



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

HEARING ON

“EXAMINING TRADITIONAL MEDICARE’S BENEFIT DESIGN”

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The Alliance for Retired Americans appreciates the opportunity to submit comments to the Committee on Ways and Means, Subcommittee on Health for the hearing entitled “Examining Traditional Medicare’s Benefit Design,” which will focus on MedPAC’s recommendations to redesign Medicare benefits. While the concept of a cap on out-of-pocket costs is appealing, the Alliance has real concerns with other aspects of MedPAC’s recommendations and the full implications of implementing such a plan.

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

Before discussing MedPAC’s proposal, one must consider who would be impacted by this 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 \$22,000 and one third of beneficiaries have annual incomes under \$16,755. A typical Medicare household has a lower average budget than the average household (\$30,818 versus \$49,641 respectively) but spends three times (14.7 percent versus 4.9 percent respectively) as much on medical expenses than does the average household. Given this sobering reality, it is difficult to comprehend how anyone can expect Medicare beneficiaries to pay more.

The Alliance views the combined deductible as a huge shift in cost to beneficiaries who are relatively healthy and do not need hospital services. According to data from 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. According to a report by the Kaiser Family Foundation, if the combined deductible were coupled with a uniform co-insurance rate, 75% of Medicare beneficiaries would experience increased out-of-pocket spending. While MedPAC’s plan uses a tiered co-insurance rate, MedPAC admits that, under their plan, more beneficiaries would see their out-of-pocket spending increase by \$250 rather than decrease in spending. This includes 42 percent of the 4.1 million beneficiaries who do not have supplemental policies in 2013.

The Medigap supplemental policy surcharge proposed by MedPAC is also troubling. The idea behind the surcharge is that beneficiaries overutilize services because it doesn’t cost them anything and that beneficiaries need to have more “skin in the game”. The surcharge is designed to impact beneficiaries’ medical spending habits. This thinking is flawed in many ways. First, Medigap policies are expensive. In

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

Another troubling aspect is that the surcharge will not only affect seniors with Medigap plans, but also those with employer-sponsored supplemental plans. Those individuals often received health benefits in lieu of pay raises. They agreed to forfeit pay for health benefits, because it gave them peace of mind, knowing the benefits would be there for them when they needed it. It is unconscionable that Congress would now take that away from them.

Another troubling provision in MedPAC's proposal is the establishment of a tiered-copayment for different services. This will result in beneficiaries paying copayment for services where none was required before. Currently, there is no co-insurance for the first 60 days of a hospital visit or hospitalization in an inpatient psychiatric facility or the first 20 days in a skilled nursing facility. Nor is there any co-insurance for home health or hospice. Under MedPAC's proposal, those individuals would for the first time pay co-insurance as follows: \$750 per hospital admissions, \$80 per day for skilled nursing facility stays, \$150 per episode for home health care. The new co-insurance could force some seniors to forgo needed medical care endangering their health.

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 under the government's FEHBP plans or those under 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 when such a plan is being offered in the context of deficit reductions.

If Congress is, in fact, looking for health savings, there are other areas that it should consider. One example 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 would not negatively affect Medicare beneficiaries or shift costs to them.

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