentives for health care providers to deliver care based on quality rather than quantity. The reforms contained in the Affordable Care Act have already started to make progress in this direction. The USW submits that we should be redoubling and accelerating those efforts, rather than shifting more costs to seniors.

The USW is particularly troubled by the part of the MedPAC benefit proposal that would increase the cost sharing for inpatient hospital stays to $750 per stay. This would impose significant hardship on many seniors. And it would have little impact on utilization and health care costs, since providers rather than individuals normally make the decision to admit someone to a hospital.

The USW also opposes the proposals by MedPAC, BPC and MTP to restrict supplemental "Medigap" coverage for seniors, as well as similar proposals made by other parties. Sometimes these proposals are designed as an outright prohibition on so-called "first dollar" coverage. Sometimes they are structured as a surcharge on the Part B premiums paid by seniors, or as a surcharge/excise tax on the supplemental policies themselves. Whatever the structure of the proposals, the net effect is to expose seniors to substantial additional health care costs. In our judgment, this would cause significant hardship for many seniors who simply

cannot afford to bear these costs. In addition, as the National Association of Insurance Commissioners recently indicated in a December 19, 2012 letter to Secretary Sebelius, Medigap coverage is not a driver of unnecessary medical care by seniors. Peer reviewed studies do not indicate that increased cost sharing would promote a more "appropriate" use of physicians' services. Instead, this more likely would result in delayed treatments that could increase Medicare program costs.

The USW believes it would be particularly problematic to apply surcharges or benefit prohibitions to supplemental health care benefits provided to retirees by employers, Taft Hartley plans or VEBAs. With individual Medigap policies, the individual always has a choice about whether to prospectively purchase the supplemental coverage. But in the case of supplemental health care benefits provided to retirees by employers, Taft Hartley plans or VEBAs, the retirees have already given up wages during their active working years based on the promise that they would receive this additional health care protection during their retirement. In our judgment, it would be manifestly unfair to now change the rules and deprive the retirees of the bargain that they negotiated many years ago and that they effectively paid for by foregoing part of their wages. For this reason, if there were going to be some type of surcharge or benefit prohibition, we believe it should be structured as proposed by the Obama administration, so that it would only apply to individual Medigap policies purchased by beneficiaries who enroll in Medicare after some future date.

In conclusion, the USW appreciates the opportunity to submit our views to the Subcommittee on Health of the Ways and Means Committee regarding proposals to change the cost sharing policies in Medicare. We look forward to working with Members of the Subcommittee and the entire Congress as you consider these important issues.

Respectfully submitted on behalf of,

UNITED STEEL, PAPER and FORESTRY, RUBBER, MANUFACTURING, ENERGY, ALLIED INDUSTRIAL and SERVICE WORKERS INTERNATIONAL UNION

By
United Steelworkers, Legislative Department
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202-293-5308 (fax)

May 24, 2013

Ways and Means Committee Office
1102 Longworth House Office Building
Washington D.C. 20515
waysandmeans.submissions@mail.house.gov

RE: Hearing on the President's and Other Bipartisan Proposals to Reform Medicare

Dear Sirs:

By copy of this letter, the Virginia Association for Home Care and Hospice is providing written comments to Chairman Brady's Hearing on the President's and Other Bipartisan Proposals to Reform Medicare on May 21, 2013. We strongly support the comments of Chairman Brady, Ranking Member McDermott and Congressmen Pascrell, Kind, Thompson, and Blumenauer, that health reform should be given a chance to work before we go cutting benefits or reimbursement.

As Mr. Baker of Medicare Rights noted, Medicare beneficiaries receiving the home health benefit are "the poorest, the oldest and the sickest". As a condition of coverage, they must be so frail and sick that they cannot leave home without assistance. Of home health beneficiaries, "30% are age 85 or older, compared to 13% among the general Medicare population, and 63% are women." They "tend to have lower incomes than the average Medicare beneficiary and already higher health care costs." Also, "Home health users also have more limitations in one or more activities of daily living than the average Medicare beneficiary".

Home health care for frail, sick and disabled Medicare beneficiaries should be regarded as "preventive" care which, as Ms. Rivlin noted, should not have a copayment, since it prevents unnecessary hospitalizations and nursing home admissions.

As Mr. Antos observed, "the savings measured in the ten-year budget window are modest". The fact that some beneficiaries may have Medigap coverage for copayments merely means that costs will be shifted, not avoided. If the costs are simply shifted to another payer, complexity is added without savings, and there would be no deterrent to unnecessary utilization that Ms. Rivlin mentions.

Congress has intentionally not instituted a home health copayment to encourage the use of less costly health care services. Increasing out-of-pocket medical expenses on

the elderly and disabled discourages individuals from seeking this more affordable, necessary care and forces them to seek care in more expensive institutional settings. Home health patients, their families and friends already provide an estimated $450 billion a year in unpaid care at home, costs that would be incurred by Medicare if these patients were in a hospital or nursing home.

The Virginia Association for Home Care and Hospice respectfully ask that the House Ways and Means Committee preserve access to home health services by rejecting home health copayments. We can achieve Medicare savings and improve quality outcomes, but doing so requires thoughtful reforms - not the imposition of a new copayment on beneficiaries.

Over 3 million senior citizens and Americans with disabilities enrolled in Medicare rely on home health care services. This benefit allows individuals to receive quality, affordable health care services in the comfort of their homes rather than a more costly hospital or nursing home setting.

For the reasons presented in these comments, the Virginia Association for Home Care and Hospice strongly believes that copayments would be devastating to access to care for home health patients.

Respectfully submitted,

Marcia Tetterton, MS, CAE
Executive Director
Virginia Association for Home Care and Hospice
8001 Franklin Farms Drive, Suite 110
Richmond, VA 23229
804-285-8636
Fax 804-288-3303
mtetterton@vahc.org

cc:

Rep. Kevin Brady, TX, Chairman

Rep. Sam Johnson, TX
Rep. Paul Ryan, WI
Rep. Devin Nunes, CA
Rep. Peter Roskam, IL
Rep. Jim Gerlach, PA
Rep. Tom Price, GA
Rep. Vern Buchanan, FL
Rep. Adrian Smith, NE

Rep. Jim McDermott, WA, *Ranking Member*
Rep. Mike Thompson, CA
Rep. Ron Kind, WI
Rep. Earl Blumenauer, OR
Rep. Bill Pascrell, NJ

VNAA
Advancing Nonprofit Home Healthcare and Hospice

Committee on Ways and Means
Hearing on the President's and Other Bipartisan Proposals to Reform Medicare
May 21, 2013

Statement for the Record

The Visiting Nurse Associations of America (VNAA) thanks the Committee for this opportunity to submit a statement for the record for the hearing on the "President's and Other Bipartisan Proposals to Reform Medicare." We remain staunchly opposed to proposals, such as co-pays, that would harm access to care and look forward to working with its Members on home health and hospice issues.

VNAA represents community-based nonprofit home health and hospice providers across the United States. Our members care for patients with serious and often chronic conditions by providing a full array of healthcare services along with care coordination, management and prevention. Our members are a vital link between homebound patients, their physicians and acute care settings. VNAA members serve all patients without regard to their ability to pay or the severity of their illness, with a particular focus on ensuring access for vulnerable patients.

VNAA regularly works with Congress and other policymakers to support the goals of providing access to cost-effective, high-quality healthcare and eliminating fraud and abuse. We have a long track record of recommending solutions to policymakers that improve the Medicare system while maintaining access to care for vulnerable Medicare beneficiaries.

VNAA respects the need to place the Medicare program on sound fiscal footing. However, our members' experience with patients clearly indicate that establishing a copay will decrease access to medically-necessary home health and increase unnecessary and more expensive acute care admissions.

Despite the fact that proposals to establish a Medicare home health copay have been put forward in many venues, the home health copay has been consistently opposed by VNAA and many organizations such as the Leadership Council on Aging Organizations, a consortium of sixty-eight prominent national aging advocacy organizations including the AARP and national organizations representing Catholic, Jewish and Lutheran seniors.[i]

It is important to note that Medicare home health is *only available* if a physician orders it for a patient who is homebound and requires skilled care. The establishment of copays for home health would most heavily burden the oldest and sickest Medicare beneficiaries.

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Here is what we know about Medicare home health users:

- About eighty-six percent of home health users are age sixty-five or older, [ii]
- Sixty-three percent are seventy-five or older, and nearly thirty percent are eighty-five or older;
- Sixty-three percent are women; and
- Home health users have more limitations in activities of daily living than other beneficiaries.

VNAA urges policymakers to look to home healthcare providers as key partners who: 1) ensure high-quality care for homebound patients; 2) provide critical care coordination for patients with chronic conditions; 3) reduce costs across systems of healthcare; and 4) keep vulnerable patients at home and out of expensive acute care settings.

A copay would be a major step backwards for both patients and the healthcare delivery system. Congress modernized the home health benefit by eliminating copays in 1972 and a home health deductible in 1980 to encourage use of less costly, noninstitutional services. In an analysis of various proposals, the Urban Institute's Health Policy Center concluded that 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."[iii]

Like vulnerable patients who skip medications and become sicker, an important concern is that the economically stressed beneficiaries will skip medically-necessary care that their physician has ordered because they are not able to make a copayment.

The elderly already spend twenty-two percent of their income on health care; those in poor health spend forty-four percent and those who are low-income women over the age of eighty-five spend fifty-two percent of their income[iv]. An analysis by Avalere Health in 2011 confirms that patients who would be affected by a home health copay tend to be poorer; fifty-two percent have incomes below 200 percent of the poverty line, compared to forty-one percent of the overall Medicare population[v].

Recently, VNAA completed a study that focused on vulnerable patients who received home health. Study results support VNAA's concerns that imposing additional out-of-pocket cost requirements – especially on these most vulnerable seniors – will only exacerbate problems in the current system that may limit access to care for these patients.

The study found that Medicare home health episodes for patients with the following characteristics tended to have significantly lower reimbursement compared to cost:

- Communities with lower median household incomes
- Poorly-controlled chronic conditions (e.g. hypertension, diabetes, peripheral vascular disease)
- Intensive treatments including respiratory, intravenous, infusion therapy, and parenteral nutrition
- Clinically complex post-acute and community admissions
- Serious or frail overall status
- Problematic (higher stage) pressure ulcers
- Urinary and bowel incontinence
- No caregiver assistance for activities of daily living (eating, mobility, hygiene) as well as medication administration or medical procedures such as wound cleaning

Given the findings of this important study, VNAA has advocated that any changes to the Medicare home health payment system, including rebasing set to begin in the near future, must take into consideration the costs of providing care to patients with these characteristics.

VNAA welcomes the opportunity to further discuss with the Committee the implications of this study both as it relates to any proposals for home health copays and the need to make improvements to the Medicare home health payment system. If you have any questions please contact Kathleen Sheehan, Vice President of Public Policy, VNAA at 202-384-1456 or ksheehan@vnaa.org.

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

[ii] Table 7.2 Medicare & Medicaid Statistical Supplement, 2010, available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2012.html

[iii] The Urban Institute, *A Preliminary Examination of Key Differences In the Medicare Savings Bills*, 1997, available at: http://www.urban.org/publications/406988.html

[iv] The Commonwealth Fund, *Medicare's Future: Current Picture, Trends and Prescription Drug Policy Debate, Updated Charts,* 2003, available at: http://www.commonwealthfund.org/~/media/Files/Publications/Chartbook/2004/Feb/Medicares%20Future%20%20Current%20Picture%20%20Trends%20%20and%20Medicare%20Prescription%20Drug%20Improvement%20%20%20Modernizatio/cooper_chtpack_659%20pdf.pdf

[v] Avalere Health, LLC, *A Home Health CoPayment: Affected Beneficiaries and Potential Impacts*, 2011, available at: http://www.avalerehealth.net/pdfs/hhs_copay.pdf