NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

August 16, 2013

United States House of Representatives
Committee on Ways and Means, Subcommittee on Health
Washington, DC 20510

Dear Members of the Subcommittee:

The National Senior Citizens Law Center (NSCLC) appreciates the opportunity to comment and we write to express our strong opposition to the draft Medicare cost-sharing proposal circulated by the Subcommittee. NSCLC is a non-profit organization whose principal mission is to protect the rights of low-income older adults through advocacy, litigation and counseling of local advocates.

Increasing Medicare premiums and deductibles is bad policy. Medicare costs are significant, and this proposal further threatens the economic and health security of millions of older adults with low, fixed incomes. Beyond the immediate harm to beneficiaries, this proposal undermines the integrity and universality of the Medicare program in the future.

Medicare beneficiaries spend a lot on health care-and they cannot afford to pay more

Poverty rates could increase if older adults were required to pay higher cost-sharing or premiums.[1] Medicare families already are responsible for significant health expenses as Part B requires a 20% coinsurance after meeting at $147 deductible. Cost-sharing under Part A requires a $1,184 deductible. Part D premiums and co-payments add to the burden. These families are already paying more of their household budgets for health care than non-Medicare households.[2]

The proposed Part B deductible increase may appear modest, but any suggestion that it is benign ignores the heavy impact it has on low-income Medicare beneficiaries. First, as the Census Bureau has reported, current calculations on senior poverty underestimate the number of individuals who live in poverty.[3] When the Census Bureau

[1] Kaiser Family Foundation, "A State-by-State Snapshot of Poverty Among Seniors: Findings from Analysis of the Supplemental Poverty Measure," (KFF, State by State) available at http://kff.org/medicare/issue-brief/a-state-by-state-snapshot-of-poverty-among-seniors.
[2] Kaiser Family Foundation, "Policy Options to Sustain Medicare for the Future," at pg. 11, available at http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8402-section-one.pdf. Medicare households commit 15% of their income to health care, while non-Medicare households commit 5%.
[3] KFF, State by State.

National Senior Citizens Law Center
www.nsclc.org
nsclc@nsclc.org
1444 Eye St., NW, Suite 1100
Washington, DC 20005-2210
202-289-6976 • Fax: 202-289-7224
3701 Wilshire Blvd., Suite 750
Los Angeles, CA 90010
213-639-0930 • Fax: 213-368-0774
1330 Broadway, Suite 525
Oakland, CA 94612-2522
510-663-1055 • Fax: 510-663-1051

applied an updated, supplemental poverty measure, that considers seniors' health expenses, it found that, nationally, nearly half of all seniors live with incomes below $22,000, which is 200 percent of the poverty threshold.[4]

For low-income individuals already dedicating much of their limited income to health care, the increased deductible will limit access to the Medicare benefit they earned. Half of the Medicare beneficiaries with incomes below $22,000, though living on very limited incomes, cannot qualify for federal assistance with out-of-pocket expenses, and are most at risk in this proposal.[5] Faced with a higher Part B deductible, these Medicare beneficiaries may forego a necessary physician or outpatient service, despite the fact they or their spouse earned their Medicare benefit.

A home health co-payment would fall most heavily on the most vulnerable and may increase costs for Medicare

A home health co-pay is an inefficient and regressive punishment that targets the oldest, sickest and poorest Medicare beneficiaries while driving up inpatient costs. Compared to other Medicare beneficiaries, home health users are sicker, more likely to have a disability, and live alone.[6] 86% of home health users are 65 or older, 63% are 75 or older, and nearly 30% are 85 or older.[7] With nearly 60% of home health users living on incomes below 200% of poverty,[8] most simply cannot afford to pay for home health care out of pocket and may avoid care. Not only is this dangerous for the individual, but studies demonstrate that when individuals avoid care due to co-payments, inpatient costs may increase.[9]

Further, adding a home health co-payment is counter to a major theme in health reform as it relates to seniors and persons with disabilities, "rebalancing" of incentives to

[4] KFF, State by State. The twelve states are: California, Colorado, Connecticut, Hawaii, Massachusetts, Maryland, Minnesota, New Hampshire, New Jersey, Nevada, Wisconsin, and Wyoming.
[5] Eligibility with Medicare cost-sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100% of poverty ($111,412 for singles, $15, 372 for couples) and non-housing assets below just $6,940 for singles and $10,410 for couples.
[6] Avalere Health, "A Home Health Co-Payment: Affected Beneficiaries and Potential Impacts" (Avelere), available at http://www.avalerehealth.net/pdfs/hhs_copay.pdf.
[7] CMS Office of Information Services, Medicare & Medicaid research Review, 2011 Supplement, Table 7.2, available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2011.html.
[8] Avalere.
[9] Avelere.

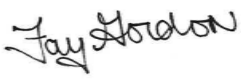
encourage more care at home and in the community and less in costly institutions.[10] Forty percent of seniors enrolled in Medicare have at least three chronic conditions.[11] Keeping these individuals healthy enough to continue to live in the community should be a key policy goal and putting financial barriers to access to home health does not serve that goal. Instead, imposing co-payments for home health care further tips the balance in the wrong direction, disincentivizing the lower cost community care that so many people want and need.

Means testing undermines the integrity and universality of Medicare

Medicare has consistent, broad-based support as insurance for people over 65 and certain individuals under 65 with disabilities. Means testing may undermine the social insurance nature of Medicare. As noted by the Kaiser Family Foundation, "there is a possibility that proposals [to further means test Medicare] could lead some higher-income beneficiaries to drop out of Medicare Part B and self-insure, which could result in higher premiums for all others who remain on Medicare."[12]

Thank you for the opportunity to comment on these proposals. If you have questions, please contact Fay Gordon at fgordon@nsclc.org.

Sincerely,



Fay Gordon
Staff Attorney

[10] See, e.g., Kaiser Family Foundation, "How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports (LTSS) Today? State Adoption of Six LTSS Options," available at http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8079-02.pdf.
[11] Kaiser Family Foundation, "Medicare's Role and Future Challenges,"available at http://jama.jamanetwork.com/article.aspx?articleid=1456081.
[12] Kaiser Family Foundation, "Income-Relating Medicare Part B and Part D Premiums Under Current Law and Recent Proposals: What are the Implications for Beneficiaries?" available at: http://kff.org/medicare/issue-brief/income-relating-medicare-part-b-and-part.