

**TESTIMONY BEFORE THE COMMITTEE ON WAYS AND MEANS**

**BY**

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**ON**

**INVESTING IN THE U.S. HEALTH SYSTEM BY LOWERING DRUG  
PRICES, REDUCING OUT-OF-POCKET COSTS AND IMPROVING  
MEDICARE BENEFITS**

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Chairman Neal, Ranking Member Brady and members of the committee, I am pleased to speak with you this morning on improvements in the benefits Medicare now provides to 60 million older and disabled Americans. That Medicare's benefits need improvement should not obscure current Medicare's enormous value to its beneficiaries and their families. But after 50 years, it's necessary to recognize that a benefit structure modeled on private insurance benefits of the 1960s is inadequate to guarantee the access to affordable health care that is Medicare's core commitment.

My goal this morning is to highlight four features of the Medicare program that demand remedies through more investment—excessive beneficiary exposure to out-of-pocket costs, specific gaps in Medicare's benefits, administrative barriers and biases that limit access to guaranteed benefits, and threats to the Medicare program's long-term fiscal solvency.

**Excessive beneficiary exposure to out-of-pocket costs.** As already noted, Medicare's benefit structure largely reflects the design of private health insurance at the time of its enactment in 1965. In the following decades, employer-sponsored health insurance expanded its protections against out-of-pocket costs by establishing caps on deductibles and copayments. Medicare lacks those protections. Its deductibles and copayments, which increase annually with health care costs, mean substantial financial burdens for the sickest beneficiaries whose costs rise with their need for care. While Medicare Advantage plans—private insurance plans through which roughly a third of beneficiaries now receive their Medicare benefits—are now required to provide a limit on out-of-pocket spending, no such protection is available for the two-thirds of beneficiaries who prefer to retain the provider choice of traditional Medicare for their Part A and

Part B benefits. The absence of an out-of-pocket cap exposes Medicare beneficiaries to catastrophic costs, making it necessary to supplement Medicare with the purchase of private Medigap insurance for which premiums rise as health costs increase. Part D's prescription drug program, a Medicare "modernization" enacted in 2003 also lacks a hard cap on out-of-pocket spending—a problem H.R. 3 would address.

[The Kaiser Family Foundation estimated](#) that in 2013 half of beneficiaries in traditional Medicare spent at least 14 percent of their per capita income on out-of-pocket health costs, with the highest shares spent by the oldest, the sickest, and beneficiaries with modest incomes. More than one-third (36 percent) of beneficiaries in traditional Medicare spent at least 20 percent of their incomes on out-of-pocket health care costs.

**It is past time to truly modernize Medicare benefits by legislating a cap on beneficiaries' out-of-pocket spending throughout the Medicare program.** Such caps have long been a feature of most employer-sponsored insurance and are now required under the affordable care act. Not to have such a cap in Medicare is a disservice to older and disabled Americans who are most likely to need care.

While a cap on out-of-pocket spending will improve catastrophic protection for all Medicare beneficiaries, it will be insufficient to protect those beneficiaries with low and modest incomes whose resources impede their ability even to reach a reasonable cap. Medicaid has always played a critical role in subsidizing premium and cost-sharing obligations for the poorest Medicare beneficiaries, and Medicare itself provides full or partial subsidies (Medicare Savings Program) to people with incomes up to 135% of the poverty level (150% of the poverty level for

Part D). But these benefits are insufficient to protect people from catastrophic expenses. [The Commonwealth Fund estimated](#) that in 2016 two fifths of beneficiaries with incomes below this level (about 8 million people) spent 20 percent or more of their income on premiums and care.

Current protections for low and modest income Medicare beneficiaries are significantly more limited than those provided younger Americans under the Affordable Care Act, despite the greater likelihood of care needs among older people and people with disabilities. **Equity requires the expansion of Medicare’s subsidies for modest income beneficiaries to afford them protections against burdensome spending on a par with protections for the younger population.**

**Specific gaps in Medicare benefits.** Improving Medicare with caps on out-of-pocket spending and stronger subsidies for premiums and cost-sharing aim at assuring the affordability of the services Medicare covers. But they do not address the financial burdens or barriers to access for services that Medicare leaves out. Medicare does not cover dental care, eyeglasses or hearing aids—all critical to the health and well-being of its beneficiaries. Although the statute reflects the intent to exclude “routine services,” the Center for Medicare Advocacy finds that [narrow administration of its benefits](#) limits benefits for the “medically necessary dental care” that the statute actually covers. That [oral health affects overall health](#) is well-documented. Not only can oral health examinations identify underlying disease, poor oral health increases the risk of cardiovascular diseases and mortality for those with kidney disease. Yet [the Kaiser Family Foundation reports](#) that almost two-thirds of Medicare beneficiaries are without insurance for dental care and nearly half had not had a dental visit in the previous year.

The Medicare coverage gap posing perhaps the greatest risk to its beneficiaries is the prohibition on coverage for what the statute refers to as “custodial” care or long-term services and supports (LTSS). Although Medicare covers post-acute services delivered by LTSS providers, it does not cover long-term personal care for people whose impairments leave them unable to care for themselves. Indeed, [both public and private insurance are lacking](#) to protect Americans of all ages against the catastrophic risk of extensive LTSS, whether provided at home or in nursing homes. Medicaid is the nation’s LTSS safety net—but unlike insurance which protects people against financial catastrophe, its benefits are only available after people who need it have exhausted all their resources. [In 2016, half of all beneficiaries had savings below \\$74,450](#) – not enough for a full year of nursing home, assisted living or full-time care at home:

The absence of insurance not only leads to impoverishment; it leads to such extensive reliance on family caregivers that their own financial and health security are endangered by their commitment to care. And despite that commitment, inadequacies in care persist, leaving people with the most extensive care needs at risk of falls, missed meals, and other serious consequences.

Legislation proposing a Medicare LTSS benefit include [a discussion draft released in 2018 by Congressman Frank Pallone](#) as well as broader legislation aimed at assuring an affordable health care system. **Given the failure of the private insurance market for LTSS, a Medicare or other social insurance benefit is essential to addressing this critical problem—especially as the population ages.**

**Administrative Barriers and Biases.** Alongside Medicare coverage limitations based on the underlying statute are limitations resulting from administrative actions that inappropriately limit or reward inadequate service. Barriers to receipt of medically necessary dental care are noted above. But administrative limitations limiting access to covered home health and skilled-nursing-facility benefits are equally egregious. Medicare benefit administration has long constrained home health benefits, lest the program bear the costs of the custodial or LTSS benefits precluded by the statute. But overzealous administration has created [enormous barriers to the delivery of the home health benefits that Medicare guarantees](#)—including not only the skilled nursing or therapy people required, but also the aide services also covered for people who meet the skilled care requirements. Administrative restrictions are exacerbated by payment arrangements based on “episodes of care” that [reward home health agencies for skimping on needed care](#), producing the highest profit margins to agencies that provide fewer visits, despite serving patients with greater measured care needs.

Similarly, administrative efforts to prevent unnecessary hospital admissions have resulted in the increased classification of patients admitted to the hospital as in [“observation status”](#)—an outpatient benefit that includes patient cost-sharing and, because it is not a hospital stay, fails to establish the three days of hospital care the law requires as a prerequisite to receipt of Medicare’s skilled nursing facility benefit. This [barrier to Medicare’s guaranteed coverage will be exacerbated by a new rule](#), scheduled to go into effect in January 2020 that will pay home health agencies approximately 20 percent more for patients served following a hospital admission than for patients admitted from the community—including those in observation status. The result will likely be to further restrict access to home health benefits for people entitled to receive them.

Administrative action also results in inappropriate steering of Medicare beneficiaries to private Medicare Advantage plans and away from traditional Medicare—action that puts beneficiaries at risk and increases Medicare costs. The opportunity for beneficiaries to obtain their Medicare benefits—and potentially extra benefits—in private plans was dramatically expanded by [the Medicare Modernization Act of 2003 which paid MA plans substantially in excess of the costs of traditional Medicare benefits](#) – a strategy advocates of Medicare privatization promoted under the guise of “consumer choice.”

Although subsequent legislation has reined in some of these excessive payments, MA plans continue to receive payment in excess of costs, in part because of the [“upcoding” of enrollees’ medical conditions](#) and [disenrollment of sicker beneficiaries](#). [Congress has nevertheless encouraged enrollment in MA](#) plans is by allowing these plans to provide benefits that traditional Medicare does not and, in the current administration, by [presenting beneficiaries inaccurate information about MA plans’ potential costs](#) in enrollment materials and enrollment counseling. These costs include potentially restricted access to providers—as, unlike traditional Medicare, MA plans may limit service to physician and hospital networks. Furthermore, the presumed option beneficiaries have to return to traditional Medicare and its open choice of providers may be foreclosed since most states do not guarantee access to supplementary Medigap insurance without regard to pre-existing conditions. State, not federal, law now governs Medigap enrollment practices which, in most states means [the absence of the guaranteed issue and community rating provisions that are essential to assuring meaningful coverage against catastrophic expense](#). In many states, people who come onto Medicare because of a disability can

be denied a policy due to a pre-existing condition, and in most states, an older beneficiary, permitted by law to switch from an MA plan to traditional Medicare for whatever reason during the open enrollment period, can be similarly denied a Medigap policy. The result is to lock them into MA as a means to avoid unlimited financial exposure.

Achieving Medicare's promise to its beneficiaries rests not just on the benefits included in the statute but on administration that assures receipt of the benefits to which they are entitled. **An effective guarantee of adequate coverage requires the elimination of arbitrary barriers to the receipt of covered benefits, an end to provider or plan payment practices that reward skimping on care or avoidance of sicker patients, elimination of "oversell" and other practices that favor enrollment in MA plans rather than traditional Medicare, and federal assurance that individuals always have access to Medigap that supplements traditional Medicare, regardless of pre-existing conditions.**

**Long-term sustainability of the Medicare program.** Consideration of Medicare investments would be incomplete without considering the long-term financial stability of the Medicare program. In the coming decade, the share of Americans aged 65 or over will increase from 15% to 20% of the population. That inevitably means an increase in Medicare spending. But it is critical to remember that in recent years, Medicare total cost increases have been heavily driven by increases in enrollment as the baby boom population turns age 65. [Medicare's per capita cost growth has, in fact, been remarkably slow](#), relative to the past and to per capita cost growth in private insurance. Medicare's ability to control its costs reflects, in part, the program's considerable market power when it comes to paying providers. [Private insurers, who lack that](#)

[market power, now pay hospitals two to three times more what Medicare pays for hospital services.](#) MedPAC finds that concentration in hospital markets leads to high costs, inefficiency and low margins on Medicare patients. [By contrast, in markets where hospitals compete, hospital costs are lower, hospitals are more efficient, costs lower and Medicare margins higher.](#)

Effective use of Medicare's market power would be greatly enhanced by the prescription drug legislation you have before you today. But it can be further enhanced with continued vigilance in payment practices throughout the Medicare program. That vigilance not only means addressing overpayments to MA plans, as noted above, but addressing [overpayments to physicians that result from an outdated fee schedule](#), which excessively rewards specialists and underpays primary care providers. **Greater attention to appropriate prices, which drive the nation's health care costs, must accompany the attention to appropriate service use that has come with the payment innovations in the Affordable Care Act.**

Vigilance in payment, however, is unlikely to be sufficient to cover the costs of a growing Medicare-eligible population. [The Medicare Trustees reported last spring](#) that Medicare's Part A Trust Fund will be exhausted in 2026, as the ratio of payroll-tax paying workers to elderly beneficiaries continues to decline. From that point on, revenues from payroll taxes will be sufficient to pay only about 80 percent of current benefits. Hence the need for additional revenues to support Medicare's current obligations. Despite claims to the contrary, projected [projected GDP growth is more than sufficient to meet that need](#). Projections are that GDP per adult will grow 23 percent between now and 2035, even after accounting for inflation and the

increase in Medicare spending—just 2 percentage points lower than if Medicare spending grew at the same rate as the economy as a whole.

This analysis does not mean that public policy should not look for ways to reduce Medicare cost growth (and overall health care cost growth) as well as ways to improve the distribution of income. **But it does mean that the nation can and must continue to strengthen and fully fund Medicare to make health care more affordable, even as the baby boom generation ages.**