



601 E Street, NW | Washington, DC 20049
202-434-2277 | 1-888-OUR-AARP | 1-888-687-2277 | TTY: 1-877-434-7598
www.aarp.org | twitter: @aarp | facebook.com/aarp | youtube.com/aarp

March 13, 2015

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives
Washington, DC 20515

Dear Chairman Pitts:

Thank you for the opportunity to testify before the Subcommittee on Health on Thursday, January 22, 2015 at the hearing entitled "A Permanent Solution to the SGR: The Time is Now." Attached, please find written responses to the questions sent in a letter dated February 27.

We are pleased at the progress made thus far in creating a Medicare reimbursement system which rewards value, not volume. AARP looks forward to continuing to work with you and the Subcommittee in finding a solution which does not unduly shift costs to beneficiaries. If you have any further questions or comments, please contact Ariel Gonzalez, of our Government Affairs staff, at agonzalez@aarp.org or 202-434-3770.

Sincerely,

Eric Schneidewind
AARP President-elect

Cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Real Possibilities

Responses to the Honorable Joseph R. Pitts

- 1. In your testimony, you expressed strong support for the Qualifying Individual (QI) Program. That program pays Part B premiums for beneficiaries with incomes between 120 percent and 135 percent of the Federal Poverty Line—about \$14,000 to \$15,750. Certainly, I think it's fair to say all members of this Committee care about low-income seniors. At the same time, as a practical matter, for programs to be extended, they will have to be paid for. So, in the interest of extending the QI program, what is AARP's position on paying for that extension by charging much wealthier seniors higher premiums?**

AARP is opposed to further income-relating of premiums for Medicare Part B or Part D. The current income threshold for higher premiums is \$85,000 for an individual and \$170,000 for a couple filing jointly. Premiums scale upwards, such that higher incomes pay a greater share of Medicare costs, ending at 80 percent for those earning \$214,000 (\$428,000 for couples) or more. Additional income-relating will simply shift greater costs to seniors, harming both Medicare beneficiaries and the Medicare program, without actually reducing health care costs.

First, proposals to lower the threshold below \$85,000/\$170,000, or to hold the threshold in place until 25 percent of beneficiaries are affected, directly impacts the middle class. An income below \$85,000 is not *wealthy* by any definition. Moreover, when determining who is subject to the income-related premium, the Medicare program relies on the beneficiary's tax return from the prior year, which reports income made from the year before. Income-related premiums are thus based on two-year old information. The beneficiary's income is likely to have dropped, often precipitously, from their working years; thus premiums may not at all reflect their current financial situation.

Second, raising the percentage paid by the highest earners could push beneficiaries out of the program. As incomes rise, people tend to be healthier and spend less on health care. If the beneficiaries in the highest income group are asked to pay an even greater share of the Medicare cost, they could decide not to enroll in Medicare and seek alternative sources of insurance. This would worsen the Medicare risk pool by leaving more-costly beneficiaries in the Medicare program, which would raise costs for everyone.

Third, not only do higher income seniors already pay much higher premiums, but higher income workers already pay much more into the program since Medicare payroll taxes (unlike for Social Security) are collected on all their wage income.

Specifically, with regards to offsetting the permanent extension of the Qualifying Individual (QI) program, "charging wealthier seniors higher premiums" is unequitable and unnecessary. In the 113th Congress, the Congressional Budget Office (CBO) scored a proposal to extend the QI program by five years as costing \$6.9 billion over a ten-year period.¹ Even assuming that an extension of QI for a full ten years costs more than \$15 billion, this is still far short of the \$49.7 billion score the CBO calculated for a proposal in the President's budget² and which the Ways and Means Committee discussed in a May 2013

¹ CBO cost estimate of S. 1871, the *SGR Repeal and Medicare Beneficiary Improvement Act of 2013*, January 24, 2014.

² CBO, *Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's 2015 Budget*, April 17, 2014.

hearing. And ensuring low income seniors can afford healthcare is a societal goal, the cost of which should not be borne only by other seniors.

- 2. In your testimony, you said that AARP will not consider SGR repeal legislation "complete" unless three beneficiary protections -QI, therapy caps, outreach and enrollment assistance to low" income Medicare beneficiaries-" are included in a final bill. Does that mean that if permanent SGR reform were adopted but it did not include a permanent extension of these three programs, AARP would oppose it?**

As stated in our testimony, AARP and its members will not consider SGR repeal legislation complete if the beneficiary protections of QI, therapy cap exceptions process, and enrollment assistance for low-income Medicare beneficiaries are not included, and therefore we will not be able to endorse such legislation. Whether AARP actively opposes the legislation will, of course, depend on the policies contained in the final bill.

- 3. In your testimony, you said that "for over a decade, millions of Medicare beneficiaries have heard annual warnings that their health care provider would stop seeing them if the schedule payment cuts due to the sustainable growth rate occur.... Medicare beneficiaries remain fearful of losing access to their doctor." Please explain what you think would be the practical effect for seniors if this subcommittee fails this Congress to permanently fix the SGR?**

In truth, it is impossible to predict the practical effect allowing the SGR cuts to occur will have on seniors. However, it is important for Congress to act in order to prevent the worst-case scenario. Should Medicare providers see their reimbursements reduced by over 20 percent on April 1, it is likely that some or many of them would stop seeing Medicare patients, or stop accepting new patients. This could create access problems for Medicare beneficiaries trying to see a health care provider.

- 4. In your testimony you said "it is important to remember that half of all Medicare beneficiaries live on an income of less than \$23,500 per year, and on average already spend 17 percent of their income on health care." I can assure you there's bipartisan interest in protecting the most vulnerable. Toward that end, what is AARP's position on some combination of reforms which would protect the most vulnerable by creating predictable cost-sharing between hospital and physician services, while at the same creating a new maximum out-of-pocket protection to give seniors peace of mind?**

AARP has long been in favor of "predictable cost-sharing between hospital and physician services", as well as "creating a new maximum out-of-pocket protection". We would also like to see coverage for dental, hearing, and vision services. Our concerns and objections generally regard the manner in which these goals are implemented. Changing the Medicare benefit, especially combining Part A and Part B, should not be done with the intent of deficit reduction because such proposals merely shift costs to beneficiaries and create more losers than winners. The Medicare benefit should be reformed and improved with the beneficiary's best interest in mind. Recent Congressional proposals to reform the benefit structure have pursued cost-savings as a primary objective, through higher deductibles and additional copays. Such plans simply shift costs to seniors and potentially reduce access, and do nothing to lower health care costs or improve quality. Even supposed deficit-neutral proposals need to be examined further, in order to understand the full impact across the spectrum of beneficiaries. We look forward to a separate, in-depth conversation which

considers the implications of various deductible amounts, cost-sharing, supplemental coverage interactions, and Medicare trust fund financing changes.

- 5. Last May, the Office of the Actuary at CMS said that Medicare's Hospital insurance Trust Fund could be insolvent as soon as 2021, or as late as 2030. Under current law, there is no ability for the program to then pay claims on behalf of seniors. At the hearing, you were asked if you acknowledge that, if left unaddressed, Medicare's coming insolvency could present an access problem for seniors on Medicare? Your response was that this scenario "would certainly have an impact on seniors." That response is a rather muted and understated response to what could present cataclysmic disruption for millions of seniors. So the committee can better understand AARP's position, does your organization think the coming insolvency of Medicare and the threat it presents to seniors is a problem requiring Congressional action?**

Yes, AARP believes Congress should act in order to ensure Medicare remains financially sound both for current beneficiaries and for the long-term. However, this does not mean we should start shifting costs onto the backs of beneficiaries. Reimbursement reform presents the greatest opportunity to lower health care costs in a sustainable and non-harmful manner. Tying payment to quality and value, and greater use of coordinated care, will continue to slow Medicare spending growth and prolong the program's solvency. Medicare costs are already growing at a slower rate than private insurance; per capita costs have held steady despite Medicare population growth; and recent reforms are already having an impact on long-term spending projections. Likewise, reforming prescription drug policies will yield significant Medicare savings now and in the future. Strengthening Medicare's finances does not necessitate forcing older Americans to spend more out of pocket to see a doctor.

- 6. The President's FY2015 budget to Congress included a proposal that "would introduce a Part B premium surcharge for new beneficiaries who purchase Medigap policies with particularly low cost-sharing requirements, starting in 2018. Other Medigap plans that meet minimum cost-sharing requirements would be exempt from the requirement. The surcharge would be equivalent to approximately 15 percent of the average Medigap premium (or about 30 percent of the Part B premium)." What is your organization's position on this policy?**

Medigap policyholders tend to have low or moderate incomes, and are more likely than average Medicare beneficiaries to be female, older, and live in rural areas. According to the Kaiser Family Foundation, in 2009, about 41 percent of beneficiaries with Medigap and/or employer coverage had incomes between \$10,001 and \$30,000 per year.³

AARP opposes the elimination of the choice of Medigap/first dollar coverage. The typical senior already spends 17 percent of their income on health care. In 2012, of the 10.2 million beneficiaries enrolled in Medigap policies, 66 percent chose plans C or F which provide first dollar coverage; seniors often prefer policies that offer certainty of cost should they need to see a doctor.⁴ Evidence shows that if cost sharing is increased, seniors will go to the doctor less. This could cause them to become sicker and eventually cost the Medicare system more.

³ Kaiser Family Foundation, "Medicare Eligibility, Beneficiary Costs, and Program Financing," page 18; Jan. 2013

⁴ "Trends in Medigap Coverage and Enrollment, 2012," AHIP, May 2012. Accessed 10/30/13.

Some suggest that Medigap policies, by shielding beneficiaries from the costs of their care, may drive up utilization. The literature in this area is mixed. Additional cost-sharing for beneficiaries may reduce utilization, but it reduces both necessary and unneeded care. As a result, the evidence does not factor in increased utilization and costs associated with patients getting sicker because they delay needed care, thereby needing increased care later.

In late 2012, the National Association of Insurance Commissioners convened a panel of experts including state insurance regulators, representatives of CMS, insurers, consumer groups and trade associations. Their conclusion did not, “agree with the assertion being made by some parties that Medigap is the driver of unnecessary medical care by Medicare beneficiaries [because] Medigap pays benefits only after Medicare has determined that the services are medically necessary and has paid benefits.”⁵ Secretary Sebelius accepted the panel’s recommendations not to increase nominal cost sharing.

Patients do not order tests and services. To reduce unnecessary services, there should be greater focus on health care providers and their ordering habits, rather than patients. AARP supports Medigap changes that would better protect seniors, such as improved medical loss ratios and preventing Medigap pre-existing coverage denials. We also support efforts to add a catastrophic cap to Medicare which is already included in most private health plans.

- 7. As you know, for us to be successful in getting SGR reform passed into law, we need willing partners in the Senate-and at the other end of Pennsylvania Avenue at the White House. Please outline in detail what your organization has been doing since January 1, 2015 to support a permanent SGR fix with bipartisan offsets, including actions such as:**
- **Publicly endorsing specific, concrete bipartisan offsets**
 - **Meeting with White House officials on the need to repeal SGR this year and pay for it with bipartisan offsets**
 - **Meeting with House Democrats on the need to repeal SGR this year and pay for it with bipartisan offsets**
 - **Meeting with Senate on the need to repeal SGR this year and pay for it with bipartisan offsets**
 - **Meeting with Senate Democratic leadership on the need to repeal SGR this year and pay for it with bipartisan offsets**
 - **Designing or implementing public advocacy efforts to inform consumers and seniors of the need to repeal SGR this year and pay for it with bipartisan offsets**

AARP’s message on SGR reform has been consistent, regardless of party, chamber, or branch of government. Throughout the Medicare reimbursement reform debate, in 2015 and past years, we have voiced the concerns of our members. We have raised concerns about the impact on access by failure to address stability in provider payment in Medicare. We have repeatedly stated that SGR is a flawed formula and should be replaced with a new system that encourages quality and value. We have been clear that SGR reform should not be paid for on the backs of beneficiaries.

We all share the desire to contain the cost of Medicare and health care, while imposing the least amount of harm on beneficiaries. That is why AARP continues to urge legislators and policymakers to consider savings from reducing costs in our health care system, such as by

⁵ Letter to Secretary Sebelius from NAIC Senior Issues Task Force; November 30, 2012.

reducing prescription drug costs and other sources, before they consider shifting the burden to older Americans and persons with disabilities.

Responses to the Honorable Eliot Engel

1. **I have been hearing from the physician community in New York for years about their growing frustration at the constant threat of significant reimbursement cuts. They frequently mention that the cost of running their practice is increasing each year and they are trying to properly treat patients with increasingly complicated medical conditions. All the while, facing double digit reimbursement cuts. It just isn't right.**
 - a. **Can you elaborate on why it is urgent for physicians and patient access to care that Congress reform the Medicare reimbursement system now and how another patch would be detrimental to our Medicare program?**

Medicare beneficiaries need the stability and predictability that their health care provider will continue to see them, or that they will be able to find a new provider when needed. The regular threats of providers leaving Medicare due to reimbursement cuts creates fear and uncertainty among older Americans. We continue to urge Congress to permanently repeal the SGR formula to help bring peace of mind to both providers and beneficiaries.

Responses to the Honorable Doris O. Matsui

1. **Your testimony indicated you agree that as Congress seeks to finally fix the SGR rollercoaster once and for all, beneficiaries also deserve the peace of mind of having the QI program similarly fixed in this legislative exercise. Can you please discuss this further?**

The Qualifying Individual (QI) program is a critical program that pays Medicare Part B premiums, amounting to \$104.90 per month, for individuals with incomes between 120% to 135% of the federal poverty level (FPL)—about \$14,100 to \$15,900 per year—and less than \$7,280 in assets. According to a recent analysis, Medicare beneficiaries with incomes between 101% and 150% FPL spend more than one quarter (26.1%) of their income on out-of-pocket health care costs, more than any other income group. Receipt of the QI benefit also qualifies individuals for the Medicare Part D Low-Income Subsidy (LIS), or Extra Help, to help them pay for prescription drugs. In 2013, 575,000 older adults and people with disabilities were enrolled in the QI program. Since its inception, the QI program has needed to be regularly reauthorized and funded. This has usually been done in conjunction with SGR patches, and for the same duration. In the event of permanent SGR repeal, it is crucial that QI be made permanent as well. The program for low-income beneficiaries should not be forced to continue this cycle of temporary patch after patch.

2. **Could you please talk about some of the other beneficiary improvements that AARP has supported?**

As mentioned in our testimony, in addition to permanently extending the QI program, we support repeal of the therapy cap or the permanent extension of the exceptions process, as well as permanent funding for outreach and enrollment assistance. Other beneficiary improvements which AARP has advocated for include coverage for dental, hearing, and vision services. AARP also urges that we ensure consumer stakeholders are involved in the quality measure development process, and improve access to information and data which will help consumers make more informed decisions.

3. Can you talk about the potential impact on beneficiaries of a combined Part A and B deductible?

Combining Medicare Part A and Part B into a unified benefit program will have myriad implications for beneficiary cost-sharing and program financing. Specifically, regarding the deductible amount, it is important to remember that about 20 percent of beneficiaries use Part A hospital services in a given year. Thus, 80 percent of beneficiaries do not use Part A services and are not subjected to the current \$1,184 deductible per hospital episode period. We are concerned that a combined Part A and B deductible will be considerably higher than the current \$147 Part B deductible. The vast majority of Medicare beneficiaries will be faced with higher out-of-pocket costs and may choose to delay or forgo seeing their provider for Part B services. This could lead to poorer health and higher costs (for both the Medicare beneficiary and the program) later down the line.

4. Already faced with high health care costs, many people with Medicare are forced to choose among basic needs, such as buying groceries or seeing the doctor for a persistent cough. How would Medicare benefit redesign proposals worsen this problem for seniors and people with disabilities?

Most Medicare benefit redesign proposals have been intended to reduce federal spending on Medicare, rather than improving access and care for the beneficiary. Such proposals shift costs to beneficiaries through higher copays and deductibles. Higher out-of-pocket costs deter people, particularly low-income individuals, from seeking care. Preventative care or treatment at first onset of illness is better, for both the health and financial well-being of the patient, than waiting until they are much sicker.

While various proposals to redesign the Medicare benefit will save money for some beneficiaries, the vast majority of beneficiaries will see their out-of-pocket costs rise. In order to fully understand the impact of such significant policy changes, we must examine a range of scenarios and situations. Any redesign of Medicare cost-sharing will undoubtedly affect various groups of Medicare beneficiaries differently. All too often, proposals are evaluated as if all beneficiaries are identical. In fact, they are not, and they will be affected differently. The impact will depend on the types of services they use, the intensity of their use, whether and what type of supplemental coverage they have, and their income.

5. How would a \$7,500 dollar spending cap play out for a beneficiary with an income of \$23,500 dollars or less?

If the spending cap only pertains to Medicare covered services, and does not include Part B, Part D, and Medigap premiums or non-Medicare covered services, then it is unlikely to have much practical effect since only 10 percent of beneficiaries ever exceed \$3,000 in out-of-pocket expenses for Medicare covered services. Much of their out-of-pocket spending is due to premiums or spending on items Medicare does not cover, such as dental, vision, hearing, and long term care. Likewise, for someone living on the median Medicare beneficiary income of \$23,500, a cap of \$7,500 would be too high to have much value compared to no cap at all, because \$7,500 is still unaffordable. Low- and moderate-income beneficiaries will choose to forgo care if costs become too high for their personal pocketbook. Ultimately, this will cost Medicare (and possibly Medicaid) more later.

6. Some Medicare "reform" proposals seek to incentivize beneficiaries to make better choices about the health care they receive by charging them more; in other words,

some policymakers want more people to have more "skin in the game." How much "skin in the game" do Medicare beneficiaries already have, and what is the likelihood that charging more in cost-sharing will lead to better decisions by beneficiaries about their health care?

Medicare beneficiaries already have considerable "skin in the game". Half of all beneficiaries spend at least 17 percent of their income on health care. Put another way, half of all beneficiaries spend over \$3,300 of their own money on health expenses each year. The burden of health care costs is even heavier for the sickest and oldest beneficiaries. It is unreasonable to suggest that additional cost-sharing or copays will lead to better decisions. First, patients do not order tests or recommend treatments – providers do. We should be creating a reimbursement system which incentivizes physicians and clinicians to provide appropriate care; not rewarding excessive utilization. Second, raising out-of-pocket costs creates barriers to care without distinguishing between necessary and unnecessary care. Patients will be discouraged from seeking preventative services or early interventions if they have to pay more for it. Waiting until a health problem can no longer be ignored adds costs to the system for everyone.

Responses to the Honorable Ben Ray Lujan

- 1. The current Sustainable Growth Rate (SGR) Medicare payment system is unsustainable and needs to be fixed. In New Mexico, I continue to hear from providers and seniors about their frustration with SGR and the uncertainty that it creates. We cannot continue to patch this broken system, and we've been talking about a permanent fix for years. We need to deal with this now, and I support the bipartisan/bicameral SGR structural reform that was crafted last Congress that is supported by both provider and beneficiary groups.**
 - a. In New Mexico there is a shortage of primary care physicians. Can you speak to how delivery system reform is connected to SGR repeal? How do you see the move away from fee for service impacting doctors' participation in Medicare?**
 - b. Given all we know about the impact of primary care on quality, patient satisfaction, and costs, what more do you believe we should do to promote and support our primary care physicians?**

SGR repeal presents an opportunity to move away from fee-for-service and towards reimbursement models which pay for quality and value, including for the many primary care services not currently valued, such as time spent managing care or checking in with patients. Encouraging primary care providers to coordinate with specialists and continue patient engagement outside the office will likely yield savings and improve quality and outcomes. Reimbursement policy should appropriately reflect the time and effort it takes to fully work with a patient. Better payment policies may also entice medical students and younger health professionals to pursue careers in primary care.