



Alliance *for* Retired Americans®

2009 LEGISLATIVE CONFERENCE

Health Care: Checking the Pulse Workbook for Breakout Sessions 1 & 2 Table of Contents

Session 1 – Health Care Reform	2
Chapter 1: Health Care Legislation Timeline	2
Chapter 2: Why We Need Health Care Reform Now!	2
Chapter 3: Key Elements of Health Care Reform	4
Chapter 4: Shared Responsibility - Pay or Play	5
Chapter 5: Taxation of Benefits – What’s It All About? .	7
Chapter 6: A Public Plan – Where Does It Stand?	9
Session 2 – Retirees’ Stake in Health Care Reform	11
Chapter 7: Ways to Improve Medicare.....	11
Chapter 8: Reining in Medicare Advantage	13
Chapter 9: Medicare Buy-In	14
Chapter 10: Long Term Services and Supports	16
Chapter 11: Means-Testing Medicare Part D	19

Session 1 – Health Care Reform

Chapter 1: Health Care Legislation Timeline

Both the House and Senate will consider health care legislation in June and July. In the Senate, the Health, Education, Labor and Pensions (HELP) Committee will begin to consider a bill on June 16. HELP Committee deliberations and votes, known as a mark-up, will take two weeks at the least. The HELP Committee will create the structure for what health care in America will look like. The Senate Finance Committee, in a separate bill, will begin its markup shortly after the HELP Committee. This bill will consider how to pay for health care reform. In July, the full Senate will consider the combination of the two committee bills.

In the House, three committees – Education and Labor, Energy and Commerce, and Ways and Means - will consider health care reform. There will be one bill that each committee will consider part of. The committees will have hearings in late June and early July and then have markups during the week of July 13. The full House will then consider the health care reform bill in late July. After the House and Senate complete their work, a House-Senate conference committee, composed of members of each body, will merge the bills starting in August while Congress is in recess. A separate vote in the House and Senate on a conference committee bill will likely occur in September or October.

Your Turn

1. What committees in the House and Senate will take up health care reform?
2. Is your Representative or Senator a member of one or more of the health care committees?

Chapter 2: Why We Need Health Care Reform Now!

America's health care system is in crisis; health care reform cannot wait. The moment we can make a difference is right now! We are living in the midst of an economic crisis that cannot be fixed until we repair our broken health care system. If we continue with the status quo, health care costs will continue to devastate families, individuals, businesses and government at all levels. The share of the federal budget that will be consumed by the rapidly rising health care costs will squeeze out spending for any non-health care priorities. No one understands this better than retirees over 55 years old. Individuals 55+ are heavy health care consumers and are all too familiar with rising health care costs. YOU have a major stake in the success of comprehensive health care reform that delivers high quality health and behavioral health care to retirees.

Our main objective is to get health care costs under control and bring down costs for retirees! We cannot get control of Medicare spending and improve the program for future retirees if we do not get control of escalating health care costs. If we fail at health reform, Medicare cuts are up next!

Make sure that those between 55-64 have access to affordable health care coverage. The security of employer-based health care plans is a growing concern for current and future retirees who often depend upon these plans to close the gaps in Medicare and other health care coverage. Nearly two-thirds of early retirees (between ages 55-64) are now without insurance coverage based on prior employment.

We need to make a public health insurance plan an option for everyone. Health care reform now is critical for everyone - children, adults, families, workers, and retirees. Together, the extension of public coverage and the improvement of the delivery system will work to remedy a system currently plagued with problems. It's time we all have access to affordable health care.

Startling Facts on Health Care Costs & Spending

- Nearly 50 million Americans now lack health insurance, and tens of millions more hold private policies that provide little protection in the event of serious injury or illness. Even well insured Americans, facing a job loss, can find themselves thrown into the ranks of the uninsured and “uninsurables” overnight.
- About 200 million Americans obtain health insurance today through their employers and the private health insurance market. About 80 million Americans get their coverage through federal and state health programs, chiefly Medicare and Medicaid.
- One out of every six dollars in the United States goes to health care. That's over \$7,000 a year for each man, woman or child in America.
- Health insurance premiums are going up three times faster than salaries. The average cost of the premium for health insurance coverage for a family today is **more than \$13,000**, almost *double* what it was in 2000. This average includes poor health plans.

Your Turn

1. How many Americans now lack health insurance? _____¹
2. About what percent of Americans had a problem paying for medical care during the past year? _____%²

¹ Nearly 50 million

Talking Points

- **Health care reform MUST happen now.** We need health care reform now so that families and individuals do not have to risk bankruptcy in the face of mounting health care bills.
- A key piece to cost containment is ending windfall profits to insurance companies, and only paying for good quality health care, as opposed to quantity of care.
- The Alliance supports a public plan option in health care reform. A public plan will help contain costs and make private insurers more competitive.
- The Alliance supports “pay or play” in health care reform. Health care should be a shared responsibility between individuals, employers and government.
- The Alliance supports the ability for 55-64 year old retirees to obtain affordable health either through a Medicare buy-in or reinsurance to former employers.

Chapter 3: Key Elements of Health Care Reform

The following are the key elements that we want to see in health care reform:

- A plan that allows you to keep the health care you have to minimize disruption;
- A national health care exchange through which individuals and small employers can obtain health care coverage;
- Guaranteed issue of coverage without regard to pre-existing conditions;
- Various levels of standard benefit packages;
- Shared responsibility among employers, government and individuals (pay or play) for providing & obtaining health care coverage;
- A cap on out of pocket costs for health care expenses;
- End the overpayments to Medicare Advantage;
- Provide a Medicare buy-in for 55-64 olds or subsidy to employers for private retiree health insurance (Senate only); and
- Coverage for costs related to long term services and supports, such as the CLASS Act (currently in Senate only).

Financing Health Care Reform

Health reform must bring down costs. We cannot cover everyone without bringing down costs, and we cannot control costs without getting everyone in the system. Necessary fixes include:

² 25%

- Employer contributions for their uninsured workers;
- Eliminating overpayments to privatized Medicare plans;
- Stopping offshore tax avoidance & abuses by wealthy individuals and corporations;
- Raising rates on \$250,000+ earners and applying Medicare tax to unearned income;
- Prescription drug negotiation and reforms;
- Limiting tax deduction to 28% for high income earners; and
- Savings from delivery system changes and the new public health insurance plan.

Chapter 4: Shared Responsibility - Pay or Play

The responsibility for financing our health care system must be shared by employers, families and the government, and must ensure that benefits are comprehensive and cover the health care services that people need. All employers, public or private, must either provide comprehensive coverage or make a substantial payment into a fund to finance coverage so their workers can obtain coverage. Small business should be able to avail of a subsidy to assist with funding this mandate and employers that contribute to pre-Medicare retiree benefits should similarly get relief to comply with this known as **“Pay or Play.”** This means that employers must **“PLAY”** in the health care reform movement and provide good worker health coverage or **“PAY”** significantly into public fund that will assist with providing health care coverage. Full employer participation is essential to prevent unscrupulous employers from discontinuing coverage for low-wage employees who might qualify for subsidized coverage.

“Pay or Play” is fair at reasonable levels. It will level the playing field so free rider firms can’t continue to shift costs to the employers that offer good benefits. This would take away the unfair competitive advantage of employers who do not provide these benefits. It will also hold down federal costs by preventing employers from dumping their workers into the new subsidized plans, and will bring in needed revenue to help fund subsidies for low-income individuals and the uninsured. Pay or play will shore up employer-based coverage and minimize disruption for those who now have coverage and want to keep it.

“Pay or Play” facilitates the ability to make quality coverage available and affordable to everyone. Without full employer participation, the cost of coverage will shift to families and the government. A public health insurance plan option should be available to all employers to purchase affordable coverage. A public

health insurance option will provide employers with a cost-efficient alternative to private coverage.

- A recent study found more than \$1,000 of every family plan premium goes to cover the cost of care for the uninsured, most of which are workers.
- Responsible employers are not only providing health coverage for their employees, but they are also paying for uncompensated care for the employees of businesses that do not provide coverage. This adds 8%, or \$1,100, to the cost of the average annual family premium.

Businesses and their allies will argue they can't afford to meet this requirement in such a bad economy. However, the vast majority of firms that currently offer health coverage will not see any new costs. Instead, they will see their costs go down when we eliminate cost-shifting. The only firms that may see their costs increase are those who don't currently offer any health care benefits to their employees or those who offer benefits that are too inadequate to meet a reasonable test. The vast majority of firms that don't offer are small and mostly low-wage. As noted above, we support health care reform that will give these small firms more affordable options through additional subsidies for those with low-wage workers.

Your Turn

1. What are the two main reasons we support "Pay or Play" as part of health care reform?³
2. Right now, who pays for health care for the uninsured workers?⁴

Talking Points

- The responsibility for financing our health care system must be shared by employers, families and the government.
- Without "pay or play" and full employer participation, the cost of coverage will shift to families and the government. We need this in order to make health care reform possible.
- "Pay or Play" is a fair solution. It levels the playing field and it takes away the unfair competitive advantage of employers who do not provide these benefits.

³ It's *fair*: (It takes away the unfair competitive advantage of employers who do not provide health benefits.)

Funding: (Through shared responsibility we can make quality coverage available and affordable to everyone.)

⁴ Employers who offer benefits to their own employees and employee premiums foot the bill to cover uninsured workers.

Chapter 5: Taxation of Benefits – What’s It All About?

Although Barack Obama campaigned against taxing health care benefits while running for President, the issue is under serious consideration in the Senate. The Senate Finance Committee is considering capping the current tax exclusion and making some health care benefits taxable. The committee is considering capping the tax exclusion based on income, benefit amount or a combination of the two. But capping the tax exclusion is the wrong way to go. Eliminating or capping the tax exclusion would undermine employer-sponsored coverage.

More than 200 million people get their coverage through the workplace as a worker, dependent or retiree. Coverage through the workplace evolved, in part, as a response to tax changes in the 1940s and 1950s that excluded employer contributions from taxable wages. These changes encouraged employers to provide health coverage and also encouraged healthy employees to enroll in workplace plans, providing for the formation of stable and sustainable risk pools. Employers provide a ready-made, stable, risk pooling mechanism; coverage with lower administrative costs than individual coverage; and skills and expertise to carry out complex negotiations with insurers that the average family is not equipped to perform. Taxing health care benefits would not only make coverage more expensive for families, it would destabilize our current system and drive many employers to stop providing health benefits for their workers. In addition, taxing benefits would encourage younger and healthier workers to opt out of employer-sponsored coverage and seek less comprehensive coverage. The loss of these workers to employer risk pools would drive up the cost of coverage for older and less healthy workers, and increase their tax burden.

Taxing benefits would undermine the quality of coverage. It would drive high wage employees, with higher marginal tax rates, to demand that employers reduce coverage. While highly-paid employees may be able to afford high deductibles and other reductions in coverage, this would be a financial burden for average families.

Taxation raises costs on workers. One approach would tax health benefits for only the highest income workers. But that won’t raise much revenue for health reform. Another approach would tax only high cost plans. But the exact same family plan could cost well under \$15,000 in one company and more than \$20,000 in another depending on the age and health status of the workforce or even where the company is located.

- Studies show that putting a cap on tax-free health benefits will disproportionately hit workers in small firms and firms with older workers

and retirees. That's because insurance companies regularly charge higher rates for coverage for these workers.

- Studies confirm that a cap could hit family plans harder than individual coverage since proposed caps don't account for the higher costs associated with a plan that includes children.
- Economists say the tax exclusion leads workers to get too much coverage. If that were true, our benefits would keep getting better. Instead, we've fought to hold onto the benefits we have and in many cases we've seen benefits cut back. But our costs just keep going up.
- President Obama has called taxing employee health benefits "the largest middle-class tax increase in history."

Capping the tax exclusion won't make it more progressive. Some will argue that the tax exclusion is regressive, because higher income workers get a bigger tax advantage out of making health benefits tax-free. Economists have united around this traditional tax code view. But that's only part of the story. A recent report points out that while households in higher tax brackets may get a bigger benefit from the tax exclusion in absolute dollar amounts, low and moderate income workers will see their taxes increase by a bigger share than higher income workers. The report found that workers with employer-provided health benefits making between \$40,000 and \$50,000 would see their tax liability increase on average 28 percent and those making between \$50,000 and \$75,000 would see their tax liability increase on average 20 percent. In contrast, those making more than \$200,000 would see an average increase in their tax liability of only one tenth of one percent.

Taxing health benefits will be so unpopular, it could doom health care reform. In an environment where health costs are already crippling families, taxing health benefits is wildly unpopular. Congress and the President have said health reform will build on what works and have assured Americans they can keep the coverage they have if they like it. This makes good political and policy sense. But a cap on the tax exclusion threatens to disrupt the primary source of health coverage and financing for most Americans, because employers may either substantially change or even eliminate benefits. If workers have to pay more in taxes because some of their co-workers have costly medical conditions, health coverage will change from a workplace benefit that everyone supports to one that will split workforces between the healthy and the sick. We hope and expect health reform will lower costs and make coverage available to uninsured workers through new private and public plan options. But until health reform has been proven successful and sustainable on both fronts, we should not undertake changes that might threaten the source of coverage for 160 million Americans.

Health care was a deciding factor for many voters last year and taxing health benefits was the clear dividing line between Obama and McCain. If voters expect health reform will make their costs go up rather than down, they may turn their backs on health reform.

Talking Points

- The Alliance opposes taxing health care benefits, and agree with President Obama who said that taxing employee health benefits “the largest middle-class tax increase in history.”
- Limiting the tax exclusion punishes employees who have sacrificed salary increases to maintain comprehensive health benefits. It would be extremely unfair to now impose a premium-based tax on their coverage.
- A 2009 national survey found that voters oppose taxation of health benefits by an overwhelming margin of 80% to 17%, and that such a tax would weaken support for comprehensive health care reform.

Chapter 6: A Public Plan – Where Does It Stand?

Baby Boomers and retirees might remember the creation of Medicare, and know why a public plan option is best. They may understand that the relationship of a public plan, such as Medicare, to private coverage is an important foundation of health care delivery. In health care reform a public health insurance plan should be an option for everyone alongside private health insurance plans. A public health insurance plan makes reform work. It will bring down costs and guarantee quality affordable health care for all. Giving everyone the choice of a strong public health insurance plan will inject needed competition into the market and drive lower costs and improved quality across all plans. It will also mean that health care will be there for all of us, no matter what.

Health care reform must build on what works – coverage we get through jobs and public programs. Most in Congress agree that if families like the coverage they have now, they should be able to keep it, but that those who are not satisfied with their coverage, or cannot afford it, must have options. One of those options should be a public health insurance plan that would compete on a level playing field with private plans and would be administered by government but funded through premiums. Because public health insurance plans have lower administrative costs, it would be a less expensive option. In addition, a public health insurance option would guarantee that families will always have high quality coverage no matter what happens to their private coverage.

Experience with traditional, government-administered Medicare demonstrates that public programs are more cost efficient than private coverage.

- Medicare's administrative overhead is about 2% of total cost. Administrative costs (including profits) in private group coverage run 12% to 15% of total costs.
- In a recent study, the Commonwealth Fund estimates that reform which includes a public health insurance option will create cumulative savings of \$3 trillion over 10 years, while reform without the public option would save less than one-third of this amount.
- In 2000, the two largest health insurers covered a combined total of 32 million lives. As a consequence of mergers and acquisitions, the two largest insurers in 2007 covered a combined 67 million lives.

A Public Plan Promotes Competition: A public health insurance option, coupled with a more regulated private insurance market, will break the stranglehold a handful of companies have on the insurance market and will give consumers enough choices to vote with their feet and change plans.

Improved Quality & Provider Payments That Make Sense: Just as Medicare has led the way with payment reforms that are driving quality improvements that the private plans are now adopting, a public health insurance plan can similarly develop innovative payment mechanisms, expand quality incentives and adopt evidence-based protocols.

Stable and Continuous Coverage: Private insurance plans can change their benefits, alter cost-sharing, contract with different providers and move in and out of markets. A public health insurance plan will always be there (even in rural America) to provide coverage when it is needed and it offers security as we build a new system of highly regulated private health insurance options.

- The public supports a public health insurance plan option. A public health insurance plan is supported by 73% of voters, even when they hear the sharpest insurance industry attacks. This support crosses all political lines and geographic regions. This includes Democrats (77%), Independents (79%) and Republicans (63%), as well as urban (73%) and rural (71%) voters.
- About 25% of Americans said their family had problems paying for medical care during the past year. They know that public insurance could have helped to avoid such pitfalls.

Your Turn

1. What industries are generally not in favor of a public plan option?⁵
2. What percentage of voters are in favor of a public health insurance plan?
_____ %⁶

Talking Points

- The Alliance supports including the choice of a new public health insurance option in health care reform.
- A public plan option, like Medicare, is the most cost effective solution reform. Like Medicare, there is no private insurance middleman or CEO taking profits off the top and away from your care. No insurer comes between you and your doctor.
- A public health insurance option will foster healthy competition between plans, and sets a standard of good value coverage. It can help drive quality improvements in the system, by helping to implement measures that reward quality, increase prevention and improve patient health outcomes.
- In a recent survey, 73 percent of Americans support including the public plan option in health care reform.

Session 2 – Retirees’ Stake in Health Care Reform

Chapter 7: Ways to Improve Medicare

Medicare has provided quality, affordable health care for seniors since its creation in 1965, but recent changes have had a negative impact on the program. The 2003 Medicare Modernization Act created the Part D prescription drug plan and the Medicare Advantage plans that cost the federal government 12 to 19 percent more than what the same services would cost under traditional Medicare.

Despite numerous efforts to add beneficiary improvements, Medicare still does not cover all health care needs, such as: long term care, dental, podiatry, and vision care. Most changes to Medicare have actually resulted in the increased participation of private health insurance plans and higher out-of-pocket costs for participants rather than an expansion of benefits. Improvements to Medicare will not only benefit older Americans, but will also benefit active workers because if their employers do not have to pay catastrophic health care costs, then they may ultimately even provide preventative and/or dentals coverage. The time is ripe to bring improvements to Medicare in the following ways:

⁵ The insurance industry, drug companies, business lobby, medical device industry, right-wing politicians, medical specialists, for-profit hospitals, and retail health clinics.

⁶ Around 73% of voters

Improve Medicare’s Prescription Drug Program by creating a national, public plan option in Part D, eliminating the coverage gap, allowing beneficiaries to change plans whenever necessary, prohibiting Part C and D plans from making mid-year formulary deletions, granting the Secretary of Health and Human Services authority to negotiate drug prices to reduce costs, and improving the appeals/exceptions process reducing cost sharing in the specialty tier.

- Every year, Part D plans change what drugs they cover, what restrictions they impose on coverage and what they charge. By contrast, Medicare – a public plan - has a proven record of providing stable coverage of hospital and doctor care for people with Medicare of all income levels.
- Medicare beneficiaries who lacked coverage in the donut hole reduced their monthly prescriptions by 14 percent per month once they entered the donut hole.
- Prices under Medicare Part D are at least 50% higher than prices for veterans, because the Veterans Administration is allowed to bargain, while Medicare is not.
- If Medicare could negotiate directly with drug companies, the savings over the first eight years of the Part D program would be almost \$560 billion, enough to completely eliminate the doughnut hole.

Enhance Medicare benefits by covering geriatric assessments, care coordination/management and chronic disease self management; eliminating cost sharing for preventive services; adding a catastrophic stop-loss for beneficiary cost sharing; and enrollment assistance.

Address gaps in coverage. Medicare currently has significant coverage gaps, particularly in comparison to the typical large employer health plan or the Federal Employees Health Benefits Program. High cost-sharing in Part A, the lack of an out-of-pocket limit in Parts A and B, and the “doughnut hole” coverage gap in Part D put older people at serious financial risk.

Your Turn

1. One in how many Americans say someone in their family skipped pills, or postponed or cut back on needed medical care due to costs?⁷
2. How many Medicare beneficiaries fell into the doughnut hole in 2008?⁸
3. How much money must a Medicare beneficiary pay out of pocket to get out of the doughnut hole?⁹

⁷ 2

⁸ 3.4 million

⁹ \$4,350 in 2009.

4. How much did Humana increase its premiums for Part D coverage between when the program started in 2006 and today?¹⁰

Talking Points

- The Alliance supports the Medicare Prescription Drug Savings and Choice Act of 2009, S. 330 / H.R. 684, which creates a government-administered prescription drug plan, as part of the health care reform package. This bill is designed to produce a less expensive, easier-to-understand drug insurance plan for consumers. The price reductions would result from bulk price negotiations with drug makers, the elimination of plan marketing expenses and greater reliance on generic brands. According to the Center for Economic and Policy Research, the overall savings to Medicare and beneficiaries could be huge: At least \$600 billion in potential savings over a 7-year period!

Chapter 8: Reining in Medicare Advantage

Nearly 43 million Americans are Medicare beneficiaries who receive health care services through traditional Medicare. Of those beneficiaries, nearly 8.3 million enroll in Medicare Advantage (MA) plans to receive coverage offered by private insurance companies under contract with Medicare. The government pays these plans 12 to 19 percent more than what the same services would cost under traditional Medicare. Ironically, MA plans were brought into the Medicare program to reduce costs by offering more comprehensive health care management. These MA overpayments will cost the government and taxpayers more than \$54 billion over 5 years, rapidly rising to about \$190 billion over 10 years. The overpayments are depleting the Medicare Trust Fund. At this rate, it could run out of money 2 years earlier than currently expected.

The overpayments to insurance companies are unequal and unfair because all beneficiaries pay extra for the few who are in private plans. It costs every Medicare beneficiary an extra \$3 a month in Part B premiums to cover the cost of the subsidies going to the private companies offering MA plans.

Private insurance companies offering MA plans control how the overpayments are used. They pick and choose which extra benefits to provide. Private plans provide extra benefits that disproportionately benefit the healthy, and often reduce benefits for sicker beneficiaries in order to deter them from enrolling. Finally, the extra benefits cannot be relied upon because benefits the private plans provide can change from year to year.

¹⁰ 329%

In order to pay for some of health care reform, congress is planning to take back some of the money that is being overpaid to Medicare Advantage plans. It is important that health care reform that uses money from Medicare overpayments include improvements in quality and access to traditional Medicare. If Congress were to cut the overpayments to MA plans, that money could potentially be used to strengthen the program and improve Medicare for all beneficiaries especially programs benefiting all low-to-moderate-income Medicare beneficiaries.

Your Turn

1. How much are private Medicare Advantage plans overpaid, in comparison to traditional Medicare?¹¹
2. What are two things that should be done to improve Medicare with monies available after scaling back over payments to private Medicare Advantage plans?
3. What do the private Medicare Advantage plans want you to think will happen if the government takes steps to level the playing field by scaling back their current overpayments?

Talking Points

- The Alliance supports ending the overpayments to Medicare Advantage private insurance companies. Ending these overpayments will save \$190 billion over 10 years, funds that can be used to improve Medicare and health care reform.
- Currently all Medicare beneficiaries pay an additional \$3 per month in their Part B premiums to subsidize MA plans, whether or not they participate in these plans. MA participants should no longer have higher cost sharing for individual services than those under traditional Medicare.

Chapter 9: Medicare Buy-In

The Alliance has long supported a Medicare buy-in option for people 55-64 years of age. Four million Americans in that age group currently do not have health insurance coverage. This is a population that has more chronic care needs than younger Americans while, at the same time, it has great difficulty in finding affordable health insurance coverage. A recent study by the Kaiser Family Foundation (“Health Insurance Coverage for Older Adults: Implications of a Medicare Buy-in,” May 2009) found that the median family income in 2007 for uninsured adults in the 55-64 age group was \$20,800. Nearly two-thirds of early

¹¹ 13-15%

retirees are now without insurance coverage based on prior employment. Retiree health care benefits do not have the same protections that defined benefit pension plans have under federal law. Many early retirees who are not old enough for Medicare find it difficult or impossible to obtain coverage.

The design and success of a Medicare buy-in program must recognize the cost to beneficiaries. Having the beneficiary pay the full premiums for Medicare Parts A, B, and D, along with a five percent additional administrative fee, will effectively render the buy-in option unavailable for a population that is in dire need of health care coverage. The Alliance believes that it is reasonable to expect that monthly premiums could reach \$1,000 at the beginning of such a program, which the Senate Finance Committee has proposed. Unless beneficiaries have the benefit of a premium subsidy program, an unsubsidized Medicare buy-in program would not significantly increase the number of 55-64 year olds with health insurance coverage, according to the Kaiser Family Foundation.

The Alliance urges a premium subsidy as part of a Medicare buy-in program. There are several models available. One is what Congress enacted as part of the 2003 Medicare Modernization Act regarding Part D drug coverage. There are employer subsidies that keep employers from dropping drug coverage for retirees. The Alliance urges the inclusion of premium subsidies as well as the option for employer buy-ins when constructing a Medicare buy-in program.

The Senate Health, Education, Labor and Pensions (HELP) Committee proposal is to create a reinsurance program to provide reimbursement to employers for the cost of providing retiree health care to 55 to 64 year olds. The bill would authorize \$10 billion for this program. Coverage would come from the insurance carrier of the retiree's former employer, not Medicare.

Your Turn

1. How many Americans ages 55-64 do not have health insurance?
2. What percentage of early retirees do not have health insurance based on their prior employment?
3. Without a subsidy, how much would premiums be just to buy Medicare Parts A, B, and D?

Talking Points

- The Alliance supports a Medicare buy-in for 55-64 year olds if the premiums are affordable.
- The Alliance supports the employer reinsurance program in the Senate HELP Committee bill.

Chapter 10: Long Term Services and Supports

There is no coordinated, national public-private system for delivering long term services and supports to individuals with chronic care needs in the United States. (LTSS refers to the wide array of health care and supportive services a person with limited functional capacity or chronic health condition needs and receives over an extended period of time.) The absence of a LTSS program is one of the most serious deficiencies in our healthcare system for seniors and people with disabilities. Medicare, Medicaid, and private health care programs do not offer adequate comprehensive long-term services & support options. Private LTSS insurance is both widely unavailable and unaffordable to retirees, especially those with pre-existing conditions. Medicare's LTSS coverage is limited mainly to skilled nursing facilities for short periods following hospitalization, and to intermittent nursing care at home. It is not comprehensive coverage. Although some LTSS coverage is available through Medicaid, this coverage is only available to those who have less than \$2,000 in savings and individuals whose total monthly income is no more than an allowance of about \$30 a month from Social Security. Medicaid pays for nearly half of institutional and home-based LTSS, but many states consider the expense increasingly unsustainable and suspect that they will not be able to meet the projected future LTSS needs.

- With 10 million individuals in need of these services today and estimates that the number will rise to 26 million by 2050, there is an urgent need to address the serious deficiency in LTSS.
- The increasing costs of LTSS impoverishes thousands of seniors and their families every year as the current system forces people into long-term care institutions, as they “spend-down” into poverty to be eligible for financial assistance to help with the spiraling costs.
- Individuals and families will increasingly need viable options for services and care to maintain their respective health and independence, both in the community and in formal residential care settings.
- Improved coverage options will spur economic growth by creating employment opportunities and a more stable and professional health care workforce.

Nursing Homes & Mandatory Arbitration

Binding mandatory arbitration clauses in nursing home contracts force the elderly and those with disabilities and their families to waive their constitutional right to seek redress in the courts when a nursing home resident suffers harm. These clauses are typically buried in contracts signed by families during one of the most stressful events in their lives – entrusting the care of a vulnerable loved

one to strangers – and the clauses effectively compel family members to consent that they will waive the legal rights of a loved one if she or he is injured or dies from neglect or physical abuse while in the facility. The Alliance is against mandatory arbitration and supports the Fairness in Nursing Home Arbitration Act of 2009 (S. 512/H.R. 1237), which would invalidate pre-dispute mandatory arbitration provisions in nursing home, assisted living, and other long-term care facility contracts.

Nursing Home Transparency

Although the nursing home industry receives more than \$75 billion a year from Medicare and Medicaid, companies are creating ownership and management structures—limited liability corporations, REITs, subsidiaries, and complex operating systems—that obscure their operations from public scrutiny and insulate them from responsibility. Regulatory agencies often do not know who owns a facility, whether a facility is part of a chain with a record of substandard care or fraudulent activity, or whether a facility is near financial collapse. The lack of transparency in nursing home ownership is problematic because without proper access to this information, it is very hard for a family member to file and resolve complaints when a loved one is abused or neglected. The Alliance for Retired Americans supports the Nursing Home Transparency and Improvement Act of 2009. In addition to requiring disclosure of owners and other entities that run nursing homes, the bill will provide consumers with timely, accessible and accurate information on the level and stability of facilities' nursing staff; their expenditures for nursing care, including wages and benefits; inspection results; and the number of complaints and the types of penalties nursing homes have received over a three-year period. Such information is good because it informs whether quality service is being provided. For instance, updated information on the number of nurses and aides on staff to help residents is a key factor in determining whether quality care is being provided. The legislation will also require pre-employment staff training in dementia care and abuse prevention.

CLASS Act of 2009

On March 25, 2009, Senator Edward Kennedy (D-MA) and Congressmen Frank Pallone (D-NJ) introduced the *Community Living Assistance Services and Supports Act of 2009* (CLASS Act) (S. 697 and H.R. 1721); the bills would create a national insurance program for adults who become functionally disabled. This legislation will help people with severe functional impairments and their families to pay for the services and supports they need to stay functional and independent. It will also allow them to have choices about community participation, education and employment.

The program is financed by voluntary premium payments collected through payroll withholding (not to exceed \$30 a month) and placed in a “National Independence Fund.” Anyone who is 18 years old and actively working would be automatically enrolled in this program and would contribute to it through payroll deductions. A worker may opt out of the program. Retirees and individuals that are not working and are over 18 years old, may also pay into the system, and receive benefits.

- **Benefit Eligibility:** People who have contributed to the program for a minimum of 60 months and are unable to perform two or more activities of daily living, such as feeding, dressing, bathing, toileting, or walking; or individuals who have an equivalent cognitive disability will be eligible to collect a benefit.
- Eligibility for CLASS Act benefits will be independent of whether or not an individual is eligible for Social Security Disability Insurance (SSDI) or retirement benefits, so participation in the CLASS Act program will not impair an individual’s ability to remain qualified for SSDI.
- If an individual is eligible for CLASS Act benefits and is also eligible for the long-term care benefit under Medicaid, CLASS Act benefits can be used to offset the costs to Medicaid, thus producing Medicaid savings for the state.

Your Turn

1. On average, about how much money does a caretaker spend out of pocket to care for an aging parent or relative?¹²
2. Do you, or someone you know, need additional support/help with two or more activities of daily living, such as feeding, dressing, bathing, toileting, or walking? What kind of help and support do they receive?
3. How much would it cost the government to implement the Nursing Home Transparency and Improvement Act of 2009 and the Fairness in Nursing Home Arbitration Act of 2009 (S. 512/H.R. 1237)?¹³
4. Of all people turning 65 in the United States, what percentage will need long term services or support? What percentage will requires LTSS for 2+ years?¹⁴

Talking Points

- The Alliance supports the CLASS Act legislation (S. 697 and H.R. 1721) and urges Congress to include it in the health care reform package.

¹² \$5,500. A recent study by the National Alliance for Caregiving (NAC) and Evercare found that caregivers spend on average about \$5,500 a year out of pocket to care for an aging parent or relative. A smaller study by the NAC showed the numbers may be much higher: Those who lived with their parent spent almost \$15,000 a year for care.

¹³ Nothing. These two are no-cost bills.

http://www.nccnhr.org/uploads/File/NCCNHR_Transition_Team_Recommendations_with_sign_ons_1_9_09.pdf

¹⁴ 69% will need LTSS. 40% will require for 2+ years.

- The Alliance supports the Empowered at Home Act (S. 434), and urges Congress to pass this bill, which would increase access to home and community based services by giving states new tools and incentives to make these service more available to those in need.
- The Alliance supports the Nursing Home Transparency and Improvement Act (S. 2641) and the Nursing Home Transparency and Quality of Care Improvement Act (H.R. 7128), two no-cost bills requiring disclosure of owners, operators, and expenditures, and better federal oversight of multi-state chains and urges Congress to pass these two bills.

Chapter 11: Means-Testing Medicare Part D

The Alliance opposes the means-testing of Medicare Part D premiums. Adjusting Part D premiums based on a Medicare beneficiary's income undermines the foundation of Medicare as a social insurance program where benefits are based on premiums paid, not a beneficiary's income.

Unlike Social Security, there is no income cap for Medicare withholding. This means that higher-income seniors contribute more to Medicare via their Medicare payroll taxes since there is no earnings cap. Under the current Part B means-testing scheme, higher income retirees pay more in premiums, as much as \$308.03 per month in 2009, to receive the basic benefits. Means-testing Part D would further raise costs for those who have already paid the most into the program.

In addition to violating social insurance principles, means testing of Part D premiums would present significant administrative challenges. Unlike Part B, which is means-tested and which the Medicare program administers, Part D is a complicated program where the benefit administration is through private insurance providers. There is no one central administrative point in Part D to determine whether a beneficiary must pay more or less in monthly premiums. Given the fractured nature of the Part D program, the Alliance believes that there would be very high administrative costs in implementing Part D means testing with very little positive revenue left. Therefore, we are opposed to the means-testing of Part D.

Your Turn

1. Under Part B means testing now, how high can monthly premiums be?

Talking Points

- The Alliance opposes means testing Part D premiums. Means testing destroys the social insurance concept of Medicare.
- Because Part D is administered through many private plans, means testing would be complicated and not produce much revenue.