



Leadership Council of Aging Organizations

Leadership Council of Aging Organizations Recommendations for Health Reform & Older Americans

Older Americans have a major stake in the success of comprehensive healthcare reform that delivers high quality health and behavioral health care to Americans of all ages. Such reform must offer a choice of providers, be affordable, efficient and effective, and reduce disparities in health care.

The U.S. lacks a coordinated, national public-private system for delivering services and supports to individuals with chronic care needs. This gap in coverage represents one of the most serious deficiencies in our healthcare system for seniors and people with disabilities. With 10 million individuals needing these services today and that number projected to rise to 26 million by 2050, the need to address this problem is urgent. State Medicaid programs clearly cannot afford to meet these future needs. The cost of this care impoverishes thousands of seniors and their families every year. Improved coverage will spur economic growth by creating employment opportunities and a more stable and professional health care workforce.

The Leadership Council of Aging Organizations (LCAO), a coalition of 60 national not-for-profit organizations concerned with the well-being of America's 87 million people over age 50, offers the following recommendations for key elements of upcoming health care reform initiatives

To achieve these goals, we recognize the need to create financing mechanisms, cost savers and cost containment measures that are equitable and sustainable.

Under-65 Population

- 1. Offer a nationwide public-plan option to improve the efficiency and quality of care, help hold down costs, encourage innovation, and devote a higher percentage of premiums to patient care.** Such a plan would introduce a new level of competition in the 97 percent of local and regional insurance markets now considered highly concentrated.
- 2. Require community rating for setting premiums.** The law should prohibit premiums based on discriminatory factors such as age, health status and gender as it already does those based on race and ethnicity.
- 3. Provide high-quality, affordable coverage to the pre-Medicare population.** This opportunity should include buying into the Medicare program. One of the most vulnerable groups of health care consumers consists of displaced workers and uncovered employees and retirees aged 55 to 64. They are too young to qualify for Medicare but often have acute and chronic health conditions that go untreated or lead to debt and bankruptcy.

4. **Health coverage for individuals and families must be sufficiently subsidized to be affordable.**
5. **The current two-year waiting period for receiving Medicare for Social Security Disability Insurance beneficiaries should be eliminated.**

Medicare

6. **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.
7. **Maintain the basic defined benefit structure guaranteeing choice of providers and affordable, quality benefits for all older and disabled Americans.** Repeal the scheduled 2010 premium support demonstration Projects and Medical Savings Accounts, which undermine the current successful structure.
8. **Expand access to enhanced 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.
9. **Improve Medicare’s prescription drug coverage** by adding a national public plan option in Part D, eliminating the coverage gap, allowing beneficiaries to change plans at any time, 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.
10. **Align payments to Medicare Advantage (MA) plans with expenditures for traditional Medicare and use savings for beneficiary improvements.** 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. In addition, MA participants should no longer have higher cost sharing for individual services than those under traditional Medicare.
11. **Provide enhanced coverage for low-income beneficiaries.** The Medicare Savings Programs (MSPs) and the Part D Low-Income Subsidy (LIS) should be expanded, aligned and simplified to promote consistency and uniform eligibility; asset eligibility tests should be eliminated or asset levels should be significantly increased; income eligibility levels increased; the Qualified Individual program made permanent; and funding for outreach and enrollment increased.

Medicaid

- 12. Expand eligibility by creating a higher uniform federal income level.** Income eligibility should be set at a point substantially above the federal poverty level. Raising the cap on eligibility to, for example, 133 percent of the federal poverty level (\$14,412/yr. for an individual; \$19,391/yr. for a couple in 2009) would cover additional older Americans. In most states, Medicaid eligibility for seniors is currently restricted to those below 74 percent of the poverty level (\$8,019/\$10,665).
- 13. Simplify Medicaid eligibility** so that all who meet financial eligibility requirements qualify, regardless of age or family status.
- 14. Continue to provide incentives for states to cover populations with income above the federal floor.**
- 15. Provide permanent additional federal financing for these reforms.**
- 16. Create an automatic trigger for FMAP increases during significant economic downturns.** State budgets are too vulnerable during economic downturns to be able to take on substantial additional financing obligations.
- 17. Reverse punitive asset transfer provisions in the Deficit Reduction Act.**

Chronic Care Services & Supports

- 18. Improve access to long term services and supports by creating a national insurance program that helps people with chronic care needs to receive services in the setting of their choice.** Such a program should include broad risk pooling, affordable premiums financed primarily by individual payroll deduction, and federal subsidies for low income individuals. The program should guarantee consumer choice, control over the delivery of services, and care coordination for those with multiple chronic illnesses. A comprehensive health reform bill should include core elements of the CLASS Act (S. 697/ H.R. 1721)
- 19. Expand eligibility for and access to Medicaid home and community-based services (HCBS) to reach parity with institutional care.** Medicaid, the nation's largest payer for LTSS, devotes an estimated 75 percent of its \$100 billion spending to institutional care. HCBS are often inaccessible due to short supply and long waiting lists. Federal funding for HCBS should be expanded and initiatives undertaken to encourage states to increase the availability of Medicaid HCBS, including care coordination, while at the same time updating income and asset requirements to allow beneficiaries to retain more of their assets. The health reform bill should include key elements of bills such as the Empowered at Home Act (S. 434).
- 20. Improve consumers access to non-Medicaid home and community-based services** by expanding the capacity of the Older Americans Act to offer three programs proven to be

effective: person-centered access to information (e.g., Aging and Disability Resource Centers); evidence-based health promotion and disease prevention activities; and enhanced nursing home diversion services.

- 21. Improve the quality of care for nursing home residents by increasing transparency, promoting accountability among nursing home owners and operators, and expanding residents' legal rights.** Reforms should include requirements for detailed reporting of nursing staffing levels, full disclosure of nursing home ownership and affiliated party arrangements, and prohibition of pre-dispute arbitration agreements that eliminate resident access to the courts in disputes. Additionally, funding should be provided for the Long-Term Care Ombudsman Program to ensure quality care for Medicare and Medicaid beneficiaries in long-term care facilities by identifying and investigating complaints, providing information, monitoring regulations, and participating in resident advocacy organizations.

Systemic Reform

- 22. Institute a comprehensive system of professional care coordination based on the needs of the individual patient/client and delivered by interdisciplinary teams** to improve the quality of care, reduce costs, and link health, psychosocial, and long-term services and supports. Care coordination services should be part of all public and private health care coverage programs, including Medicare and Medicaid. Care coordination should be seamless for individuals eligible for more than one program and among all providers and settings. Care coordination programs should support family caregivers' ability to care for their loved ones at home, promote chronic care self-management in the community, and provide assistance to individuals who are unable to manage their own care.
- 23. Support a sufficient, well-trained, skilled workforce to meet the needs of older adults.** Sufficient training and compensation are needed to ensure patients and clients have access to high-quality health care and long term supports and services.
- 24. Improve programs to support family caregivers,** including strategies to help maintain their financial security.
- 25. Prudently employ health information technology, comparative effectiveness research, and payment reforms** to improve the quality of care, reduce health care disparities, and address escalating health care costs, inefficiencies, and uneven quality of care. Health information technology must include consumer privacy protections. Comparative effectiveness research must include input from consumers and family caregivers.