



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

HEARING ON

“PRESERVING AND STRENGTHENING MEDICARE”

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The Alliance for Retired Americans appreciates the opportunity to submit comments to the Committee on Ways and Means Health Subcommittee on the hearing titled, "Preserving and Strengthening Medicare." While the Alliance encourages Congress to examine ways to improve Medicare's benefits and its finances, we have real concerns with proposals that shift costs to beneficiaries.

Founded in 2001, the Alliance is a grassroots organization representing more than 4.3 million retirees and seniors nationwide. Headquartered in Washington, D.C., the Alliance and its 35 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 discussing any proposal, one must consider who would be impacted by such policy. While many in Congress believe that Medicare beneficiaries are well off and can afford to pay a little more, it is important to note that only 5% of Medicare beneficiaries are considered higher income -- meaning they have incomes of \$85,000 or above -- and those beneficiaries already pay more for their Part B and Part D premiums. Half of all Medicare beneficiaries have annual incomes under \$24,150 and one quarter of beneficiaries have annual incomes under \$14,350. Unfortunately, the future is not any better. In 2030, it is estimated that half of all Medicare beneficiaries will live on annual income of \$28,450 or less. Older adults also spend three times (14 percent versus 5 percent respectively) as much on medical expenses than does the average household. Given this sobering reality, it is difficult to comprehend how anyone can expect Medicare beneficiaries to pay more.

During the March 16th hearing, several proposals were discussed as ways to reduce costs in the program, including Medicare Advantage, premium support, raising the age of eligibility, more means testing and Medicare redesign. All these proposals shift costs on to beneficiaries while doing nothing to reduce the cost of health care. Please allow us to share our concerns.

Medicare Advantage

During the hearing, Medicare Advantage (MA) was touted as providing beneficiaries with good quality care and keeping costs down. However, MA plans have historically been paid more than traditional Medicare. Prior to the Affordable Care Act (ACA), the overpayment also raised Part B premiums for seniors and the disabled, including those not on MA plans, by \$90 a year per couple. The ACA restructured government payments to MA plans to keep it more in line with that of traditional Medicare. However, MA plans that provide good quality care are paid bonuses that allow them to continue to receive higher reimbursements.

Premium Support

This proposal fundamentally alters the 50-year old Medicare program. While supporters assert that this proposal will continue to offer beneficiaries access to

traditional Medicare, experience with MA plans has shown that private plans tend to siphon off healthier beneficiaries leaving the sickest and most frail beneficiaries in the Medicare program. While the premium support model recognizes this and does provide for some risk adjustment — adjusting payments to reflect the average health status of enrollees -- the increased payment will be insufficient to cover the full increase in costs. Over time, costs under traditional Medicare will become so expensive that it will be unsustainable.

Raising the Age of Eligibility

This proposal is a lose-lose proposition for older Americans. A 2014 Kaiser study found that if Medicare beneficiaries who are 65 and 66 years old were forced to purchase insurance in the individual market, two in three beneficiaries would pay an average of \$2,200 more for their health care. While Medicare would generate a savings of \$5.7 billion in net savings raising the eligibility age would increase out-of-pocket costs for beneficiaries by \$3.7 billion and increase costs to employers who provide retiree coverage by \$4.5 billion. In addition, the Part B premiums of those beneficiaries 67 years and older who remain in Medicare would rise by three percent as the younger and healthier beneficiaries are removed from the Medicare risk pool.

More Means Testing

Most Medicare beneficiaries, through their premiums, pay 25% of the cost to provide care under the Medicare Part B and Part D programs. However, five percent of Medicare beneficiaries are considered higher income – individuals with incomes above \$85,000 and couples with incomes above \$170,000 – and pay higher Part B and Part D premiums. Last year's SGR bill further increased premiums for these beneficiaries. There are various proposals that would require these beneficiaries to pay even higher premiums and in some cases pay 100% of the costs under Part B and Part D. We are opposed to further means testing these beneficiaries which would destroy the universality of the program and erode public support. Other proposals would gradually increase the number of Medicare beneficiaries paying higher premiums until one out of four are paying higher premiums. According to a 2013 Kaiser study, if this policy were in effect today, it would affect seniors with incomes of \$47,000 and above. The Alliance opposes this policy which would hurt middle income seniors.

Medicare Redesign

The Alliance views the combined deductible proposal as a huge cost shift to beneficiaries who are relatively healthy and do not need hospital services. According to data from Centers for Medicare and Medicaid Services (CMS), in 2006, only 17% of beneficiaries had hospital visits. If the combined deductible had been in place then, 83% of Medicare beneficiaries would have paid a higher deductible. At the hearing, Dr. Moffit did suggest coupling the combined deductible with a catastrophic cap. The Alliance agrees that restructuring the Medicare benefit could be beneficial for seniors and people

with disabilities if done to help seniors with high costs. Medicare benefits are less generous than those of government's FEHBP plans or large employer plans. A cap on out-of-pocket spending would benefit beneficiaries who are chronically ill and experience numerous hospitalizations, but increasing cost-sharing for healthier beneficiaries at the same time is not something we can support. The Alliance is especially apprehensive if such a plan is being offered in the context of deficit reductions.

Equally troubling is that Dr. Moffit also suggested making changes to Medigap and supplemental insurance policies. Various proposals have been offered in the past, including requiring beneficiaries with these policies to pay a surcharge or a deductible before Medigap benefits can kick in. The idea behind the surcharge and the deductible is that beneficiaries over-utilize services because it doesn't cost them anything and that beneficiaries need to have more "skin in the game." The surcharge and/or deductible is designed to impact beneficiaries' medical spending habits. This thinking is flawed in many ways. First, Medigap policies are expensive. 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. Most beneficiaries do not have the expertise to make medical decisions. Third, while the surcharge or deductible may initially reduce demand for care and 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 and/or deductible will not only affect seniors with Medigap plans, but also those with employer-sponsored supplemental plans. Individuals with employer-sponsored supplemental plans often received those 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.

The Alliance believes that Congress must do more to reduce the cost of Medicare. The ACA made numerous delivery systems reforms that are already helping bring down spending but more can be done. One area that deserves consideration is pharmaceutical costs. According to a study by the Center for Economic and Policy Research, if Medicare used its bulk purchasing power to buy prescription drugs, the government could potentially save over \$500 billion and beneficiaries could save over \$100 billion over 10 years. Numerous bills are before Congress that would reduce drugs cost for the government and Medicare beneficiaries, those include rebates for low-income Medicare beneficiaries, negotiating lower prices for all beneficiaries, ending pay-for-delay agreements between pharmaceutical companies and generic manufacturers and reducing the exclusivity period for biologics. These options would

save the program billions of dollars and without negatively affecting Medicare beneficiaries or transferring costs to them.

Also more could and should be done to reduce drug costs by eliminating waste in the system. On March 1, 2016, *The Washington Post* reported that a study found that \$3 billion in cancer drugs are wasted each year. The study focused on 20 cancer drugs that are infused -- administered intravenously or injected -- by doctors' offices or hospitals. These drugs come in dosages based on patients' weights and body sizes, but often the doses are too large and the remainder is tossed out. While some point to safety as the reason for discarding the leftover drug, surely guidelines can be developed that provide safety while at the same time reducing waste. We urge Congress to hold hearings to address this practice. These and other wasteful spending must be reviewed before considering any proposals that shift costs on to beneficiaries.

On behalf of its more than 4.3 million members, the Alliance for Retired Americans appreciates the opportunity to submit this testimony on this critically important issue.