Issue Brief
Strengthening and Protecting Medicare

Improve Medicare for Beneficiaries with Multiple Chronic Conditions

Medicare improvements are needed to better manage costs and enhance quality for beneficiaries with multiple chronic conditions. The Senate Finance Committee Chronic Care Working Group, co-chaired by Sens. Isakson (R-GA) and Warner (D-VA), are developing recommendations to address these concerns. This group, along with health leaders in the House, should make these issues a priority this year and craft legislation that would strengthen Medicare to improve access to evidence-based community and on-line programs, such as Chronic Disease Self-Management Education and Falls Prevention interventions, which have been shown to reduce costs and improve quality. This can be accomplished through:

- Developing a targeted demonstration program with the primary purposes of improving health and quality of life outcomes for older people who have multiple chronic conditions and reducing preventable hospitalizations, readmissions and emergency room visits in order to lower per capita health care expenses;
- Expanding the use of patient-centered quality measures that best address chronic care needs. The most thoughtful, reliable measures were developed for Patient Centered Medical Homes (PCMH). PCMH Standards 4 (on planning and managing care) and 5 (on tracking and coordinating care) should be more uniformly applied across other entities serving similar chronically ill populations. Such alignment will provide improved data on comparative performance, inform policy reforms, and result in better patient outcomes;
- Improving the Medicare Annual Wellness Visit, for example, by including requirements for screenings and referrals to evidence-based chronic disease management and falls prevention interventions, and developing standards for post-visit follow-up to better ensure compliance with the personalized prevention plan; and
- Promoting partnerships between health plans and aging network community organizations.


Strengthen Medicare Low-Income Protections

Low-income cost sharing assistance for Medicare beneficiaries is failing to meet the needs of poor, vulnerable seniors and people with disabilities and must be fixed. While Medicare assistance in paying for premiums is available for beneficiaries that meet stringent asset tests with incomes of up to 135% of poverty, help with cost sharing (deductibles and copayments), is only available for those with incomes up to 100% of poverty ($11,880 for an individual).

In addition, eligibility for Medicare cost sharing assistance for low-income beneficiaries is much more restrictive than for Americans under age 65 not on Medicare. In fact, because of this eligibility cliff, some low-income baby boomers turning 65 are losing the protections they once had. This is because:
For those under age 65 not on Medicare, cost sharing help is available for those with incomes below 138% of poverty, with no asset test.

For Medicare beneficiaries, cost sharing help is available for those with incomes below 100% of poverty, with a strict asset test (generally non-housing assets below $7,280 for individuals) that unfairly penalizes retirees who did the right thing by putting aside a modest nest egg of savings during their working years.

Members of Congress should take steps to address this unfair disparate treatment of vulnerable older Americans. We urge Senators and Representatives to introduce and support legislation to “Fix the Cliff” for low-income Medicare beneficiaries.

Oppose Further Increases in Medicare Beneficiary Out-of-Pocket Costs

Often couched in terms of “entitlement reform,” some members of Congress want to cut Medicare by further increasing out-of-pocket costs for Medicare beneficiaries. Claims that seniors and people with disabilities need more “skin in the game” are ill-informed and ignore important facts, including:

- People with Medicare already have average yearly out-of-pocket health costs of over $5,000. Beneficiaries with incomes between $20,000 and $30,000 spend over $6,200 out-of-pocket on average - up to almost one-third of their income.
- On average, Medicare households spend more than twice as much on health care than non-Medicare households as a percentage of income (15% vs. 7%).
- Half of Medicare beneficiaries have incomes below $24,150.
- Growth rates in Medicare spending per person have been at historic lows. Spending per person increased by less than 1 percent per year from 2010-2015. Last year was the sixth consecutive year in which growth in Medicare spending per person was below the growth in gross domestic product (GDP) per person. Medicare spending per person in 2015 was about $1,200 lower than what the Congressional Budget Office had projected in 2010.
- About 75% of the Medicare cuts that helped to pay for the “doc-fix” bill (the Medicare Access and CHIP Reauthorization Act of 2015) that was enacted into law in April last year, came from increases in beneficiary out-of-pocket costs.

Too often, arguments about the need to cut Medicare include scare tactics about impending “bankruptcy” and “insolvency.” The truth is, last year’s 2015 Medicare Trustees Report found that the Medicare Part A Hospital Insurance Trust Fund is fully-funded for 15 years through 2030, and faces a modest shortfall thereafter when it can pay 86% of its obligations. Projections of a Medicare Part A shortfall have varied widely over the past 50 years, with the Trustees in 1970 projecting a shortfall in 2 years and in 1997 projecting a shortfall in 4 years. However, the Trust Fund has never run out of money because Congress has always taken action to ensure that Part A continues to meet its obligations. It is also important to understand that Trust Fund solvency concerns are only relevant to Medicare Part A, which comprises about one-third of Medicare spending.

Members of Congress should oppose further increases in out-of-pocket costs to people with Medicare. If we want to reduce Medicare spending, there are better ways to do it that can contain the actual cost of care received, improve efficiency, reduce waste and overpayments, and not harm the millions of beneficiaries currently struggling to afford the health care they need.

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