ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults®*

February 15, 2013

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

Dear Senator Hatch:

On behalf of the American College of Physicians (ACP), an organization representing 133,000 internal medicine physician specialists and medical student members, I am writing to express our views on the structural reforms to Medicare and Medicaid that you proposed in January of this year. We appreciate your efforts in wanting to address entitlement reform as part of any deficit reduction proposal. In that spirit, we are pleased to provide you with feedback on each aspect of your proposal, as outlined below.

ACP recognizes that there is an urgent need to reduce the federal budget deficit, and specifically, federal spending on health care in a fiscally- and socially- responsible way. ACP has already provided Congress with recommendations to achieve hundreds of billions in savings by targeting the real cost-drivers in medicine, including over-use of tests and procedures with marginal or no benefit to patients driven in part by physicians' fear of malpractice lawsuits, as well as by making necessary changes in entitlement programs and health care tax policies. We hope you and your colleagues will give some consideration to these recommendations, as submitted to Congress in 2011, as you go about entitlement reform in the months ahead.

Specifically, with regard to your proposal, ACP would like to offer the following observations and suggestions:

1. **Adjust the Medicare Eligibility Age for Seniors from 65 to 67 Years of Age**: This proposal would gradually increase the eligibility age of seniors for Medicare to age 67 within a decade of enactment. This new policy would reflect the increase in life expectancy of seniors from 70 years in 1965 when Medicare was enacted, to the current life expectancy rate of 78 years.

   ACP Views: ACP supports an increase in the Medicare eligibility age to correspond with the Social Security eligibility age only if affordable, comprehensive insurance is made available to individuals who are made ineligible for Medicare. Any changes in the Medicare eligibility age must be initiated with care, as was done by gradually phasing-in increases in the Social Security normal retirement age, to ensure that individuals currently approaching the age of Medicare eligibility (e.g., those currently age 55 and above) remain eligible for Medicare coverage beginning at age 65.

   If implemented improperly, an increase in the Medicare eligibility age could have drastic unintended consequences, including reduced access to insurance, higher premiums in Medicare and the commercial insurance market, higher state expenditures due to increased Medicaid roles, and higher insurance costs for employers. College policy assumes that the coverage and insurance reforms established in the Affordable Care Act (ACA), such as

requiring insurers to cover individuals with pre-existing conditions, would remain in law. Seniors whose Medicare eligibility age would increase under this proposal must also be able to access health insurance through the reforms of the ACA that expand eligibility for Medicaid or allow individuals to purchase health insurance through a federal or state-based exchange with the aid of tax credits. The College acknowledges that this may be difficult to achieve since the ACA restricts Medicaid expansion eligibility to those under age 65 and the likely scenario that many states will choose not to expand their Medicaid programs. However, ACP believes it is vital that affordable, comprehensive coverage is made available to those made ineligible for Medicare due to a change in the program's eligibility age. ACP supports efforts to change the ACA if the Medicare eligibility age is raised to ensure that older Americans are able to access coverage options such as Medicaid and tax credits to purchase insurance through federal and state based exchanges. Additionally, ACP recommends the creation of a Medicare buy-in option to permit individuals aged 55 and up to purchase coverage through the Medicare program. The establishment of a buy-in program would be especially important to provide transitional coverage for those made ineligible due to an increase in the Medicare eligibility age.

2. **Modernize the Medigap Program:** This proposal would require that seniors pay a deductible associated with their Medigap coverage. It would limit first dollar Medigap coverage to encourage seniors to make wise choices regarding their health care that ensure quality care while lowering costs for the entire Medicare population.

   ACP Views: We believe that Medigap plans should only be altered in a manner that encourages use of high quality, evidence-based care and does not lead Medicare beneficiaries to reduce use of such care because of cost. Preventive procedures such as those rated an A or B by the United States Preventive Services Task Force, should be exempt from cost sharing. Any changes made to the structure of Medigap plans should be made prospectively and not affect existing beneficiaries.

3. **Simplify Medicare Beneficiary Cost-Sharing and Establish a Catastrophic Limit:** This reform would streamline Medicare cost sharing into a single combined annual deductible for Medicare Part A and B services, establish a uniform coinsurance rate for amounts above the deductible, and institute an annual catastrophic cap to financially protect seniors in cases of serious health events.

   ACP Views: ACP supports combining Medicare parts A and B with a single deductible under certain circumstances. However, without sufficient detail as to how your proposal would impact beneficiaries' out-of-pocket health care costs and their access to primary and preventive care services, we are unable to determine if we can support this reform at this time. ACP could support combining Medicare parts A and B into a single deductible under the following conditions:
   a. Specified primary care, preventive and screening procedures of high value based on evidence are not subject to the deductible, and no co-insurance or co-payments would apply;
   b. A limit is placed on total out-of-pocket expenses that a beneficiary may incur in a calendar year (i.e., stop loss coverage);
   c. The deductible is set at an actuarially appropriate level that does not cause an undue financial burden on beneficiaries, especially lower-income beneficiaries; and
   d. Medicare payment levels to physicians for covered primary care and preventive benefits are adequate to ensure that beneficiaries have access to such services, the payments rates cover physicians' resource costs (including annual increases in the costs of providing

services due to inflation) and adequate annual updates are issued that are fair and predictable.

4. **Implement Medicare Competitive Bidding:** This reform would allow health plans to compete with traditional fee-for-service Medicare to reduce costs and preserve the quality of care. The federal government would continue to define a package of required benefits that would constitute comprehensive Medicare coverage, as it does today. Each year, private insurers and traditional Medicare would submit bids to provide guaranteed Medicare benefits. The government would then provide, on behalf of each senior, a risk-adjusted payment based on those competitive bids in their area of the country. Seniors who choose plans that cost less than the government payment would get the difference back through lower premiums or additional health benefits.

   ACP Views: ACP does not support conversion of the existing Medicare defined benefits program to a defined contribution model. However, ACP could support testing of a defined benefits premium support option, on a demonstration project basis, with strong protections to ensure that costs are not shifted to enrollees to the extent that it hinders their access to care. Such a demonstration project would offer beneficiaries a choice between traditional Medicare and qualified premium support plans offered through the private sector subject to Medicare requirements relating to benefits, delivery system improvements, cost-sharing, access to services, and premiums, while providing financial support to cover the Medicare benefit package.

5. **Strengthen Medicaid While Improving Patient Care: Per Capita Caps:** This proposal would reform the federal government's share of Medicaid funding by providing block grants that cap the amount of spending the federal government sends to states and also proposes to limit the amount of federal dollars spent for each Medicaid beneficiary. (per capita caps)

   ACP Views: ACP does not support proposals that would transform Medicaid into a block grant program. In general, we believe that the Medicaid program should continue to serve as the coverage foundation for low-income children, adults, and families regardless of categorical eligibility. Medicaid minimum eligibility standards should be uniform on a national basis, and federally mandated Medicaid coverage expansions should be fully subsidized by the federal government. Further, policymakers should refrain from enacting policy changes that would result in vulnerable persons being dropped from Medicaid coverage. The College also recommends that during times of economic stress, the federal government provide a counter-cyclical funding mechanism substantial enough to accommodate the increased need for Medicaid as unemployment increases and access to employer-based health coverage decreases.

   ACP believes that states should be allowed to build and test innovative models that seek to improve the way Medicaid delivers care to beneficiaries, provided such innovations meet federal standards. The College recommends that federal and state stakeholders work together to streamline and improve the Medicaid waiver process, ensuring timely approval or rejection of waiver requests and sufficient transparency to allow for public consideration and comment. ACP also urges federal and state governments to collaborate on efforts to combat fraud, waste and abuse within the Medicaid program to ensure its continued viability, provided that policies do not place an undue burden on physicians who do not engage in illegal activities. Additionally, the Medicaid program should increase use of comparative effectiveness information to ensure that physicians have the tools necessary to deliver high-value, evidence-based care to their patients.

ACP appreciates the opportunity to comment on your proposal and hopes that our feedback will help inform future discussions on entitlement reform. If the College can be of any assistance going forward, please do not hesitate to contact Brian Buckley at 202-261-4543 or if you have any questions regarding this letter. We look forward to working with you.

Sincerely,

David L. Bronson, MD, FACP
President