

June 28, 2012

Congressman Wally Herger, Chair
Congressman Pete Stark, Ranking Member
SubCommittee on Health of the
Committee on Ways and Means in the House of Representatives

The Honorable Chairman Herger:

Our organizations represent millions of Medicare beneficiaries. Each of us is an appointed consumer group member of the NAIC's Senior Issues Task Force statutory PPACA Subgroup, organized to make recommendations to the Secretary in regard to adding cost sharing to Medigap plans C and F as required by Section 3210 of the Affordable Care Act. We are very concerned about proposals that would make Medicare beneficiaries pay higher out-of-pocket costs and the misperception that seniors don't have enough "skin in the game."

We are very concerned about the MedPAC testimony at the recent Subcommittee hearing. The MedPAC testimony and report proposes a tax on the supplemental benefits Medicare beneficiaries buy as financial protection against the sudden, unpredictable, and unlimited medical costs that remain after Medicare pays its portion of covered costs. Medicare beneficiaries already pay a substantial amount of their annual incomes on direct and indirect medical care costs, and most of those costs will continue to rise even if all of recommendations in the MedPAC report were enacted.

For instance, beneficiaries pay premiums for their Medicare Part B and D benefits, in addition to their supplemental coverage, whether they buy it individually or it's a shared expense with their former employer. They are also responsible for their share of prescription drug costs, and other expenses that are not covered by Medicare at all such as dental, vision, hearing, and long-term care. Half of Medicare beneficiaries spent at least \$3,138 in all out-of-pocket costs for their health care expenses, representing 17% of their \$22,000 annual income.¹ About 10% of all Medicare beneficiaries spent as much as \$7,861 annually on all health care expenses.

The calculations in the MedPAC report create averages to make their case for "winners," who would pay less than they do today, and "losers," who would pay more with a \$5,000 annual out of pocket cap for each individual beneficiary, along with other proposed changes. Since these costs are applied to individual beneficiaries, couples would potentially be exposed to double those annual out of pocket amounts, potentially wrecking havoc on family budgets.

¹ See: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/Setting-the-Record-Straight-about-Medicare-fact-sheet-AARP-ppi-health.pdf

Unfortunately, most Medicare beneficiaries cannot accurately determine whether they are likely to be one of the “winners” or “losers” under these proposed changes and subsequently exposed to less cost or more cost than they incur today. As Medicare beneficiaries age they have a much greater risk of being one of the “losers” who will pay more. As a population with low tolerance for risk, those who can afford supplemental benefits, even with an applied tax, are likely to continue to retain or seek out supplemental benefits. Those who can’t afford it are more likely to delay care until it become unavoidable and more expensive.

The report states: “many supplemental plans cover all or nearly all of Medicare’s cost-sharing requirements, *regardless of whether there is evidence that the service is ineffective or, conversely, whether it might prevent a hospitalization.*” Under federal law, Medigap policies pay covered benefits only after Medicare determines them to be medical necessary and pays for Medicare-covered services. To protect consumers, Medigap policies cannot impose their own medical necessity determination, and therefore Medigap policies have no influence on whether or where care is received. Employer-based supplemental benefits also only pay after Medicare has approved and paid, and only if that covered service is also covered by the employer-based plan.

A \$5,000 out of pocket maximum, \$10,000 for couples, is a larger amount than most annual Medigap premiums. An out-of-pocket cost this large could be incurred in a single expensive medical event. Beneficiaries purchase Medigap policies, and take employer based benefits, precisely because they provide a predictable premium cost each month that can be budgeted against existing income, and because they don’t know when they will experience a medical event or how much money they will be obligated to pay if they don’t have supplemental coverage.

When unpredictable medical costs occur without this coverage many people tap into existing assets to pay those medical bills, thus often reducing the earning capacity of their remaining assets. Recent news reports note an upsurge in debt held by people over age 65 since the recession in 2008, and a reduction of almost of third of their net worth due to plummeting home equity and investment earnings.

No study yet presented to the NAIC subgroup has been able to connect the assumed higher utilization of Medicare covered services by Medicare beneficiaries with supplemental benefits with medical care services that were *not* medically necessary. As one study notes, the effect of supplemental insurance cannot be clearly distinguished from unobserved personal characteristics associated with higher medical spending² Another suggests that people tend to purchase Medigap policies because they expect they might need more health care and have had comprehensive insurance coverage before becoming eligible for Medicare.³

Attached to this letter is one sent jointly with the Center for Medicare Advocacy and the Medicare Rights Center in March to each MedPAC commissioner, in response to their draft recommendations for MedPAC’s June 15th report.

2. Cost sharing effects on spending and outcomes, Schwartz, Katherine, Ph.D., Robert Wood Johnson Research Synthesis Report No. 20, December 2010

3. See: <http://www.eief.it/files/2012/02/wp-03-incentive-and-selection-effects-of-medigap-insurance-on-inpatient-care.pdf>

In that letter we referenced the NAIC Discussion Paper “Medicare Supplement Insurance First Dollar Coverage and Cost Shares” that presents information relative to other proposals for increased cost sharing for Medicare beneficiaries.⁴

We urge members of the Subcommittee to balance the information presented by MedPAC with the information contained in these other documents by those of us who work with Medicare beneficiaries on a daily basis and understand their needs and their fears.

Sincerely,

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4. See:
http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf

March 21, 2012

Commissioner
Medicare Payment Advisory Committee
Individual address

Subject: Medicare and First Dollar Coverage

Dear Commissioner:

Our organizations represent millions of Medicare beneficiaries. Each of us is an appointed consumer group member of the NAIC's Senior Issues Task Force statutory PPACA Subgroup. We have been following MedPAC's discussions of first dollar coverage and the assumed effect on Medicare costs. We are very concerned about proposals that would make beneficiaries pay higher out of pocket costs, and the misperception that seniors don't have enough "skin in the game." We believe that seniors, more than any other population, are very aware of the high cost of medical care and fearful of the impact those costs may have on their retirement income and savings. Those who have supplemental benefits through their former employment or through a Medigap are grateful that they can limit the open-ended cost of their Medicare benefits. By paying a fixed monthly premium they can budget for and limit health care expenses that might otherwise seriously affect their daily living expenses and savings. Rural beneficiaries in particular are much more likely to have supplemental benefits because their access to other forms of Medicare coverage is very limited or nonexistent.

Supplemental benefits pay only after Medicare has approved and paid for covered services. By law Medicare pays first and supplemental benefits pay afterwards. After the selection of a primary care physician, beneficiaries rarely have the option to second guess the medical services ordered by their doctor or the provider of those services. They therefore have little opportunity, knowledge, or skill in choosing between a "low value" service and one of higher value. Those medically necessary decisions are made by their doctor and confirmed by Medicare when payment is made.

We are attaching the NAIC Discussion Paper "Medicare Supplement Insurance First Dollar Coverage and Cost Shares" for your review. The discussion paper is a consensus document by regulators, industry representatives and consumer groups that seeks to make federal policymakers aware of potential negative and unintended consequences of some of the changes to Medicare and supplemental coverage that are being considered.

We hope you find this information helpful and each of us would be happy to speak with you if you have any questions or are concerned about how beneficiaries will react to mandatory higher out-of-pocket costs for their medical care, or higher premiums based solely on the insurance they buy.

Sincerely,

Bonnie Burns, California Health Advocates
David Lipschutz, Center for Medicare Advocacy
Ilene Stein, Medicare Rights Center