



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

HEARING ON

MEDICARE REFORM PROPOSALS

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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 matters worse seniors are already spending a larger share of their income on health spending than 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.