

**Statement for the Record**  
**by the**  
**American Federation of State, County and**  
**Municipal Employees (AFSCME)**  
**for the Hearing**  
**on**  
**Examining Traditional Medicare's**  
**Benefit Design**  
  
**Before the**  
**Subcommittee on Health**  
**Committee on Ways and Means**  
**U.S. House of Representatives**  
**February 26, 2013**

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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.

**The Affordable Care Act Improved Medicare Benefits in Two Key Ways**

The Affordable Care Act (ACA) changed Medicare to better protect beneficiaries from unexpected health costs. Thanks to the health care reform law, 6.1 million Americans with Medicare who reached the coverage gap in Part D (known as the *donut hole*) have saved over \$5.7 billion on prescription drugs.

In 2012, the savings to beneficiaries in the donut hole helped a significant number purchase drugs managing chronic conditions such as high blood sugar, high blood pressure and high cholesterol. By reducing the prescription drug coverage gap, the ACA helped to create incentives for beneficiaries to adhere to a medication regimen prescribed by their doctors. Closing the gap in benefit coverage improves the health and quality of life of beneficiaries and saves money for Medicare. According to the Congressional Budget Office (CBO), the costs for increased prescription drug use in Medicare can offset Medicare spending in medical services, like hospitalizations.

The ACA also redesigned Medicare's incentives for beneficiaries to stay healthy by preventing disease, detecting and treating health problems early, and monitoring health conditions. Eliminating the cost-sharing barrier of co-payments and Part B deductibles for recommended preventive services has succeeded in increasing preventive services. In 2012 alone, an estimated 34.1 million people with Medicare benefited from Medicare's coverage of preventive services with no cost sharing.

These two ACA improvements in the cost structure of Medicare benefits are particularly important for a population that cannot afford more cost sharing. Most Medicare beneficiaries have low incomes and spend a larger portion of their meager household income on health care. Half of all people with Medicare live on incomes of less than \$22,000 per year, and families on Medicare spend 15% of total health care costs compared to the just 5% spent by non-Medicare households. In short, Medicare beneficiaries have *too much* "skin in the game" and are often forced to choose between making ends meet and getting the medical care they need. Increasing cost shifting onto beneficiaries will jeopardize the health of seniors and individuals with disabilities who rely on Medicare.

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

As Congress looks at changes in Medicare's structure and benefit design, the focus must be on improving and expanding benefits. Medicare benefit design must not be a diversion to disguise the shifting of costs on to beneficiaries or employers who provide retiree coverage.

While the details may vary, the underlying premise of many proposals is 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 will likely reduce utilization; tragically, it will force 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 recommending against adding 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.<sup>1</sup>

Moreover, it seems dubious at best (and potentially cruel at worst) to ask consumers 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. Cost sharing is a defective tool that 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.

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

**Similarly, changing Medicare to a premium support plan is a benefit structure redesign that gives less and less purchasing power to beneficiaries.** Even if one viewed a premium support plan as a form of competitive bidding, it ludicrously demands that every individual senior single-handedly muster more clout in negotiations with doctors, hospitals and the insurance industry than the combined forces of 50 million beneficiaries acting through the federal government. A premium support redesign puts the health of individual seniors and individuals with disabilities at risk if they cannot control health care costs better than Congress and Medicare can now. Offering both private plans and traditional Medicare uses the promise of choice and the false lure of competition to disguise the diminishment of Medicare's function to deliver guaranteed benefits, pool resources and protect beneficiaries from unexpected health care costs.

## **Conclusion**

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.

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 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.