



CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

**White House Conference on Aging
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Introduction

California Health Advocates is a non-profit organization. Our mission is to provide quality Medicare and related healthcare coverage information, education and policy advocacy. We provide training and technical assistance to professionals who serve Medicare beneficiaries, especially the local State Health Insurance Assistance Programs, which provides Medicare benefits counseling.

Many people think of Medicare beneficiaries as seniors, white and wealthy. The majority of Medicare beneficiaries are seniors, about 83% nationally. The majority is white, about 77%, but there is a growing ethnic diversity in states like California, Hawaii, New Mexico and Texas. However, the majority is not wealthy. A statistic from 2013 shows that 63% of all Medicare beneficiaries have a median income of \$23,050 which is less than 200% of the federal poverty level (FPL). When we take race and ethnicity into consideration, the median income is even lower: \$16,350 for black Medicare beneficiaries and \$13,300 for Hispanic Medicare beneficiaries.

Twenty-one percent of all Medicare beneficiaries qualify for Medicaid. Often referred to as “duals,” this population gets a lot of attention because government healthcare spending for this population is disproportionately high.

“Trapped in the gap” beneficiaries

We often wrongly assume that beneficiaries who do not qualify for Medicaid are well to-do. But 42% of all Medicare beneficiaries struggle to make ends meet. Their incomes are around \$23,000 per year; too much to qualify for Medicaid, but we know it's not enough to pay for housing, food, medications, medical care, LTC and other necessities. Sometimes referred to as "trapped in the gap," these beneficiaries are often overlooked. They are on fixed incomes, and there are no public programs for them: not Medicaid or any of the Medicare Savings Programs, or Extra Help, the assistance program for Part D. When costs increase or they need services, they need to give up something. Would it be skipping meals, not filling or re-filling a prescription, or not getting health care or treatment?

Health care costs

I'd like to focus on health care and LTC costs - two items that threaten the retirement security of Medicare beneficiaries who are "trapped in the gap." Although Medicare covers many medically necessary services, beneficiaries have out-of-pocket costs including premiums and cost-sharing. These beneficiaries pay the Part B and Part D premiums and cost-sharing since they do not qualify for Medicaid or any Medicare Savings Programs or Extra Help. In addition, they pay for services not covered by Medicare, such as dental, vision and LTC services. Some beneficiaries have supplemental insurance to cover some of these out-of-pocket expenses, such as retiree health benefits but fewer employers are providing these; Medigap policies; and TriCare for Life.

Recent discussions to reduce Medicare spending included proposals that shift costs to beneficiaries. Proposals such as combining the Medicare Parts A and B deductibles into a single annual amount. Although the proposal would decrease the Part A deductible, which only beneficiaries who need inpatient hospital stay pay, it would greatly increase the Part B deductible which most, if not all, beneficiaries pay. Another proposal would add copayments to services that do not currently have copays, and an alternative proposal would increase copayment amounts. For beneficiaries with annual incomes around \$23,000, increases in cost-sharing would be unaffordable. Where can they turn?

Some may think supplemental insurance. As we already mentioned, fewer and fewer employers are offering retiree health benefits, and those who do are planning to reduce benefits and/or shift costs to retirees. Some beneficiaries have Medigap policies or TriCare for Life, but let's examine these.

Eighty-six percent of beneficiaries with Medigap have incomes below \$40,000 per person and 47% have incomes below \$20,000, which is less than 200% FPL. Medigap policies help enrollees budget health care expenses more accurately and protect them from unexpected out-of-pocket costs, which is very helpful for Medicare beneficiaries on fixed incomes. However, a few proposals would prohibit Medigap policies from covering the first dollar while others would also include TriCare for Life in the prohibition.

Prohibiting first dollar coverage means requiring the beneficiary to pay first before any insurance can pay, like a mandatory deductible that no insurance can cover. Yet other proposals would impose a premium surcharge or excise tax on people who buy Medigap policies. These proposals are based on the assumption that beneficiaries with first dollar coverage use more services, but if beneficiaries were required to pay the first dollar, they may be less likely to seek care, thus save Medicare dollars.

If any of these proposals pass, Medicare beneficiaries would be exposed to higher, unpredictable health care costs, which does not ensure retirement security.

Furthermore, requiring beneficiaries to pay before any insurance pays would likely discourage them from seeking care, which would likely result in poorer health. Thus, besides threatening retirement security, prohibiting first dollar coverage would also threaten healthy aging.

California Health Advocates strongly advocates against shifting more costs to beneficiaries and prohibiting first dollar coverage. For beneficiaries who are "trapped in the gap," they have nowhere to turn when costs increase. We question the assumption that beneficiaries with first dollar coverage seek care without discretion. If beneficiaries receive services that are medically unnecessary, they are responsible for paying since Medicare would not pay nor their Medigap policies which pays only after Medicare pays.

Medigap policies protect Medicare beneficiaries from unpredictable health care costs, thus help to ensure financial security. If Medigap policies become unaffordable, these beneficiaries have few or no other options. Some may have Medicare Advantage plans available where they live, but others, those in rural areas, may not have any Medicare Advantage plans.

Long-Term Care costs

The probability of needing LTC services increase as we age. One recent statistic indicates that 70% of people aged 65 need LTC for an average of three years. Many think of LTC as nursing homes, which is expensive, but long term care also includes personal assistance with eating, bathing or dressing provided in one's home or community, and home health aide services such as meal preparation, housecleaning and laundry. These services are sometimes referred to as custodial care. A common misconception is Medicare covers these services - Medicare does not cover LTC services. Medicaid covers LTC services, but only for those who qualify. For people who do not qualify for Medicaid, there are few options. About 7% have private LTC insurance which they bought 20 or more years ago - they had planned ahead and they could afford the high premiums. Private LTC insurance is expensive, premiums fall in a wide range depending on several factors: age and sex of the person to be insured, where the person lives, the benefits, benefit period and waiting period. For most Medicare beneficiaries with incomes around \$23,000, private LTC insurance is not affordable.

Those who have savings would be forced to spend their savings on LTC. Once they spend down enough to qualify for Medicaid, they would join an already overcrowded safety net that is fraying. Many are already forced to choose among the necessities: do they skip meals or skip medications or forego medical care or long-term care?

Let us not perpetuate a system that waits for people to spend down to qualify for Medicaid. Instead, let's find ways to help them access services they need. One recommendation is to develop a sliding scale for services rather than one rate for

Medicaid and another for everyone else presumably well-to-do. There are some wealthy beneficiaries, but they are not the majority. There are more beneficiaries who struggle.

In addition to recognizing these beneficiaries and their needs, we need to educate families about planning for long term care. Family planning should not be just for young couples; we need to include grandparents and even great grandparents are more and more people live past their 80's and 90's. Many family members are caregivers. They are unpaid. Many gave up jobs and careers. They need support in their caregiver responsibilities, and they need support to plan for their own future. As unpaid caregivers, how much Social Security retirement benefits will they have? How much savings will they have? Will they be able to re-enter the work force?

Summary

In summary, California Health Advocates oppose increasing cost-sharing on Medicare beneficiaries and advocate for innovative and affordable solutions for LTC services. Health care and LTC costs must be affordable and accessible to ensure retirement security and healthy aging. But for beneficiaries who are "trapped in the gap" - beneficiaries who do not qualify for Medicaid or other public programs, who are on their own - they are especially vulnerable to increases in these costs as they already struggle to pay for the necessities of life. We need to work together - government, providers, health plans, advocates, consumers and their families - to find creative solutions to help these individuals age in place with dignity.

Respectfully submitted,

Elaine Wong Eakin
Executive Director