



ISSUE BACKGROUND

Medicare

NAELA opposes efforts to condition Medicare eligibility on income or assets.

Today, health insurance coverage through Medicare coverage for Americans age 65 and over is almost universal.

Overall, the rising cost of health entitlements is driven not by demography, but by technological advances in the health area – the same factors that drive private sector health spending (Population Aging, Entitlement Growth, and the Economy, AARP Public Policy Institute). Therefore, any efforts to contain costs in the Medicare program must be made in the context of overall health care reform.

While Medicare is highly successful and should be protected, it can also be improved:

NAELA supports the Ending the Medicare Disability Waiting Period Act of 2009 (S. 700/H.R. 1708) sponsored by Senator Bingaman (D-NM) and Representative Gene Green (D-TX-29), which would phase out the 2-year waiting period for Medicare for SSDI beneficiaries. The Coalition to End the Two-Year Wait for Medicare, to which NAELA and over 120 other organizations belong, also supports S. 700/H.R. 1708.

- Nearly 40 percent of the 1.5 million people waiting for Medicare are without health insurance coverage at some point during their wait for Medicare; 24 percent have no health insurance during this entire period. Many cannot afford to pay COBRA premiums to maintain coverage from a former employer, and private coverage on the individual market is unavailable or too expensive for this population. The waiting period forces people with severe disabilities to endure two years during which treatment and care of their condition are put at risk. Many forgo medical treatment and/or stop taking medications, compromising their already fragile health and resulting ultimately in conditions more costly to treat when Medicare coverage finally begins.

NAELA supports the restoration of equity in payment between traditional Medicare and Medicare Advantage, and using the savings to improve Medicare.

- The Medicare Modernization Act of 2003 (MMA) provided generous subsidies to Medicare Advantage (MA) plans that amount to over \$15 billion a year. The average payment to MA plans is 14% more than payments to traditional Medicare. The Chief Actuary acknowledges that, in 2008, the MA overpayments caused Part B premiums to increase by about \$3 per month per beneficiary. The Congressional Budget Office (CBO) estimates that equalizing the payment policies for MA plans with those for traditional Medicare would save Medicare at least \$150 billion over the next nine years. (“Options for Real Reform,” Center for Medicare Advocacy) The Medicare Payment Advisory

Commission (MedPAC) recommends that payments to MA plans be brought in line with traditional Medicare.

NAELA supports passage of the Medicare Prescription Drug Savings and Choice Act of 2009 (S. 330), to create a prescription drug benefit offered through the traditional Medicare program.

- The Medicare Part D prescription drug benefit is offered by private companies that enter into annual contracts with CMS. Plan sponsors can decide not to renew their contract or, more commonly, they can change their benefit structures or consolidate plans. Because the changes reflect plans' business strategies rather than beneficiaries' needs, they translate into reduced coverage and increased costs to beneficiaries each year. Moreover, each year, more than a million low-income subsidy (LIS) recipients, generally high users of prescription medications, must be reassigned to plans when their current plan no longer qualifies for the subsidy. To create a stable prescription drug benefit that does not change based on the business plan of the plan sponsors, Congress should add a prescription drug benefit offered through the traditional Medicare program. ("Options for Real Reform," Center for Medicare Advocacy) One bill which does this is S. 330, Sponsored by Senator Durbin, Congressman Berry and Congresswoman Schakowsky.

NAELA supports provision of care coordination across settings and services to older adults and people with disabilities with complex chronic conditions, disabilities, or dementia through Medicare.

- Care coordination is a person-centered, assessment-based, interdisciplinary approach to integrating health care and social support services in which an individual's needs and goals are assessed and a care plan developed to address those needs and goals. Services are managed and monitored by a trained care coordinator or interdisciplinary team according to established standards of care. Care coordination can improve the quality of and access to health care for older adults and people with disabilities and may reduce costs by helping to prevent unnecessary hospitalizations and nursing home placements.

NAELA urges Congress to ensure that older Americans are included and protected in the reform of our nation's health care system.

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