GUNDERSEN
HEALTH SYSTEM®

March 29, 2016

The Honorable Pat Tiberi
Chair
Committee on Ways & Means, Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Committee on Ways & Means, Subcommittee on Health
U.S. House of Representatives
1106 Longworth House Office Building
Washington, DC 20515

Re: Public Comment on Ways and Means Subcommittee on Health Hearing "Preserving and Strengthening Medicare."

Dear Chairman Tiberi & Ranking Member McDermott:

On behalf of Gundersen Health System, we write provide comments on the Ways and Means Subcommittee hearing *"Preserving and Strengthening Medicare."* We were very pleased to hear committee members and panelists supporting healthcare delivery that is value-based. Gundersen echoes this strongly with our support of the development of robust value-based payment initiatives. We support the notion that properly structured incentives to provide high value care (e.g. high quality, low cost care) will result in better care for patients at a lower cost for payers.

Gundersen Health System provides integrated care for patients in predominantly rural areas along the Mississippi River in western Wisconsin, northeast Iowa, and southeast Minnesota. As the largest employer in the La Crosse, Wisconsin region with over 6,000 employees, Gundersen provides integrated healthcare services including: clinical care, level II trauma care, medical education, and air and ground ambulance services. In addition, Gundersen has maintained a five-star rated Medicare Advantage insurance plan for the past five consecutive years, one of only five health plans in the nation to earn this achievement. Gundersen has consistently achieved top national rankings in many areas of medical excellence including being named as a Healthgrades Top 50 hospital in overall care, many clinical specialty services, and patient experience.

External Affairs Department 1900 South Avenue, Mailstop: H02-009, La Crosse, WI 54601
Email: ExternalAffairs@gundersenhealth.org Phone: 608-775-1400 Fax: 608-775-6225

We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. As a founding member of the Healthcare Quality Coalition (HQC), we strongly support continued implementation of payment systems that reward value. In supporting this approach, a study by the Medicare Payment and Advisory Commission (MedPAC) found the La Crosse, Wisconsin region to have the lowest utilization of Medicare services per beneficiary in the nation. This demonstrates our efficiency in caring for our Medicare patients, and coupled with our quality outcomes make us a provider of high value care.

Movement to Value Key for Long-term Medicare Viability

Medicare's predominantly fee-for-service (FFS) payment system, which rewards quantity over quality, is now widely acknowledged to be fragmented, inefficient, and financially unsustainable. The FFS system pays physicians based on the services they furnish and offers no incentives to coordinate care. The result is a system of fragmented care. FFS payments also create a financial incentive to promote volume over value, encouraging overutilization and discouraging low-cost, high-value services. Given the rising cost of health care and the resultant threat to the nation's long-term economic security, a payment system that supports an inefficient delivery system is not only undesirable but also unsustainable.

Gundersen Health System strongly believes that Medicare should pay for value in the health care system. Congress should not rely on across-the-board payment reductions as means to achieving value and program sustainability. In fact, this is in contrast to these goals. We believe that over time, value-based care will achieve the policy and financial goals to a sustainable Medicare system.

As a starting point, Gundersen supported and focused on programs that make modifications to the FFS scheme, such as the Physician Value-based Payment Modifier and Hospital Value-based Purchasing. These payment adjustments, however, are built on the FFS chassis, and the fundamental incorrect incentives of FFS remain the predominant payer source in the Medicare system. Just recently, Health and Human Services announced that 30% of medical service reimbursement in Medicare is now linked to various forms of non fee-for-service payment. Gundersen believes this is a good step.

Gundersen Health System expressed support for the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) last year. The enactment of this bill was historic in that it not only eliminated the antiquated Medicare Part B Sustainable Growth Rate, but also consolidated existing physician performance initiatives and advanced value-based payment. We commend the efforts of the Ways and Means Committee to craft and advance bi-partisan, bi-cameral legislation to reform Medicare Part B service reimbursement. We ask the committee to continue their work on evaluating the implementation of MACRA, and be amenable to changes that may be necessary to ensure program success, accelerate the process towards value-based care, and reward high performing physicians. For example, we have ongoing concerns about the statutory thresholds for qualifying as an Alternative Payment Model (APM) under MACRA. We are looking forward to the regulatory

implementation process and hope CMS uses as much flexibility as possible to ensure providers have the ability to be innovative and successful.

Reform and Advance Value-based Policy in Medicare for Hospitals

Last year, the enactment of MACRA was a major step forward in reforming Medicare Part B payment. But advancing public policy cannot stop or even slowdown. To continue driving forward value-based policy, we ask the Ways and Means Committee to collaborate and develop bi-partisan legislation that would consolidate and reform performance and value-based payment for hospitals. We believe, to the extent feasible, that Medicare Part A and B should include comparative value-based reimbursement policy. To that end, we offer the following key points of emphasis for devising an improved Medicare value-based payment for hospitals that resembles the concepts of MACRA. Specifically, we ask the committee to:

- Consolidate and reform existing penalty-only programs into an improved Hospital Value-Based Purchasing Program, offering incentives and rewards for high performance
- Improve efficiency as a unit of *value* by modifying the improved Hospital Value-Based Purchasing program to weigh measures of cost and quality equally
- Advance value-based care by increasing the amount of payment tied to hospital performance
- Eliminate overlap with quality measures between separate hospital programs
- Provide opportunities for developing and expanding hospital Alternative Payment Models

Step 1: Reform existing Medicare Hospital Penalty Programs

Gundersen Health System comprehensive value-based payment policies that integrate risk and offer rewards to hospitals that lead in improving patient experience, outcomes, and reducing the cost of care. We strongly believe properly structured payment reforms have an opportunity to significantly reduce the cost of care. However, performance-based programs that only assess penalties fall short of comprehensive value-based models. Reforming existing penalty programs to incent value by consolidating into a single Hospital Value-Based Purchasing program would align incentives, reduce duplication, and increase overall impact of the independent programs.

In the Hospital Readmissions Reduction (HRR) program, hospitals are compared to average performance of hospitals with similar patient case mix. In FY 2015, over 75% of eligible hospitals in the nation were subject to some level of readmissions penalty (maximum -3%), totaling over $420 million despite drops in national readmission rates.[1] [2] Meanwhile, the Hospital-Acquired Conditions (HAC) Reduction program assesses a 1% penalty for hospitals with the highest quartile rates of infections, injuries, and illnesses. Even though there has been a 17% national reduction in HACs[3] from 2010-2013, as designed, the HAC Reduction program will penalize 25% of hospitals every

[1] Sabriya Rice, "Most hospitals face 30-day readmissions penalty in fiscal 2016," *Modern Healthcare,* August 3, 2015, http://www.modernhealthcare.com/article/20150803/NEWS/150809981

[2] Jordan Rau, "Half Of Nation's Hospitals Fail Again To Escape Medicare's Readmission Penalties," *Kaiser Health News,* August 3, 2015 http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicares-readmission-penalties/

[3] Agency for Healthcare Research and Quality, *2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013,* AHRQ Publication No. 16-0006-EF (Rockville, MD, 2015), http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/hacrate2013.pdf

year, regardless of improvement. Further, like the Hospital Readmissions Reduction initiative, the HAC program is penalty-only.

While the HRR and HAC initiatives are designed to improve quality and reduce unnecessary spending, both are penalty-only programs, and do not provide positive incentives for high-quality, cost-effective care. Furthermore, as structured, the programs base performance on national averages, meaning hospitals may continue to be penalized even if they improve their readmission, infection, or safety rates. Finally, some measures are used in multiple programs, such as infection measures which result in overlap. Reforming the penalty-only structure of the program and consolidating into the Hospital Value-Based Purchasing program provides better incentives and eliminates the overlap and duplication of quality measures.

Step 2: Improve the Hospital Value-Based Purchasing (VBP) Program

Gundersen supports the goals of the hospital VBP program to reward high quality hospitals and to incentivize performance improvement.[4] Overall, Gundersen believes hospital VBP is moving in a positive direction by emphasizing patient outcomes, assessing payment adjustments by actual performance, and maintaining the current weighting of efficiency and cost reduction metrics.

However, the current statutory structure of the program is ineffective in driving meaningful reform. The incentive amounts are small, payment differentiation is minimal, and is not sufficient to drive meaningful changes in hospital care.[5,6] The current 2% statutory cap on incentives will not sufficiently motivate hospitals to strive toward value-based care delivery. Removing the ceiling will link more payment to value and drive quality improvement forward.

In addition to removing the statutory cap on Hospital VBP, Gundersen continues to support value as an equal reflection of cost and quality. Currently, the VBP program includes efficiency and cost reduction measures weighted at 25%. To further improve the program, we recommend the following steps: 1) Develop and implement a plan to increase the weight of efficiency and cost reduction domain to 50%; and 2) Incorporate additional risk-adjusted measures of efficiency in addition to the current Medicare Spending Per Beneficiary (MSPB) metric.

Step 3: Develop and expand voluntary hospital Alternative Payment Models

There are currently an array of programs and initiatives aimed at reducing cost and improving quality. Although the Medicare Accountable Care Organization (ACO) program has demonstrated mixed results,[7] experience from providers and hospitals participating as an ACO and other innovative models are integral for developing improved payment policy. In addition, as noted, MACRA was a milestone in Medicare physician payment policy by driving value-based care through

[4] Daniel Blumenthal and Anupam B. Jena, "Hospital value-based purchasing," *Journal of Hospital Medicine* 8, no. 5 (2013): 271, doi:10.1002/jhm.2045
[5] Rachel M. Werner and R. Adams Dudley, "Medicare's new hospital value-based purchasing program is likely to have only a small impact on hospital payments," *Health Affairs* 31, no. 9 (2012): 1932, doi:10.1377/hlthaff.2011.0990
[6] U.S. Government Accountability Office, *Hospital Value-Based Purchasing: Initial Results Show Modest Effects on Medicare Payments and No Apparent Change in Quality of Care Trends,* GAO-16-9 (Washington, DC, 2015), http://www.gao.gov/assets/680/672899.pdf
[7] David Muhlestein, "Medicare ACO's: Mixed initial results and cautious optimism," *Health Affairs Blog,* February 4, 2014, http://healthaffairs.org/blog/2014/02/04/medicare-acos-mixed-initial-results-and-cautious-optimism/

existing programs and new payment models. Improved hospital payment policy should take a similar approach, providing statutory authority for encouraging and incentivizing hospitals to undertake new models of care with opportunities for improved integration with clinical services.

In providing opportunities for future hospital alternative payment models to flourish, we ask lawmakers to follow these guiding principles:

- Hospitals should have the opportunity to take on risk—rewarding quality and efficiency.
- Incentivize coordinated care and build on existing initiatives and infrastructure.
- Capitated payment should be a core component of an alternative payment model.
- Flexibility and proper tools are essential to improve quality and reduce cost, including provider and hospital networks.
- Beneficiaries should be engaged in delivery system reform, such as patient involvement and understanding their stake in achieving value-based outcomes.

Conclusion

In conclusion, we appreciate the opportunity to provide comments and ideas to the Ways and Means Subcommittee on Health for ensuring a sustainable Medicare program. We believe the long-term viability lies in crafting reimbursement for services provided to Medicare beneficiaries that reflect robust value-based policy with measures of cost and quality. We look forward to being an active partner with the committee in moving value forward.

Please feel free to contact me with any questions.

Sincerely,

Michael D. Richards
Executive Director of External Affairs
Gundersen Health System

AARP®
Real Possibilities

601 E Street, NW | Washington, DC 20049
202-434-2277 | 1-888-OUR-AARP | 1-888-687-2277 | TTY: 1-877-434-7598
www.aarp.org | twitter: @aarp | facebook.com/aarp | youtube.com/aarp

March 30, 2016

The Honorable Pat Tiberi
Chairman
Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Tiberi and Ranking Member McDermott:

On behalf of AARP and millions of Medicare beneficiaries, thank you for holding a hearing on March 16, 2016, to discuss preserving and strengthening Medicare. AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. We agree the high cost of health care generally needs to be brought under control in order to preserve access to and the affordability of Medicare for future generations. Growing spending on health care has strained the Medicare Hospital Insurance Trust Fund (Part A) and has required an increasingly larger portion of general revenues (Parts B and D). We are concerned, however, that some of the options discussed by the Committee do not address the underlying causes of high health care spending. Instead, they merely shift the financial burden onto older Americans and others who depend on Medicare for their health security.

In addition to high health care costs, increased Medicare expenditures are due primarily to a growing Medicare population. Spending per beneficiary has actually grown slower than both GDP and private insurance in recent years. Proposals which force beneficiaries to pay more, without improving the value and quality of care received, essentially punish the beneficiary for being sick. Moreover, when half of all beneficiaries earn less than $24,150 per year and already spend 18% of their income on health care expenses, adding to their personal costs is no solution – it simply shifts costs and reduces access to care. Some of the ideas discussed in the hearing – increasing cost-sharing; increasing income-relating of premiums; and raising the age of eligibility – are prime examples of shifting costs to beneficiaries without addressing the causes of high health costs.

First, when confronted with paying a deductible or copay, the patient considers whether to utilize the service or not. If the provider orders a test, the patient either accepts the doctor's advice or chooses to forgo care. The individual, or their caregiver, is not thinking about finding a better

deal elsewhere. Once engaged with their physician, the patient usually follows the doctor's advice. Seldom do beneficiaries second-guess the doctor's decision as to the necessity of the service. Moreover, the notion that Medicare beneficiaries deliberately over-utilize the health system, and that having "more skin in the game" would lead to better choices, ignores the role providers play in influencing their patients. Increased cost-sharing may reduce utilization, but it reduces both necessary and unnecessary care. Patients forgoing necessary care due to higher cost may end up costing Medicare more in the long run.

Second, raising the applicable percentage amount for premiums or expanding income-relating to 25 percent of the beneficiary population is a direct cost-shift felt hardest by the middle class. To put this in perspective, presently only 5 percent of beneficiaries reach the income threshold for higher premiums. If a 25-percent quota were instituted, as some have recommended, the threshold would have to be set under $50,000 (instead of the current $85,000). This income related payment would be in addition to the existing tax paid to Medicare by middle-income Social Security beneficiaries with incomes over $34,000 ($44,000 couple filing jointly) -- aside from premiums and other cost-sharing, middle class beneficiaries above these thresholds continue to finance Medicare during their retirement through a dedicated income tax – paid to Medicare – on up to 35 percent of their Social Security benefit.

Moreover, 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 from the year before). Thus, new retirees (whose income is likely to have dropped precipitously from their working years) would be subject to higher income-related premiums based on their previous wages, not their current financial situation.

Unfortunately, a common refrain among proponents of greater cost-sharing is Medicare beneficiaries receive three times more in benefits than they contribute. Such a dollar-in/dollar-out assessment of the Medicare program is limited and inaccurate. Mainly, the "average" lifetime benefit does not reflect any individual's circumstances. We know, for instance, the small percentage of beneficiaries with multiple chronic conditions use a significant percentage of Medicare resources. In fact, recent numbers indicate Medicare spending on those with even one chronic condition is 5.4 times greater in Part A and 2.35 times greater in Part B compared to beneficiaries without chronic conditions.[1] The few high-cost beneficiaries skew the average. Thus, most beneficiaries never reach the "average" lifetime benefit.

Also, the spending numbers do not reflect value. Some experts have argued that up to 30 percent of Medicare spending is wasteful and does little to improve health. These lifetime benefit estimates, therefore, include wasteful spending. The problem with concentrating on the gap between contributions and benefits is it inevitably calls for either increasing taxes or cutting benefits, or both, without addressing the underlying inefficiencies in the system. Instead, we must focus on responsible solutions to get better value for our health care dollars. As the health care system embraces the goals of better care, better health, and lower costs, the gap between the lifetime amount of Medicare contributions paid and benefits received will likely fall.

Third, raising the age of Medicare eligibility would likely do more harm than good by raising per capita Medicare costs. Removing the youngest and healthiest older Americans from the Medicare risk pool will result in higher premiums for those remaining in the program. It would also raise costs for the 65 and 66 year olds no longer eligible, as private insurance for 65 and

[1] Centers for Medicare and Medicaid Services; *Medicare & Medicaid Research Review,* Medicare Payments: How Much Do Chronic Conditions Matter? 2013, volume 3, number 2.

66 year olds costs more than Medicare. Even in the Marketplaces, seniors will pay three times more for insurance than younger individuals. Raising the Medicare eligibility age would also raise costs for businesses in the private insurance market, because adding older individuals to private insurance risk pools will skew health care costs higher, raising everyone else's premiums and employer health care costs.

Medicare and Social Security are not the same, and should not have the same eligibility age. While eligibility for full Social Security retirement benefits is being raised to 67 years old, people may also choose to accept a lesser benefit amount beginning at age 62. Most beneficiaries choose to receive Social Security before the age of 65.

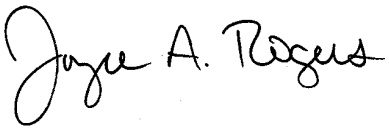
Finally, we have concerns with proposals to move Medicare from a defined benefit to a defined contribution program. Proposals that have been discussed in the past have not adequately considered how the federal contribution, or premium support amount, would keep pace with health care costs. Nor has enough consideration been given to ensuring Medicare beneficiaries, particularly low-income beneficiaries, have access to high-quality, low-cost options.

We recognize that changes need to be made to Medicare in order to preserve and strengthen the program now and for future generations. However, we reject the notion that this must be done on the backs of older Americans who have paid into the program their entire working lives and now rely on it for their health security.

Instead, Congress should continue to focus on and support improvements to our health care quality and coordination infrastructure. AARP was proud to work with you, and your colleagues in the House and Senate, to reform the physician reimbursement system. The Merit-based Incentive Payment System and the development of alternative payment models will shift Medicare from volume-based payments to value-based payment. This has tremendous power to improve care and lower costs to the program. In order to reach its full potential, though, Congress must give health care providers and consumers the necessary tools. This includes greater data availability to make better decisions; more and improved quality measures; and the removal of restrictions which hinder the use of telemedicine and technology to improve care access and delivery.

AARP looks forward to working with you to improve Medicare, for example, by improving care coordination, expanding technology, and lowering the high prices of prescription drugs. Ultimately, the greater the value and quality of care is, the lower the cost to both taxpayers and beneficiaries. Please feel free to contact me or have your staff contact Ariel Gonzalez of our Government Affairs staff at agonzalez@aarp.org or 202-434-3770 if you have any questions.

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 Preserving and Strengthening Medicare

Before the Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

March 16, 2016

331/07

American Federation of State, County and Municipal Employees, AFL-CIO
TEL (202) 429-1000 FAX (202) 429-1293 TDD (202) 659-0446 WEB www.afscme.org 1625 L Street, N.W., Washington, D.C. 20036-5687

Statement for the Record
by the
American Federation of State, County and Municipal Employees (AFSCME)
for the Hearing on
Preserving and Strengthening Medicare
Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
March 16, 2016

This statement is submitted on behalf of the 1.6 million working and retiree members of the American Federation of State, County and Municipal Employees (AFSCME) for the hearing held March 16, 2016 on Preserving and Strengthening Medicare.

For 50 years Medicare has helped millions of older Americans and individuals with disabilities see a doctor and get hospital care. AFSCME is proud of our history of supporting Medicare and protecting it for generations to come. Its guaranteed benefits protect seniors and their families from crushing health care costs. After years of work, beneficiaries have earned Medicare benefits. Yet, Medicare benefits can be expanded and improved to help current and future beneficiaries. AFSCME strongly opposes proposals to gut Medicare's guaranteed benefits, calls for deep Medicare cuts, and efforts to turn Medicare into a voucher program.

Strengthen – Not Repeal – the Affordable Care Act Improvements to Medicare

- **Close the Coverage Gap in Prescription Drugs *Faster***

In the past, as many as one in four seniors went without a prescription every year because they couldn't afford it. The Affordable Care Act (ACA) helps seniors have more affordable access to medications through Medicare Part D prescription drug coverage. It does so by gradually closing the gap in coverage where beneficiaries had to pay the full cost of their prescriptions out of pocket before catastrophic coverage for prescriptions took effect. The gap is known as the donut hole. The ACA closes the donut hole by 2020. Thanks to the ACA's required prescription drug discounts nearly 10.7 million people with Medicare have saved over $20.8 billion on their medications. In 2015 alone, nearly 5.2 million seniors and people with disabilities received discounts of over $5.4 billion, for an average of $1,054 per beneficiary.

We urge Congress to accelerate the required prescription drug discounts to close the gap in coverage under Part D more quickly. Such a proposal is in the President's fiscal year (FY) 2017 budget. It would save Medicare $10.2 billion over 10 years and help millions of beneficiaries have more affordable access to the medications they need.

- **Build Upon the ACA's Benefits to Medicare Preventive Screenings**

The ACA improved access to life-saving preventive services. Before the ACA, seniors had to pay part of the cost of recommended preventive screenings. This created a financial stumbling block for many seniors and prevented them from accessing key cancer screenings and immunizations. Now these and other preventive services have no deductible or co-payment.

Thanks to the ACA, some 39.2 million people with Medicare (including those enrolled in Medicare Advantage) took advantage of at least one preventive service with no co-pays or deductibles in 2015.

The preventative screening benefit under the ACA can be strengthened. For example Medicare beneficiaries are not subject to the part B deductible or co-insurance for recommended screening colonoscopies. If, however, the screening colonoscopy results in the removal of a polyp or other procedure, then beneficiaries are subject to the 20% co-insurance. **We urge Congress to remove a significant barrier to vital colon cancer screening by eliminating the Medicare co-insurance when the colonoscopy screening results in the removal of a polyp or other procedure.**

- **Protect Seniors and Medicare From the Worst Abuses of Private Insurers**

Medicare provides what commercial health insurance companies did not, would not, and could not; affordable, adequate health coverage for America's elderly population regardless of income or health status. Before the enactment of Medicare in 1965, only half the population age 65 and older had health insurance and, those who did have coverage, paid close to triple what younger people paid for premiums and other out-of-pocket costs.

Despite the reasons for the establishment of Medicare, Congress has nonetheless allowed private insurance companies to offer Medicare beneficiaries insurance policies that replace the benefits Medicare provides. Insurers are paid by Medicare to provide these benefits. Since the 1980s Medicare's private insurance program has had several variations and has been called the Medicare Risk Program, Medicare+Choice and now Medicare Advantage (MA). By any name these are private insurance plans offered as a substitution for traditional Medicare. They are not a supplemental plan and do not have the guarantees inherent in traditional Medicare.

The ACA protects seniors and Medicare from the worst abuses of private insurers. In the years before the ACA, these private insurance companies preyed on seniors with abusive marketing and sales tactics, they were inefficient, they did not provide improved care to justify the excessive cost, and they were largely unregulated. Extra payments to Medicare Advantage plans, enacted as part of the Medicare Modernization Act of 2003, were contributing to projections of future shortfalls in the Health Insurance Trust Fund as well as adding to the costs of Part B for both Medicare and its beneficiaries.

The year before the enactment of the ACA, MA plans were being paid on average $1.14 for what it would cost traditional Medicare $1.00 for the same beneficiaries. These extra payments put added strain on the Medicare trust fund and beneficiaries' budgets. In 2009, these extra payments meant an extra $1,280 per MA enrollee or $14 billion in higher aggregate payments from Medicare funds. A couple with traditional Medicare paid $86 more in their Medicare premiums to fund these extra payments to insurance companies. From 2004 to 2009, these overpayments cost the Medicare program nearly $44 billion.

The ACA addressed significant problems with the MA program and makes necessary improvements in MA beneficiary protections.

- The ACA changed Medicare payment policies to reward high-value – not high-volume – care.
- The ACA changed how Medicare pays MA plans by scaling back the overpayments and established policies so that the payments made to MA plans are close to payments and costs in traditional Medicare.
- The ACA makes changes to MA so that plan payments are done gradually and are phased in over nearly a decade so plans have time to adopt needed efficiencies.
- The ACA also forbids these private insurers from charging higher co-payments than traditional Medicare. This is particularly important to sicker beneficiaries.
- The ACA also stops MA plans from spending too much of premium dollars on overhead expenses, such as CEO salaries and perks, marketing, profits, administrative costs, and agent commissions. Insurers must use at least 85 cents out of every premium dollar to pay medical claims and provide activities that improve the quality of care.
- The ACA eliminates out-of-pocket costs for Medicare beneficiaries enrolled in MA plans or traditional Medicare for important preventive services, like mammograms, prostate cancer screenings, colonoscopies or key immunizations.
- The ACA sets up new initiatives to improve the quality of MA plans.

- **Ensure MA Plans Offer Beneficiaries Adequate Provider Networks**

For more than half a century Medicare has meant retirees can see a doctor when needed. Traditional Medicare does not have a "network." Referrals are not needed to see specialists and there is no prior authorization required to obtain services.

For some beneficiaries, moving into a Medicare Advantage plan can change access to their doctors for the worse. The MA plan may limit seniors to using a network of specific providers in order to have coverage for their care. Some MA plans may cover care outside of the network, but at a cost. Plans may only cover emergency and urgent care if a senior is out of the service area. The senior must return to the service area for follow up or routine care. Network providers can join or leave a plan's provider network anytime during the year but, generally, seniors must wait until the next year's open enrollment period to opt to leave the plan. The MA plan can also change the providers in the network anytime during the year. Network adequacy can be a problem with MA plans.

According the non-partisan and independent Government Accountability Office, report issued in August 2015, the federal agency charged with oversight of MA plans, Centers for Medicare & Medicaid Services (CMS) has had significant gaps and consumers may find themselves without adequate provider networks or accurate information about the networks.

MA provider networks must meet two criteria: a minimum number of providers and maximum travel time and distance to those providers. MA plans do not have to meet important aspects of provider availability – such as how often a provider practices at a given location. This

is in contrast to how Medicaid and TRICARE use provider availability measures to assess network

adequacy. For example, Medicaid managed care rules address providers' ability to accept new patients and TRICARE looks at appointment wait times for active duty service members. MA provider networks may inaccurately appear to CMS and beneficiaries as more robust than they actually are because they do not take availability into account. Indeed from 2013 to 2015, CMS reviews amounted to less than 1% of all networks and those did little to assess the adequacy of network data claimed by the MA plan before it enters a new market area. As a result GAO found that beneficiaries and CMS cannot be confident that MA plans meet network adequacy criteria.

For established MA provider networks, MA plans do not need to submit updated network data for review. Retirees will have no assurance that their plan's networks will continue to be adequate and provide sufficient access for them. An MA plan's providers may change at any time and plans do not have any CMS review of ongoing network adequacy against current MA criteria. GAO also found that seniors cannot be assured that MA plans will give them clear, accurate and consistent information when a provider contract is terminated.

Linda Bennett 3/15/2016 4:35 PM
Comment [1]:

Seniors deserve accurate and meaningful information on network adequacy and CMS must have the capacity to hold MA plans accountable for networks adequacy.

Cover Dental, Vision and Hearing Benefits

Medicare does not pay for routine eye or hearing exams even though vision and hearing difficulties increase with age. Untreated hearing loss can lead to depression, decreased mobility, social isolation, fatigue, cognitive decline and even dementia. Yet, Medicare does not cover routine hearing exams, hearing aids, or exams for fitting hearing aids. One in three people ages 65 to 74 have difficulty hearing. The number is higher at 75 and older. It's time for Medicare to cover basic hearing care and aids. It's also time for Medicare to cover routine eye care and glasses.

Medicare does not pay for most dental care, dental procedures, tooth extractions, or dentures. This is bad for beneficiaries' health because gum disease is linked with inflammation and conditions such as diabetes, heart disease, stroke, and respiratory problems.

It is time for Congress to expand Medicare's guaranteed coverage to include hearing, vision and dental care for all beneficiaries.

Change Laws that Allow Pharmaceutical Companies to Overcharge Medicare

AFSCME has long supported tackling escalating prescription drug prices by leveraging the collective buying power of Medicare. One in five seniors taking prescription medicine report difficulty paying for their drugs. Among seniors taking four or more medications, the share rises to nearly one in three. We urge Congress to strengthen Medicare by combatting the ways in which pharmaceutical manufacturers can overcharge Medicare, taxpayers and beneficiaries. Medicare prescription drug spending was $143 billion in 2014. Prescription drug spending in

Medicare Parts B and D was 14 % of total Medicare spending in 2014, up from 11 % in 2010 – just five years ago.

We urge Congress to enact the following policies to strengthen Medicare with respect to the pharmaceutical industry's ability to overcharge Medicare.

- **End drug overcharges for low-income beneficiaries.**
  When Medicare Part D was implemented, the cost of providing medicines to millions of people on Medicaid shot up overnight. Medicaid gets far lower drug prices than Medicare. But Medicare Part D told the pharmaceutical industry they no longer had to provide the Medicaid discount for the same people who were shifted to Medicare Part D plans. Ending this "legal" windfall for the drug industry would recover more money for Medicare than even record-breaking fraud recoveries. Restoring the Medicaid discounts for Medicare's low-income beneficiaries would save $121.3 billion over 10 years.

- **Unleash the purchasing power of 50 million Medicare beneficiaries.**
  Current law forbids Medicare from using the purchasing power of nearly 50 million Medicare beneficiaries to negotiate directly with drug companies for lower prices. The discounts obtained by private Medicare Part D plans are three times less than the ones the government gets for Medicaid. Even modest concern over Medicare's solvency and the use of taxpayers' dollars should compel Congress to give Medicare tools to pursue lower drug prices for the program. Estimates are that Medicare could save more than $200 billion over 10 years.

- **Close the Part D coverage gap, sooner.**
  As mentioned before, increasing the drug-maker discounts required by the ACA would shorten the donut hole phase-out period.

- **Stop drug manufacturers from postponing generic entry into the market.**
  Many brand-name pharmaceutical manufacturers pay off generic drug companies to delay introducing a less expensive generic drug or biologic, which keeps brand name prices artificially high for Medicare and its beneficiaries. Authorizing the Federal Trade Commission to stop these anti-competitive and wasteful pay-for-delay agreements would save Medicare $12.3 billion over 10 years. It would also help federal and state Medicaid costs.

- **Stop allowing drug companies to charge more for new drugs that are no better than current medicines.**
  Countries such as Germany, New Zealand and Australia have successfully used a review process to reduce spending on expensive new drugs. Under the administrative processes new brand name drugs that are no more effective than existing treatments do not receive additional payments from those countries' health care programs. This process encourages pharmaceutical companies to invest in innovative drugs that improve health outcomes.

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

We urge Congress not to embrace Medicare benefit design proposals that merely disguise shifting costs onto beneficiaries or employers who provide retiree coverage or make health care unaffordable for the majority of seniors and individuals with disabilities. While the details may

vary, the underlying premise of many benefit redesign proposals is to increase out-of-pocket costs for beneficiaries. The pretense of these proposals is that Medicare beneficiaries are over-insured and increased cost sharing is an appropriate means of limiting unnecessary health care services. As Congress looks at beneficiary cost sharing within the Medicare program, the focus must be on expanding benefits and reducing beneficiary costs.

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 basic expenses (like food and rent) or 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.

Further increasing beneficiary cost sharing (either directly or by further 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.

The classic RAND Health Insurance Experiment, which did not include Medicare beneficiaries, found that 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, and improved the mortality of patients, especially for the poorest patients in the experiment. The implication from this study is that reducing costs for treatable conditions can save lives and that cost sharing is an unreliable tool for reducing health care use.

It seems dubious at best (and potentially cruel at worst) to ask beneficiaries 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 co-insurance 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. Raising the out-of-pocket

costs on beneficiaries will not reduce high medical prices. Indeed, providers may increase prices if utilization drops.

Reject Proposals to Increase Means Testing for Premiums or Out-of-Pocket Costs

The bulk of Medicare Part B is financed through federal income taxes, which, although far from perfect, is a progressive tax on all Americans, including upper-income elderly. By the time higher-income Americans are eligible for Medicare benefits they have already paid far more into the program than lower income Americans.

We are concerned that proposals to further increase income-related Medicare premiums is in conflict with the fundamental principles that have made Medicare a popular, relatively stable and amazing success story for the millions of Americans it has covered over nearly a half-a-century. When former President Harry S. Truman became the first Medicare beneficiary, he was part of a program deliberately designed to embrace seniors rich and poor, sick and healthy. It was and should be a program that unites Americans.

Introducing steep income-related premiums will give healthier seniors an incentive to opt out of Part B, which undermines the Medicare diversified risk pool and widespread support. This would likely lead to a vicious dynamic of higher premiums and further departures from the program, leaving middle-income seniors at the mercy of private insurers. Moreover, if the proposal to set a quota of having one in four beneficiaries paying an income-related premium were implemented today beneficiaries with income of as low as $47,000 would be impacted.

We question whether the added burden on these individuals, the administrative aggravation and harmful erosion on Medicare's founding principles and consequent undermining of Medicare's popular support is worth this modest amount of revenues that would be generated. Making wealthier individuals and profitable corporations pay their fair share through federal income tax, not Medicare premiums, is a sounder path for combining our nation's resources to spread the costs and risk of health care coverage for Medicare beneficiaries.

Medicare Should Not Expand Balance Billing

Currently, Medicare shields beneficiaries from unexpected and limitless charges by prohibiting the vast majority of doctors from billing patients more than the amount Medicare pays for services. Without current protections, beneficiaries would face the burden of higher doctors' bills, which would create a real barrier to getting health care.

Maintaining the requirement that participating physicians cannot charge beneficiaries more than Medicare reimbursements, and non-participating physicians have a cap on the additional charges for Medicare covered services, is particularly important for a population that cannot afford more cost sharing. Most Medicare beneficiaries have low incomes and spend a larger portion of their household income on health care.

Most Medicare beneficiaries already spend a larger share of their income on health care costs than those not on Medicare. Most Medicare beneficiaries are not in a position to earn more

income to pay for higher doctors' bills. Current Medicare law helps keep costs for Medicare beneficiaries predictable and affordable. The fact that 96% of doctors fully participate in Medicare indicates that the current law has achieved the right balance between fair payments for doctors and affordability for patients.

Eliminating or eroding the protections from balance billing harms the very foundation of Medicare to provide guaranteed benefits regardless of a beneficiary's health status or income. Allowing unfettered balance billing will turn Medicare into a class-based program. Patients with resources will be seen by doctors who use balance billing and doctors who decide to forgo or strictly limit balance billing will be left caring for lower-income patients.

We urge Congress not to divide the Medicare population and harm Medicare's core principle of universality by eroding or eliminating the current billing protections in Medicare.

Conclusion

Medicare is an amazing American success story. It has opened doors to health care and given peace of mind to hundreds of millions of older people, people with disabilities, and their families. Medicare gives American workers the knowledge that after a lifetime of hard work and paying into the system, they will have access to quality health care and will not face financial ruin from injury or illness.

This landmark law can be strengthened by filling in its coverage gaps and reducing costs for current and future beneficiaries. Congress should not undermine Medicare by gutting Medicare's guaranteed benefits or turning Medicare into a voucher program. We look forward to working with Congress to protect and strengthen Medicare.

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

HEARING ON

"PRESERVING AND STRENGHENING MEDICARE"

MARCH 16, 2016

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

815 16th Street, NW, 4th Floor • Washington, DC 20006 • (202) 637-5399 • www.retiredamericans.org

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 adult 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 be 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.

March 16, 2016

The Honorable Pat Tiberi
Chairman
Ways & Means Committee
Subcommittee on Health
U.S. House of Representatives

Dear Chairman Tiberi:

Chairman Tiberi, thank you for holding today's hearing on "Preserving Medicare." This issue is important to so many people in this country, and I appreciate your leadership in starting a conversation on a topic that can become a political football.

In holding this hearing and looking at ways in which we can preserve Medicare for future generations, I hope the Subcommittee will look to new solutions like CarePayment's innovative financing program. Our program is a partnership between our company, the hospital and the patient. This connected relationship is one that has led to real savings for hospitals while at the same time offering patients solutions to help them pay for the healthcare they have and need. This program can also be used to help preserve Medicare and I hope you will consider creative solutions, like CarePayment, when it comes to any legislative action.

Though the Affordable Care Act (ACA) has made insurance available to many more Americans, challenges remain. Almost 90% of Americans now have insurance, but many of them still cannot afford to use it. 80% of HIX enrollees have chosen silver or bronze plans. Bronze plans have an average individual deductible of $5,731 and an average family deductible of $11,601.

But, according to the National Bureau of Economic Research (2013), 50% of Americans can't come up with $2,000 in 30 days. Approximately 25% of those patients report an income between $100,000 and $150,000. The majority of bankruptcies are due to medical debt, and 33% of American's or their family members have put off medical treatment due to cost.

In the meantime, seven in ten providers said it took more than a month to collect from patients, and hospitals only collect 11% of balances larger than $500.

This issue is worse for Medicare patients and the providers that service them. Patients on Medicare have no out-of-pocket maximum, so there is no safety net if or when something goes wrong. And most Medicare patients, most of whom are on fixed incomes, didn't plan for this steep increase in out-of-pocket expenses when they were planning for retirement. And providers now have a targeted reimbursement of 65% from CMS for bad debt due to uncollected out-of-pocket expenses for Medicare patients.

CarePayment has created an innovative solution that allows patients to pay off their medical bills over time with no interest, which leads to better access to care, increased patient satisfaction and improved financial performance for providers. For example, 95% of patients who participated in the CarePayment program were satisfied with their billing expenses and two-thirds of patients are more likely to recommend their provider because of CarePayment. And providers can take advantage of a contractual guarantee of net financial improvement.

5300 Meadows Road, Suite 320
Lake Oswego, OR 97035

P 503.419.3505

www.carepayment.com

Medicare patients embrace the CarePayment program since it gives them a way to fulfill their financial obligations, which is consistent with this generation's values. Medicare patients have a much higher enrollment rate in this program than other age groups.

We propose a pilot program that would provide a patient-friendly medical debt assistance program for Medicare participants on a broader basis to improve outcomes for this growing population and reduce overall healthcare costs.

Key benefits of this pilot include:

- Reduce Medicare bad debt and the overall costs of healthcare.
- Improve health outcomes for seniors by ensuring they don't forgo essential medical care due to their inability to pay for out-of-pocket expenses.
- Reduce healthcare costs associated with deferred care.
- Eliminate any fees associated with financing healthcare and make healthcare more affordable for seniors.
- Decrease consumer medical debt and help seniors avoid the negative consequences of medical debt.
- Improve provider financials helping them to maintain their presence in the community, increase the quality of care, and allocate more dollars to charity care.

As part of this pilot, CarePayment will measure key performance indicators, including:

- Reduction in Medicare bad debt and overall healthcare costs
- Access to care
- Adherence to treatment plans
- Patient satisfaction
- Avoidance of medical debt and other financial and social impacts
- Average out-of-pocket expense that is the tipping point for avoiding care or other consequences of medical debt

If you would like more information about the CarePayment program or this pilot proposal, please do not hesitate to contact us. I have included below some testimonials from CarePayment patients who are also Medicare recipients.

"I think it's fabulous because I am on a very limited income. I couldn't have come up with that kind of money at the end of the month." Linda, 73, Pennsylvania

"If I didn't have a way to pay for this treatment, I wouldn't go. This is a great benefit - it's like having a charge account with no interest." Betty, 73, Tennessee

"You see, we're both retired and on a fixed income. We don't get anything else, income wise, and we never will. I'm not sure what we would have done without CarePayment." Allen, 72, Texas

Sincerely,

Craig Hodges
Chief Executive Officer, CarePayment

5300 Meadows Road, Suite 320
Lake Oswego, OR 97035

P 503.419.3505

www.carepayment.com

March 15, 2016

U.S. House of Representatives
Ways and Means Health Subcommittee
1102 Longworth House Office Building
Washington, D.C. 20515

Re: Statement for the Record for the Hearing, "Preserving and Strengthening Medicare"

Dear Chairman Tiberi and Ranking Member McDermott:

The Healthcare Leadership Council (HLC) appreciates the opportunity to submit a statement for the record regarding the hearing entitled, "Preserving and Strengthening Medicare." We applaud the subcommittee for examining ways to set Medicare on a sustainable path for future generations.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies, post acute care providers, and information technology companies – advocate measures to increase the quality and efficiency of healthcare through a patient-centered approach (attached is a list of our members).

HLC has maintained a longstanding position that Medicare can be made a higher-quality program with greater financial sustainability if beneficiaries have enhanced power of consumer choice to drive value. An approach similar to the Medicare Part D Prescription Drug Benefit or the Federal Employees Health Benefits Program, in which private plans compete for consumer loyalties on the basis of price and quality of coverage, can make Medicare a stronger program for current and future beneficiaries. With the Medicare trustees projecting that the program will reach financial insolvency less than 15 years from now – and with 7,500 baby boomers, on average, becoming Medicare-eligible each day – HLC has made the strengthening of Medicare a high priority.

HLC supports modernizing Medicare into a more competitive, quality-driven model based on choice. Moving in this direction would help Congress and the administration

address the impending fiscal crisis the program faces. To ensure Medicare continues for future generations the current path cannot be maintained, but instead innovative ideas and a national commitment are needed. It is important for everyone to understand that the unsustainable future of Medicare affects us all. It affects our health – without change, current and future Medicare beneficiaries will not have access to high-quality, affordable healthcare; it affects our economy – without change, we cannot ensure an environment for economic growth, jobs, and innovation; and it affects our future – without change, the standard of living for our children and grandchildren will be compromised. Thoughtful, beneficiary-centered reforms are far better alternatives for reducing cost than the arbitrary cuts that could happen through the Independent Payment Advisory Board (IPAB) or deficit reduction measures.

HLC has conducted focus groups and economic modeling to examine the kinds of approaches that would be beneficiary-friendly and sustain the Medicare program. We are happy to share this work with the subcommittee. The principles that drive our work are enclosed.

Our members have been avid supporters of programs such as the Medicare Part D Prescription Drug Benefit and Medicare Advantage (MA) because they enjoy high beneficiary satisfaction levels that are rooted in choice, accessibility, and affordability. HLC feels the core structures of these programs could be used as building blocks for broader reform. In fact, a September 2013 Congressional Budget Report entitled, "A Premium Support System for Medicare: Analysis of Illustrative Options," presents a Medicare structure that can be beneficiary-centered and sustainable for future generations. Commonsense solutions that take into account the need for both stability and predictability in payments and policies that enable innovative care delivery are critical to any reform efforts.

HLC appreciates the opportunity to submit a statement for the record for the hearing on "Preserving and Strengthening Medicare." HLC is committed to educating members of Congress and the public about the need for broad Medicare reform and welcome the opportunity to work with you on refining policy solutions to ensure that all Medicare beneficiaries continue to have choice and access to high quality care.

Sincerely,

Mary R. Grealy
President

Enclosure:
Membership List
Medicare Reform Principles

2016 HLC Members
(Alphabetized by Company)

Susan DeVore - Chair
President & CEO
Premier healthcare alliance

Mark Bertolini
Chairman, CEO & President
Aetna

Steve Collis
President & CEO
AmerisourceBergen

Rolf Hoffmann
SVP, US Commercial Operations
Amgen

Susan Salka
President & CEO
AMN Healthcare

Joseph Swedish
President & CEO
Anthem

Anthony Tersigni, EdD
President & CEO
Ascension

Jonathan Bush
Chairman, President & CEO
athenahealth

Joel Allison
CEO
Baylor Scott & White Health

Marc Grodman, M.D.
Chairman, President & CEO
Bio-Reference Laboratories

J. D. Hickey
CEO
BlueCross BlueShield of Tennessee

Everett Hoekstra
Sr. Vice President & CFO
Boehringer Ingelheim USA

George Barrett
Chairman & CEO
Cardinal Health

Neil de Crescenzo
CEO
Change Healthcare

Toby Cosgrove, M.D.
CEO & President
Cleveland Clinic Foundation

Tim Ring
Chairman & CEO
C. R. Bard

Alex Azar
President, Lilly USA
Eli Lilly and Company

John Finan, Jr.
President & CEO
Franciscan Missionaries of Our Lady Health System, Inc.

Jack Bailey
President, US Pharmaceuticals
GlaxoSmithKline

Neil Kurtz, M.D.
President & CEO
Golden Living

Daniel Evans, Jr.
President & CEO
Indiana University Health

Jennifer Taubert
Company Group Chairman, North American Pharmaceuticals

Johnson & Johnson

Jonathan Scholl
President, Health and Engineering Sector
Leidos

Susan Turney, M.D.
CEO
Marshfield Clinic Health System

Brad Bennett
CEO
Maxim Healthcare Services

John Noseworthy, M.D.
President & CEO
Mayo Clinic

John Hammergren
Chairman, President & CEO
McKesson Corporation

Omar Ishrak
Chairman & CEO
Medtronic

Barry Arbuckle, Ph.D.
President & CEO
MemorialCare Health System

Robert McMahon
President, U.S. Market
Merck

Anna Mohl
Regional Business Head, North America
Nestlé Health Science Medical Nutrition Business

Steven Corwin, M.D.
CEO
NewYork-Presbyterian Hospital

Mark Neaman
President & CEO
NorthShore University HealthSystem

Christi Shaw
US Country Head, President
Novartis Pharmaceuticals

Jesper Hoiland
President
Novo Nordisk, Inc.

Craig Smith
Executive Chairman
Owens & Minor

Albert Bourla
Group President, Vaccines, Oncology and Consumer Healthcare
Pfizer

Greg Irace
President & CEO
Sanofi US

Chris Wing
President & CEO
SCAN Health Plan

David Chernow
President & CEO
Select Medical

Tim Scannell
Group President, MedSurg & Neurotechnology
Stryker

Tom Skelton
CEO
Surescripts

Ramona Sequeira
President
Takeda Pharmaceuticals U.S.A.

Jason Gorevic
CEO
Teladoc

Barclay Berdan
CEO
Texas Health Resources

Curt Nonomaque
President & CEO
Vizient

Alex Gourlay
President
Walgreens

James Chambers
President & CEO
Weight Watchers International

Jaideep Bajaj
Chairman
ZS Associates

HEALTHCARE LEADERSHIP COUNCIL

HLC PRINCIPLES ON MEDICARE REFORM

More care coordination and ease in navigating the healthcare system is imperative for Americans who depend on Medicare. The Medicare program has played a vital role in American healthcare since it began providing benefits to seniors and individuals with disabilities 50 years ago. Medicare, however, has been slow to keep up with advances in benefit design throughout the program that would provide important care coordination and financial protection to its most vulnerable beneficiaries. While some care coordination and prevention benefits have been introduced as a result of the Patient Protection and Affordable Care Act (PPACA), more work needs to be done. The complicated structure of separate coverage for hospital benefits, physician benefits, prescription drug benefits and supplemental insurance protection (for those who can afford it) makes the system complex and difficult to manage. Medicare also does not provide catastrophic coverage to protect against excessive out-of-pocket costs. Medicare is an earned benefit. Citizens who have paid into Medicare throughout their lives and are dependent on it as their health needs increase with age deserve a modern Medicare insurance program that works best for them.

1. *Fostering value through consumer choice should be a motivating force behind reform.* Structural reform of Medicare should allow beneficiaries to have a choice of health plans and options from which to choose. Medicare reform should foster a marketplace that encourages development of healthcare delivery models, coverage options and products that stem from an innovative, competitive environment while protecting Medicare's earned benefits.

2. *Empowering and protecting beneficiaries must be a central component to reform*. Medicare beneficiaries should be empowered to choose among multiple affordable health plans, which provide catastrophic coverage and offer, at a minimum, the same benefits and actuarial value as traditional Medicare. It is also important that the government provide sliding scale financial assistance to beneficiaries based on their income levels. Beneficiaries should always have access to needed treatments and providers.

3. *Medicare reform should incorporate a system where "apples to apples" comparison of health plans, including traditional Medicare, is available to all beneficiaries.* Beneficiaries should be able to access health coverage information in a way that is simplified, whether it is through the Internet, over the phone, through written material, or face-to-face meetings. Whether they choose traditional Medicare or a private plan, they should be able to easily weigh total costs, benefits, and quality in order to compare and contrast and choose a plan that best fits their needs.

4. *Medicare reform should look to the successful competitive market-based features included in existing federal programs that provide better access to coordinated care.* The ability to coordinate care and support better care transitions results in better managed patients and better outcomes. Programs such as Medicare Part C (Medicare Advantage), the Medicare Part D Prescription Drug Benefit, and the Affordable Care Act, for example, all have features that encourage affordability, choice, quality and innovation. The best of these models should be considered and adapted as part of Medicare reform.

5. *Payments to health plans and providers should reflect accurate mechanisms to assure fairness for all beneficiaries and providers.* Medicare beneficiaries differ in many ways, from basics like age and gender, to more nuanced characteristics such as prior use of healthcare services and socioeconomic status. Payment to health plans and providers should be quality-based and risk-adjusted to reflect these important personal characteristics so all stakeholders are treated fairly and there remains ample choice and competition in the marketplace, especially for high-risk beneficiaries.

6. *Effective oversight is important to ensure the success of a modernized Medicare program.* Appropriate regulation is critical to ensure fair, robust, and consumer-centric competition in a new Medicare marketplace. By contrast, regulation that is unnecessarily burdensome or that imposes unnecessary expenses should be avoided.

7. *If we do not act thoughtfully now, the alternative will be severe.* The longer we wait to reform Medicare in a meaningful way, the more likely we risk encountering a budget environment that will implement drastic, arbitrary spending cuts and/or tax hikes to all stakeholders who participate in the Medicare program. This “death by a thousand cuts” will hinder beneficiaries’ access to healthcare services and products, negatively impact healthcare quality, and limit innovation. In addition to resulting in potential reduced services for Medicare beneficiaries, policymakers could be faced with delaying eligibility or other proposals that could harm beneficiaries.

8. *The sustainability of Medicare for future generations is at stake.* We have reached the point at which policymakers can no longer avoid addressing the serious economic challenge presented by Medicare’s inability to keep pace with incoming beneficiaries’ healthcare needs. 11,000 new beneficiaries are eligible for Medicare every day as Baby Boomers turn 65 years old. These beneficiaries will receive over three dollars in healthcare services for every dollar paid in Medicare payroll taxes during their working years. Furthermore, where we had 19 active workers supporting each beneficiary through payroll taxes in 1965, today that ratio is less than four-to-one.

Leadership Council of Aging Organizations

Max Richtman, Chair

March 29, 2016

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

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

Dear Chairman Tiberi and Ranking Member McDermott:

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

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

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

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

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

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

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

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

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

Sincerely,

Max Richtman
Chair, Leadership Council of Aging Organizations

Leadership Council of Aging Organizations

FACT SHEET

March 2016

MEDICARE BENEFICIARY CHARACTERISTICS AND OUT-OF-POCKET COSTS

Containing Medicare costs is an important goal, both to improve affordability for those who need care and to ensure the long-term sustainability of the program. Yet, some policy makers believe that older adults do not have enough "skin in the game" and propose shifting more out-of-pocket costs onto beneficiaries—an approach that would fail to address the underlying causes of cost growth. Proposals to shift costs to people with Medicare do not take into account three key facts: (1) Most beneficiaries have low or modest incomes; (2) Medicare benefits are not overly generous; and (3) Medicare beneficiaries already pay significant out-of-pocket costs.

Some plans propose increasing Medicare cost sharing, which is already high, has been increasing rapidly, and would make health care unaffordable for millions of older Americans. It is critical to understand that most beneficiaries struggle financially, already have high health costs, and cannot pay more.

LCAO recognizes the need to control health care spending. With respect to Medicare, we support savings mechanisms that address system-wide health care inflation and build on the cost savings of the Affordable Care Act. The American Academy of Actuaries agrees: "[I]mproving Medicare's long-term sustainability requires slowing the growth in overall health spending— not simply shifting costs from one payer to another."[1]

Medicare Beneficiary Characteristics

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

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

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

---

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

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

Medicare Beneficiary Out-of-Pocket Costs

- **Health care costs are a significant expense for Medicare beneficiaries.** In 2014, Medicare beneficiaries spent an average of $5,342 on health care costs.[6] In 2010, more than 5 million people with Medicare (10%) spent more than $8,030.[7] In the last 5 years of life, beneficiaries spend $38,688 on average.[8] For 25% of beneficiaries, out-of-pocket costs average $101,791 during this period. Almost half of Americans die with less than $10,000 in financial assets.[9]

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

- **Beneficiary out-of-pocket costs are increasing**. The cost of Medicare Part B and D premiums and cost sharing as a share of the average Social Security benefit increased from 7% in 1980 to 14% in 2000 and up to 26% in 2010.[11]

- **Under Medicare, many health care needs are not covered.** Medicare coverage is not comprehensive and tends to be less generous than typical large employer plans. For instance, Medicare does not cover dental, vision, hearing services, and most long-term care services and supports. In 2011, for the average senior, Medicare covered $11,930 of the $14,890 in estimated annual health care spending—less than would be covered under the federal employee plan ($12,260) or the typical Preferred Provider Organization (PPO) comparison plan ($12,800) for an employee age 65 or older.[12]

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

---

[5] Cubanski, J. "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use," (Kaiser Family Foundation: February 2013)

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

[7] Noel-Miller, C. "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care," (AARP Public Policy Institute, December 2013)

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

[9] Kelley AS, et. al. "Out-of-pocket spending in the last five years of life," *Journal of General Internal Medicine* (October 2012); National Bureau of Economic Research, "Were they prepared for retirement? Financial status at advanced ages in the HRS and Ahead Cohorts," (February 2012)

[10] Noel-Miller, C. "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care," (AARP Public Policy Institute, December 2013)

[11] Cubanski, J. "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February 2013)

[12] Kaiser Family Foundation, "How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?" (April 2012)

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

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

- **Baby Boomers face increased financial uncertainty due to the economic downturn.** Today's working adults need Medicare to remain affordable, particularly due to declining home values, diminished retirement accounts, and job loss caused by the recession. In 2030, estimates suggest half of all Medicare beneficiaries will live on annual incomes of $28,450 or less.[17] Moreover, from 1992 to 2007, the average overall debt for 55 to 64 year old households more than doubled to $70,370. Debt among older adults (age of 55+) continues to increase—63% had some level of debt. In 2014, 8% of Medicare beneficiaries had no savings or were in debt. [18]

- **Medicare low-income protection programs are broken and must be modernized**. According to the most recent estimates, only 33% of eligible beneficiaries were enrolled for Qualified Medicare Beneficiary (QMB) benefits and only 13% were enrolled for Specified Low-Income Medicare Beneficiary (SLMB) benefits.[19] In addition, rigid, unreasonably low asset tests penalize beneficiaries by denying eligibility to those who did the right thing during their working years by setting aside a modest nest egg of savings.

---

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

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

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

[16] National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper," (October 2011); Amal N. Trivedi, et. al. "Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly" *New England Journal of Medicine* (January 2010); Swartz, K. "Cost-Sharing: Effects on Spending and Outcomes" Robert Wood Johnson Foundation Research Synthesis Report No. 20 (December 2010)

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

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

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

Leadership Council of Aging Organizations

FACT SHEET

March 2016

MEDICARE "REDESIGN" PROPOSALS COULD HARM MANY BENEFICIARIES

Background

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

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

Our Position

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

Our Rationale

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

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

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

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

- **Low-income beneficiaries are not protected against Medicare cost-sharing.** Eligibility for assistance with Medicare cost-sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100% of poverty (plus $20 a month, totaling $12,012 for singles and $16,176 for couples in 2015) and non-housing assets below just $7,280 for singles and $10,930 for couples. This is far less generous than cost-sharing protections available to those under age 65, with eligibility at 138% of poverty and no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third are actually enrolled in the program.[23] Changing Medicare cost-sharing in the manner suggested by many redesign proposals would redistribute the burden of health care costs onto the most vulnerable, including those with moderate incomes and those with persistent and chronic health needs.[24]

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

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

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

---

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

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

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

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

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

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

care.[27]

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

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

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Statement

Of

The National Association of Chain Drug Stores

For

United States House of Representatives
Committee on Ways and Means
Subcommittee on Health

Hearing on:
Preserving and Strengthening Medicare

March 16, 2016
10:00 A.M.

1100 Longworth House Office Building

National Association of Chain Drug Stores (NACDS)
1776 Wilson Blvd., Suite 200
Arlington, VA 22209
703-549-3001
www.nacds.org

The National Association of Chain Drug Stores (NACDS) thanks Chairman Brady and the members of the Subcommittee on Health for the opportunity to submit the following statement for the record regarding preserving and strengthening the Medicare program. NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other health care providers to improve the quality and affordability of health care services.

NACDS represents traditional drug stores and supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS' chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.2 million individuals, including 179,000 pharmacists. They fill over 2.9 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 850 supplier partners and over 60 international members representing 22 countries. For more information, visit www.NACDS.org.

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.

NACDS believes retail pharmacists can play a vital role in strengthening the Medicare program by greatly improving beneficiary health while reducing program spending;

including through improving access for underserved beneficiaries and the better use of medication therapy management (MTM) services.

Pharmacists as Providers

As the U.S. healthcare system continues to evolve, a prevailing issue will be the adequacy of access to affordable, quality healthcare. The national physician shortage coupled with the continued expansion of health insurance coverage in recent years will have serious implications for the nation's healthcare system. Access, quality, cost and efficiency in healthcare are all critical factors – especially to the medically underserved. Without ensuring access to requisite healthcare services for this vulnerable population, it will be very difficult for the nation to achieve the aims of healthcare reform.

The medically-underserved population includes seniors with cultural or linguistic access barriers, residents of public housing, persons with HIV/AIDS, as well as rural populations and many others. Significant consideration should be given to innovative initiatives within the medically underserved population to enhance healthcare capacity and strengthen community partnerships to offset provider shortages and the surge in individuals with healthcare coverage.

Pharmacists play an increasingly important role in the delivery of services, including key roles in new models of care beyond the traditional fee-for-service structure. Pharmacists are engaged with other professionals and participating in models of care based on quality of services and outcomes, such as accountable care organizations (ACOs). Pharmacists now commonly provide immunizations MTM services.

In addition to medication adherence services such as MTM, pharmacists are capable of providing many other cost-saving services (subject to state scope of practice laws). Examples include access to health tests, helping to manage chronic conditions such as diabetes and heart disease, plus expanded immunization services. However, the lack of pharmacist recognition as a provider by third-party payors, including Medicare and Medicaid, limits the number and types of services pharmacists can provide, even though fully qualified to do so. Retail pharmacies are often the most readily accessible healthcare provider. Research shows that nearly all Americans (94 percent) live within five miles of a retail pharmacy. Such access is vital in reaching the medically underserved.

We urge you to increase access to much-needed services for underserved Medicare beneficiaries by supporting H.R. 592/S. 314, the *Pharmacy and Medically Underserved Areas Enhancement Act,* which will allow Medicare Part B to utilize pharmacists to their full capability by providing those underserved beneficiaries with services (subject to state scope of practice laws) not currently reaching them. This important legislation would lead not only to reduced overall healthcare costs, but also to increased access to healthcare services and improved healthcare quality, all of which is vital to ensuring a strong Medicare program.

The Benefits of Pharmacist-Provided MTM

Poor medication adherence costs the U.S. healthcare system $290 billion annually. Pharmacist-provided services such as MTM are important tools in the effort to improve medication adherence, patient health and healthcare affordability. Studies have shown that patients who are adherent to their medications have more favorable health outcomes, such as

reduced mortality, and use fewer healthcare services (especially hospital readmissions and ER visits). These studies included patients with cardiovascular disease, chronic obstructive pulmonary disease (COPD), high cholesterol and diabetes. Current MTM restrictions require that Medicare Part D beneficiaries suffer from multiple chronic conditions, be prescribed multiple medications, and meet a minimum annual cost threshold of $3,138 in 2015 for their prescriptions before they are eligible for Part D MTM. According to the CMS MTM Fact Sheet, approximately 85% of programs opt to target beneficiaries with at least three chronic diseases in 2014. This is a contributing factor to the lower than projected eligibility levels in the MTM program.

NACDS has long been supportive of exploring new and innovative approaches to improve the Part D MTM program. One of the approaches we believe can be successful is the Enhanced MTM Model pilot allowing Part D plans the opportunity to utilize new and innovative approaches to MTM, such as more efficient outreach and targeting strategies and tailoring the level of services to the beneficiary's needs. The Enhanced MTM Pilot program presents an opportunity to create better alignment of program incentives and has the potential to lead to improved access to MTM services for beneficiaries and greater medication adherence. NACDS believes a successful model test must include retail community pharmacists. Medication management services provided by community pharmacists improve patient care; improve collaboration among providers; optimize medication use for improved patient outcomes; contribute to medication error prevention; improve hospital and readmission cost avoidance; and enable patients to be more actively involved in medication self-management.

Since the pilot is scheduled to last for five years beginning in 2017, we also urge lawmakers to explore new and innovative approaches to improving the Part D MTM program that could be implemented in the short term. NACDS believes one short term approach is more efficiently targeting beneficiaries who can most benefit from the services that will improve medication adherence and overall program effectiveness. 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 legislation such as that introduced by Sen. Pat Roberts (R-KS) and Sen. Jeanne Shaheen (D-NH), S. 776, the *Medication Therapy Management Empowerment Act of 2015,* which will provide access to MTM for beneficiaries with diabetes, cardiovascular disease, COPD, and high cholesterol.

Conclusion

NACDS thanks the Subcommittee for consideration of our comments. We look forward to working with policymakers and stakeholders on finding ways to preserve and strengthen the Medicare program.

National Committee to Preserve Social Security & Medicare™
Trusted • Independent • Effective

Statement of
Max Richtman
President and CEO
National Committee to Preserve Social Security and Medicare

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Hearing on "Preserving and Strengthening Medicare."
Washington, DC
March 16, 2016

Chairman Tiberi and Ranking Member McDermott:

I am Max Richtman, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare, 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 dedicated to preserving and strengthening safety net programs, including Social Security, Medicare and Medicaid. These programs are the foundation of financial and health security for older Americans, but improvements are needed to ensure that beneficiaries receive the care they need and that they are protected from unaffordable out-of-pocket costs.

Medicare's Success

Last July, we celebrated the 50th anniversary of Medicare - one of our nation's most popular and successful programs - being signed into law by President Lyndon Johnson. Before the enactment of Medicare in 1965, only 50 percent of seniors had health insurance and 35 percent lived in poverty.

That was a time when even a minor illness or injury could bankrupt older Americans and their families. Fast forward to 2015 when over 55.3 million Americans are receiving guaranteed health care benefits through the Medicare program regardless of their medical condition or income. This includes 46.3 million Americans age 65 and above and 9 million Americans receiving Social Security disability insurance benefits. By the time the last of the baby boomers reaches age 65, it is expected that close to 80 million people will be covered through Medicare. Together with Social Security and Medicaid, Medicare forms the bedrock of economic security and health security for today's seniors and for tomorrow's retirees as well as for individuals who become disabled.

Minding the Gaps in Medicare Coverage

Medicare goes a long way in preventing poverty and promoting greater access to health care for people 65 years of age and older and people with disabilities. However, Medicare coverage is not comprehensive. In addition to Medicare's cost-sharing – for premiums, deductibles and coinsurance – Medicare beneficiaries must pay out-of-pocket for gaps in Medicare coverage. The standard Medicare benefit does not cover hearing, dental and vision care and most long-term services and supports. These coverage gaps often come as a surprise to beneficiaries when they need these services, and they are a great financial burden or unaffordable for many people. In 2014, Medicare households spent over twice as much as the average household on out-of-pocket health care costs even though half of all Medicare beneficiaries had incomes below $24,150. Older Americans should not have to choose between paying for health care, food or utilities. Medicare benefits must be improved, not cut, and Medicare's long-term solvency must be strengthened.

In its 50 year history, Medicare has demonstrated that it is a dynamic program, meeting the changing demographic and health security needs of older Americans. Starting in 1966, Medicare provided

only hospital and outpatient coverage, through Medicare Part A and B, and only to people 65 and older. In 1972, coverage was added for individuals with disabilities and end-stage renal disease. Starting in 1982, Medicare provided coverage for hospice care, a prescription drug benefit was added in 2003 and mental health benefits were significantly improved in 2008. And the Affordable Care Act, passed in 2010, includes many Medicare improvements to promote better health and save money.

The Affordable Care Act Strengthens Medicare

Medicare's solvency and benefits were strengthened by the Affordable Care Act (ACA). It improves care for Medicare beneficiaries by eliminating out-of-pocket costs for preventive screenings, annual wellness visits and personalized prevention plans; providing discounts on prescription drugs in the Part D coverage gap known as the "donut hole," which will be phased out by 2020; and providing incentives to improve the quality of care. The ACA strengthens Medicare's financing by reducing waste, fraud and abuse; slowing the rate of increase in payments to providers; and phasing out overpayments to private Medicare Advantage plans. Projections of the solvency of the Part A Trust Fund have increased by 13 years since passage of the ACA. There's a lot to celebrate about Medicare's past and, thanks to the Affordable Care Act, a more hopeful outlook for the present and future.

Improving Medicare's Payment and Delivery Systems

The National Committee to Preserve Social Security and Medicare's Legislative Agenda for the 114th Congress 2nd Session, http://www.ncpssm.org/Portals/0/pdf/legislative-agenda-2016.pdf, includes several proposals for strengthening the Medicare program and enhancing benefits. One of

our priorities is strengthening traditional Medicare by building on the Affordable Care Act's payment and delivery system reforms that are containing costs and promoting high-quality care. Accountable care organizations, medical homes, bundled payments and value-based purchasing are improving and coordinating care for beneficiaries with multiple chronic conditions as well as reducing costs. In part because of the savings in the ACA, the growth in Medicare spending per enrollee has slowed significantly in recent years. Spending per enrollee in 2015 was about $1,200 lower than was projected in 2010 (Source: http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/).

Expanding Medicare Benefits

The National Committee's legislative agenda includes many proposals to improve current Medicare benefits, including:

- **Enact a Catastrophic Out-of-Pocket Limit for Spending in Traditional Medicare.** There are various deductibles and copayments for services which are covered by Medicare. The Part A deductible and other cost-sharing are quite high. Medicare does not have a limit – a so-called "stop-loss" or catastrophic cap – on annual out-of-pocket spending. A catastrophic out-of-pocket limit on spending and a combined Part A and Part B deductible would bring Medicare more in line with large-employer plans and the Federal Employees Health Benefits Program (FEHBP). A recent version of this approach – Medicare Essential – would provide a new public plan with a comprehensive benefit package as an alternative to traditional Medicare and Medicare Advantage. It would combine Medicare's hospital, physician and prescription drug coverage into an integrated benefit with an annual limit on out-of-pocket expenses for covered benefits.

- **Count Observation Days Toward Meeting the Three-Day Rule.**

  Medicare beneficiaries are being denied access to Medicare's skilled nursing facility (SNF) benefit because acute care hospitals are increasingly classifying their patients as "outpatients" receiving observation services, rather than admitting them as inpatients. Under the Medicare statute, patients must have an inpatient hospital stay of three or more consecutive days, not counting the day of discharge, in order to meet Medicare criteria for coverage of post-acute care in a SNF. As a result, although the care received by patients in observation status is indistinguishable from the care received by inpatients, outpatients in observation who need follow up care in a SNF do not qualify for Medicare coverage. Observation stays must be counted toward the three-day mandatory inpatient stay for Medicare coverage of SNF services. Consideration should also be given to limiting beneficiaries' payments to the lesser of inpatient or outpatient costs.

- **Provide Vision, Dental and Hearing Coverage.**

  Medicare does not pay for routine dental care and dentures, routine vision care or eyeglasses, or hearing exams and hearing aids, all services of great importance to many older people and which contribute to their high out-of-pocket health care costs. Medicare benefits should be expanded to cover vision, dental and hearing health services and equipment because they are important for healthy aging.

With respect to hearing benefits, the National Committee supports H.R. 1653, the "Medicare Hearing Aid Coverage Act," legislation introduced by Congresswoman Debbie Dingell to expand coverage in the Medicare program to include hearing assessments and hearing aids. Passage of this legislation

would mean that millions of seniors with hearing loss could finally get the help they need to pay for assessments and treatments.

The National Committee Foundation has published an issue brief "The Case for Expanding Medicare Hearing Loss: The Economic, Social and Medical Factors Impacting Healthy Aging" http://www.ncpssmfoundation.org/Portals/0/case-for-expanding-medicare.pdf to demonstrate why Medicare should cover hearing aids which can range anywhere from $3000 - $7000. Many older Americans on modest, fixed incomes simply cannot afford to pay out-of-pocket for their hearing, vision and dental care. They go without needed treatments. In the case of hearing loss, this means that safety risks are increased because they can't hear a car coming or can't hear the phone ringing or an alarm going off. They can't clearly hear the instructions from their doctor during a check-up which could lead to mistakes in taking their medications. They can't hear – so they get confused, embarrassed or frustrated, and they gradually withdraw from their normal routine of activities. This isolation may be linked to the early onset of dementia or Alzheimer's disease. If hearing aid coverage could slow the onset of these dreaded neurologic diseases, billions of dollars in Medicare and Medicaid spending could be saved. That's why Congress should enact Representative Dingell's bill and consider other proposals to improve Medicare benefits.

Proposals to Make Benefit Improvements Affordable

Enactment of the Affordable Care Act is the most recent example of how lawmakers paid for and expanded Medicare benefits. Today, there are several proposals available to offset the cost of expanding Medicare benefits that we have included in the National Committee's legislative agenda.

Curbing high drug costs is a prime area to achieve savings. For seniors, drug costs are important because of their impact on out-of-pocket costs and their potential to threaten the sustainability of Medicare and Medicaid. High drug prices are having a direct impact on beneficiaries' Part D costs. The ten most popular stand-alone Part D plans, representing more than 80 percent of prescription drug plan enrollment, will see average premium increases of 8 percent in 2016. Accelerating the closure of the Part D coverage gap would allow beneficiaries to receive needed financial relief.

High drug costs impact the Medicare Part B program as well, as many high cost drugs such as cancer drugs are administered in physician offices. A Government Accountability Office study found that nearly two-thirds of new Part B drugs had expenditures per beneficiary in excess of $9,000 in 2013.

Due to Medicare Part B coinsurance, beneficiaries who are prescribed drugs shoulder 20 percent of the costs of their drugs. And there is no out-of-pocket cap for Part B expenses. In 2013, beneficiaries' share of the cost of these drugs ranged from $1,900 to $107,000 per drug. While many beneficiaries have supplemental insurance to help pay for their out-of-pocket costs, the impact on beneficiaries who need these drugs and who are without supplemental coverage is potentially devastating.

Without action, drug prices will continue to put pressure on the Medicare program. Total per beneficiary costs for the Medicare prescription drug program grew by almost 11 percent in 2014, driven largely by specialty drugs. According to the Centers for Medicare and Medicaid Services, total Medicare subsidies, known as reinsurance, paid to Part D plans with enrollees that have especially high drug costs have grown by more than three times the rate of premium growth.

Over the long term, these trends will continue to unnecessarily drive up costs for the program. Total Medicare Part B drug expenditures grew at an average annual rate of 4.4 percent from 2007 through 2013, which is at a much higher rate than inflation over that time. Things will only get worse as hundreds of expensive new drugs currently in development make their way to market.

We therefore support a range of policies that would reduce drug prices for the Medicare program. As a threshold matter, the cost of drug development needs to be made more transparent. Greater transparency is needed around pricing. Purchasers and payers need a better understanding of what a reasonable price for a product is based on clinical evidence of effectiveness and on a reasonable return on the cost of development. When considering ways to make Medicare more efficient, the Ways and Means Committee should monitor the implementation of various state laws that require drug manufacturers to divulge the costs associated with conducting clinical trials, the costs associated with manufacturing drugs, and the amount of government subsidies received for research. The committee should consider ways that Medicare and Medicaid could collect and use this kind of information to inform reimbursement decisions.

Sole source drugs create a particular problem for policy makers. The issue is especially problematic for Medicare, which does not receive manufacturer rebates and is prohibited from direct price negotiation with drug manufacturers. The National Committee supports lifting this prohibition. That is why we support H.R. 4207, the Medicare Fair Drug Pricing Act, introduced by Representative Jan Schakowsky, which provides such authority to the Secretary of Health and Human Services for sole source drugs.

Additional savings could be achieved from restoring the pharmaceutical drug company rebates for medicines prescribed to dual-eligibles, those on both Medicare and Medicaid, which could generate

$121 billion over ten years. In addition, more savings could be acquired by allowing the government to negotiate Part D prescription drug prices, stopping pay-for-delay agreements that keep less expensive generic drugs off the market, promoting faster development of generic biologic drugs, aligning Medicare Advantage (MA) and traditional Medicare payments, and halting the practice of "upcoding" that some MA plans engage in to receive higher payments. Finally, increasing National Institutes of Health Alzheimer's research funding could curb rising Medicare costs associated with the disease and other dementias, and save millions of lives.

Conclusion

Medicare has provided five decades of quality health care coverage to seniors and people with disabilities while lifting generations of Americans out of poverty. It has accomplished this at a cost consistent with or lower than the increase in private health insurance premiums. Medicare's success has made the program tremendously popular. Across party lines and all age groups, large majorities support our efforts to protect and improve Medicare benefits for all Americans.

Since 1965, Congress has gradually erased some of Medicare's coverage gaps, but more must be done to make benefits comprehensive and health care delivery more efficient without compromising the quality or accessibility of care.

We urge Congress to focus on improving Medicare with a new sense of urgency because the program – when combined with Social Security – has become increasingly important to the economic security of millions of retirees. Stagnant wages are grinding away at the middle class's ability to save for retirement. Many employers have significantly scaled back or eliminated the traditional retirement

benefits offered to their employees. As a result, current and future retirees cannot afford proposals to cut benefits, raise the eligibility age or privatize the program.

Now is the time to build on the program's successes in keeping older Americans healthy and "out of the poor house." While containing costs for seniors and the program itself, we should be supporting proposals to expand benefits so that Medicare provides comprehensive and affordable health care coverage.

Thank you again for the opportunity to share the National Committee's views on the future of Medicare.