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**Statement for the Record
by the**

**American Federation of State, County and
Municipal Employees (AFSCME)**

For the Hearing on

**A 21st Century Medicare:
Bipartisan Proposals**

to

**Redesign the Program's
Outdated Benefit Structure**

Before the

Subcommittee on Health

Committee on Energy and Commerce

U.S. House of Representatives

June 26, 2013

American Federation of State, County and Municipal Employees, AFL-CIO

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This statement is submitted on behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME).

AFSCME is proud of labor's historic role in the creation of Medicare, a federal social insurance program that is indispensable to our country. When President Johnson signed Medicare into law on July 30, 1965, he spoke of its profound promise:

“No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.”

For today's 50 million Medicare beneficiaries and the millions who will depend on this program in the future, the need for Medicare to remain a bulwark against financial ruin, caused by the caprice of illness and disability, rings as true in 2013 as it did nearly five decades ago.

Changes to Medicare Should be Aimed at Improving Coverage, Not Deficit Reduction or to Pay For Replacing the Sustainable Growth Rate Payments to Doctors

Medicare benefit design must not be a diversion to disguise shifting costs onto beneficiaries or employers who provide retiree coverage or making 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 making ends meet and 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.

Increasing beneficiary cost sharing (either directly or by 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.¹

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 coinsurance 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.² Raising the out-of-pocket costs on beneficiaries will not reduce high medical prices. Indeed, providers may increase prices if utilization drops.

Similarly, changing Medicare to a premium support plan is a benefit structure redesign that gives less and less purchasing power to beneficiaries. Even if one viewed a

¹ National Association of Insurance Commissioners, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011).

² Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's The Prices, Stupid: Why The United States Is So Different From Other Countries" *Health Affairs*, 22, no.3 (2003):89-105.

premium support plan as a form of competitive bidding, by breaking up the Medicare pool we are undermining the clout that seniors have in negotiating affordable prices with providers and insurers. Offering both private plans and traditional Medicare uses the promise of choice and the false lure of competition to disguise the diminishment of Medicare's function to deliver guaranteed benefits, pool resources and protect beneficiaries from unexpected health care costs.

An alternative form of premium support would provide coverage for a limited range medical services or pool of providers, but allow beneficiaries to pay for additional coverage or treatments. Some have proposed diluting Medicare's level of guarantee benefits and allowing higher-income beneficiaries to consume Medicare's current coverage – and with it the possibility of better health outcomes – through their own finances. This is a plan for rationed care, that divides the Medicare population by income, and undermines the foundation of Medicare to provide coverage regardless of a beneficiary's health status or income. Aside from the obvious problem of rationing care under Medicare, these proposals offer a new twist on what is often called balance billing. Under balance billing doctors would be allowed unfettered discretion to charge Medicare beneficiaries for covered treatment. Under this proposal, treatments and medical services now covered by Medicare would not be covered but still accessible for those able to pay the balance bill of whatever providers choose to charge.

The requirement that participating physicians cannot charge beneficiaries more than Medicare reimburses for all covered services and that non-participating physicians limit the additional charges for Medicare covered services, is particularly important for a population that cannot afford more cost sharing. Allowing unfettered balance billing will turn Medicare's promise of guaranteed benefits regardless of health status and income on its head. The new promise of Medicare under these proposals would be that after a lifetime of hard work, only the wealthy will have access to the miracles of modern medicine.

Conclusion

Medicare is an amazing success story – providing health and financial security to millions of Americans even during the worst economic crisis since the Great Depression. AFSCME urges Congress to reject proposals to redesign Medicare in a way that builds in extra cost sharing for beneficiaries. This would allow sick and older seniors and individuals with disabilities, who are on limited incomes, to be denied needed health care because of additional out-of-pocket costs.

While we oppose achieving short-run federal savings through beneficiary cost savings because such savings are shortsighted, we do support eliminating sweetheart deals for the pharmaceutical industry that lead to overpayments for prescription drugs. For example, when Congress enacted the Medicare Part D drug benefit, it prohibited Medicare from negotiating lower drug prices with drug companies. Ending this prohibition could save Medicare more than \$200 billion over 10 years. In addition, the Medicare Part D law resulted in a substantial drug manufacturer windfall because it ended the then-existing requirement that manufacturers pay rebates for beneficiaries who are eligible for both Medicare and Medicaid (known as dual eligible) and low-income Part D enrollees. Reinstating the rebates that were required before 2006 would ensure that taxpayers and the Medicare program do not overpay for Part D drugs.

We would be remiss if we did not point out that Medicare excludes the vital services that many seniors and individuals with disabilities need to maintain their independence – such as long-term supports and services. Medicare provides limited post-acute care and few Americans can

afford private long-term care insurance. Medicaid is by default the provider of long-term care services, but requires seniors and individuals with disabilities to impoverish themselves to get the services they need to complete life's daily activities. As America ages, the gaps in coverage for long-term care will further strain and challenge families, communities and our country. We urge the Committee to address this urgent and growing need for long-term supports and services.

In sum, Medicare has helped generations of Americans keep a toehold in the middle class. As Congress considers the adequacy of Medicare's benefit design, we urge you to reject proposals that seek to shift costs from the government onto beneficiaries. The goal of benefit redesign should be to ensure that benefits are adequate, not to achieve deficit reduction. Moreover, Congress must look for another way to pay for an adjustment to physician reimbursements that does not undermine the health of seniors and people with disabilities.