

MEDICARE

AARP ISSUE BRIEF

BACKGROUND

Medicare is a vital source of health coverage for people age 65 and older, people with disabilities, and people with end-stage renal disease. Congress improved Medicare in 2003 by adding a much-needed prescription drug benefit and further strengthened that benefit in 2008 with the passage of additional legislation.

Despite Congressional action, many beneficiaries are still struggling to afford rising out-of-pocket costs, which are often much greater than the costs for people with employer-sponsored coverage. The current financial crisis is likely to only make this affordability problem worse as retirement accounts shrink and out-of-pocket costs rise.

Like other public and private health payers, Medicare has been experiencing rapid growth in spending due primarily to increases in the number of people ages 65+, the expanding scope of services needed, and, most importantly, the dramatic rise in the cost of health services overall.

Importantly, the Medicare program is taking some steps to become a value-based purchaser, by revising payment incentives to promote high quality care, but additional policy changes are needed to move the program further in this direction.

LEGISLATIVE AND REGULATORY ACTION

Key areas for legislative action are those that would improve the long-term sustainability of the program and those that would safeguard beneficiaries' health and financial security.

AARP believes Congress should take action to bring down the cost of health care and improve the quality of Medicare coverage by:

- Requiring the adoption of health information technology;
- Providing incentives for prevention and healthy behaviors to reduce the need for health care services and to improve quality of life;
- Promoting care coordination programs for people with chronic conditions, such as the Independence at Home Act (S. 3613/ H.R. 7114); and
- Spurring innovations in payments, including public reporting for greater transparency, to further incentivize quality and efficiency through value-based purchasing.

Congress should also take several legislative actions to improve the health and financial security of Medicare beneficiaries. AARP supports changing the benefit design in Medicare by:

- Modernizing Medicare's cost-sharing (deductibles and co-insurance) requirements and protecting against significant premium increases;
- Further capping beneficiaries' out-of-pocket obligations;
- Strengthening post-acute care coverage;
- Eliminating Medicare overpayments to Medicare Advantage plans to achieve balance with the traditional program;

- Eliminating asset tests in the Part D low-income subsidy and the Part B Medicare Savings Programs, which penalize people who did the right thing by saving for retirement;
- Granting the Secretary of Health and Human Services the authority to use the bargaining power of millions of Medicare beneficiaries to negotiate drug prices; and
- Improving the benefit for the future by eliminating or curtailing the donut hole and improving the employer-sponsored subsidy provisions.

Policies that AARP does not support include those that would decrease health and financial security. For example, AARP does not favor premium support (under which Medicare would pay a defined percentage of an average premium amount and expenses would increase for beneficiaries), nor does AARP support the Medicare “trigger” provision, which is based on an arbitrary formula that values increases in revenues over increases in program efficiency.

On the regulatory front, fraud and abuse are still significant problems in Medicare. Considerable savings already have been realized from Medicare’s fraud and abuse efforts to recover funds from secondary payers through medical review, and prosecuting fraud, but far more savings could and should be realized.

Another area for improved regulation is around the Part D drug benefit. Specific ideas include:

- Streamlining the process for appeals, shortening time required for decisions, and allowing appeals of tier 4 payment rates;
- Helping low-income beneficiaries, especially in long-term care, by assigning them to the most clinically appropriate plans for their needs rather than simply random assignment, letting more people help them select plans, and waiving cost sharing for those in assisted living or home- and community-based services so they do not pay more than those in nursing homes;
- Allowing a special enrollment period for beneficiaries if the plan changes the formulary mid-year and such change affects the beneficiary’s cost sharing; and
- Ensuring that individuals who switch plans are not required to go through step therapy again.

THE COST OF DOING NOTHING

If the 111th Congress chooses to do nothing to strengthen and improve Medicare, health care costs will continue to go up, undermining the health and well-being of older Americans, many of whom are already skipping important preventative treatment and medication for chronic conditions because they cannot afford it. Putting off value-based purchasing and more efficient benefit design will undermine the long-term strength of the Medicare program and squander the opportunity to use Medicare reforms to drive important improvements through the broader health care system.