



Leadership Council of Aging Organizations

James P. Firman, Chair

March 12, 2013

The Honorable Kevin Brady
Chairman
Ways & Means Subcommittee on Health
Washington, D.C. 20515

**Re: House Ways & Means Health Subcommittee Hearing “Examining Traditional Medicare’s Benefit Design”
(2/26/13)**

Dear Chairman Brady:

On behalf of the Leadership Council of Aging Organizations (LCAO), a coalition of national non-profit organizations representing over 60 million older Americans, we submit this testimony in response to the above-referenced hearing.

In recent years, there have been several proposals that seek to alter Medicare’s benefit structure, often with similar elements, including creating a single, combined deductible for Parts A and B, a uniform coinsurance rate of 20%, an out-of-pocket cap on beneficiary expenses and various piecemeal changes, such as introducing home health copayments. Often these proposals to redesign Medicare’s benefits are coupled with proposals to restrict Medigap “first-dollar coverage.”

At first glance, making changes such as combining the Part A and B deductible and adding a catastrophic cap seem like a sensible endeavor. Many of the proposals to do so, however, would redistribute the burden of health care costs to those least able to afford it. LCAO supports measures to bring down costs in the Medicare program that address the systemic causes of health care inflation, not by shifting costs to people with Medicare. The most discussed Medicare benefit redesign proposals fail to meet this standard. We are writing to express the following concerns about current benefit redesign proposals:

Most Medicare beneficiaries have low- or moderate- incomes, and cannot afford to pay more for their health care.

In 2012, half of all Medicare beneficiaries had annual incomes below \$22,500 and Medicare households, in general, devote a substantially larger share of their income to medical expenses than does the average household (15% vs. 5% respectively).¹ Most Medicare beneficiaries cannot absorb more costs without facing significant hardship. To borrow a crude reference, in short, people with Medicare already have too much “skin in the game.”

Increased cost sharing is an inappropriate tool to limit unnecessary use of health services, and limits access to necessary care. Many proposals to reform Medicare, including several benefit redesign frameworks, purport to achieve federal savings by shifting costs to Medicare beneficiaries. Research demonstrates that increased cost sharing for health care services leads individuals to forgo needed health care services in the short-term. This trend is shown to result in worsening health, the need for more intensive care and higher costs to the Medicare program in the long-term.²

¹ See, e.g., LCAO Fact Sheet: “Medicare Beneficiary Characteristics and Out-of-Pocket Costs” (December 2012), and citations therein, available at: <http://www.lcao.org/files/2013/02/LCAO-Medicare-Characteristics-Costs-Fact-Sheet-Dec20121.pdf>

² See, e.g., National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, “Medicare Supplemental 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; Congressional

Current protections for low-income individuals are inadequate. Currently, full Part A, B and D subsidy protection is provided only for those with incomes up to 100% of the federal poverty level. In order to assist more people who truly cannot afford to pay for necessary health care services, the income thresholds for full subsidy protection should be increased and asset tests should be eliminated. Any discussion of redesigning Medicare's benefit structure, even one that is budget neutral, must include budget proposals to strengthen programs for those with low-incomes.

Limiting Medigap coverage and/or adding a surcharge to such policies is not a solution for savings. Instead of driving "overuse" of health services, these policies provide financial security and protection from high, unexpected out-of-pocket costs due to unforeseen medical care. Once beneficiaries seek care, medical providers—not beneficiaries—drive the number and types of services delivered. Further, it is the Medicare program—not Medigap plans—that determine which services are covered and are medically necessary.³

For these reasons, the undersigned members of the LCAO urge you to reject Medicare redesign proposals that shift additional costs to Medicare beneficiaries. Any efforts to redesign the Medicare benefit structure should be done as part of a thoughtful, deliberative process instead of part of the debt and deficit reduction debate.

Sincerely,

AFSCME Retirees

Alliance for Retired Americans

Alzheimer's Foundation of America

American Association for International Aging (AAIA)

Association for Gerontology and Human Development in Historically Black Colleges and Universities (AGHDHBCU)

Association of Jewish Aging Services (AJAS)

B'nai B'rith International

Center for Medicare Advocacy, Inc.

Easter Seals

International Union, UAW

LeadingAge

Lutheran Services in America (LSA)

Medicare Rights Center

Military Officers Association of America (MOAA)

National Academy of Elder Law Attorneys (NAELA)

National Asian Pacific Center on Aging (NAPCA)

National Association for Home Care and Hospice (NAHC)

National Association of Area Agencies on Aging (n4a)

National Association of Professional Geriatric Care Managers (NAPGCM)

National Association of Social Workers (NASW)

National Association of States United for Aging and Disabilities (NASUAD)

National Committee to Preserve Social Security and Medicare (NCPSSM)

National Consumer Voice for Quality Long-Term Care

National Hispanic Council on Aging (NHCOA)

National Senior Citizens Law Center (NCSLC)

OWL – The Voice of Midlife and Older Women

PHI – Quality Care *Through* Quality Jobs

Services and Advocacy for GLBT Elders (SAGE)

Budget Office, "Budget Options Volume 1: Health Care" (December 2008), page 155, available at:

<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>

³ See LCAO Issue Brief: "Reforming Medigap Plans: A Flawed Approach to Achieve Medicare Savings" (December 2012)

<http://www.lcao.org/files/2013/02/LCAO-Medigap-Issue-Brief-Dec2012.pdf>; also see NAIC Discussion Paper, *supra*.