

U.S. HOUSE OF REPRESENTATIVES

A Healthy Future for America's Seniors

The Benefits of Obamacare
By Congresswoman Jan Schakowsky

2012

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INTRODUCTION

In 1965, Medicare and Medicaid were signed into law, providing meaningful health and long-term care services for America’s senior citizens. Prior to Medicare, half of all seniors lacked affordable coverage. Today, virtually all seniors have health coverage. Medicaid provides help for low-income seniors and is the single largest payer for long-term care services in the nation. Over the last 47 years, Congress has built upon the foundation of security that Medicare and Medicaid provide, most recently in the Patient Protection and Affordable Care Act, known proudly by many of us as Obamacare.

In the 112th Congress, the House has twice passed Republican budget resolutions that would radically change Medicare and Medicaid for this and future generations of seniors. The Republican majority has argued that we cannot afford to maintain them given the fiscal situation we face, although they did find room in their budget for \$4.6 trillion in new tax breaks that heavily favor the top 2% wealthiest Americans.¹ Their proposals would end both Medicare and Medicaid as we know them, shifting costs to seniors and their families.

The Democratic proposal, as seen in Obamacare, takes a different approach. Instead of shifting costs, overall costs are reduced by lowering prescription drug costs, eliminating fraud and waste, and promoting greater efficiencies in how we deliver care. No guaranteed benefits are cut – traditional Medicare is strengthened, not threatened.

Unfortunately, this debate is being held at a time when there is a great amount of misinformation being circulated about these two very different approaches. Nowhere is that more evident than in the myths being circulated about Obamacare, including the false accusations of “death panels” and benefit cuts.

This document is designed to help seniors and their families understand the arguments and the facts. It includes the following:

- How Medicare and Medicaid Work for Seniors
- Obamacare and Seniors
- The Ryan Republican Budget and Seniors
- Myths and Facts
- Summary of Obamacare Benefits for Seniors
- Five Big Differences Between Obamacare and Ryan Republican Plan
- Resources for Further Information

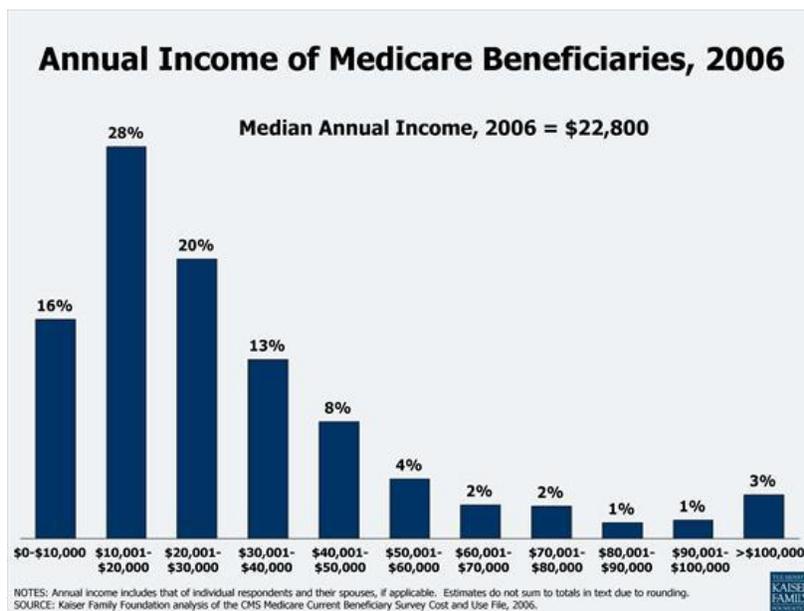
¹ “Ryan Budget's Claim to Finance Its Tax Cuts for the Wealthy By Curbing Their Tax Breaks Does Not Withstand Scrutiny,” Center on Budget and Policy Priorities, March 22, 2012.

HOW MEDICARE AND MEDICAID WORK FOR SENIORS

Seniors Rely on Medicare— In 2006, 43.9 million American seniors were getting Medicare benefits. Women made up 56% of the beneficiaries, while men accounted for 44%. Most lived in urban areas, and were in a community setting. 42% were between the ages of 65 and 74, 30% between 75 and 84, and 12% 85 or older.

Seniors Rely on Medicaid— In addition to providing health care for pregnant women, children, and adults with disabilities, Medicaid provides assistance to 1 in 5 seniors. Many seniors “spend down” their assets during retirement, making them eligible for Medicaid services as well as Medicare. Medicaid helps fill in gaps for low-income Medicare beneficiaries, such as cost-sharing requirements and some services that Medicare does not cover such as vision and dental care. Medicaid also pays for over 40% of total long-term care services provided in homes, the community and nursing homes. In fact, 7 in 10 nursing home residents are covered through Medicaid.² The 9 million Americans who are eligible for both Medicare and Medicaid are sometimes called “dual eligibles.”³

Seniors Live on a Fixed Income— In 2010, half of all people with Medicare lived on household incomes less than \$22,000 and less than \$53,000 in personal savings. Among the Baby Boomer generation, the average household income will be below \$27,000.⁴



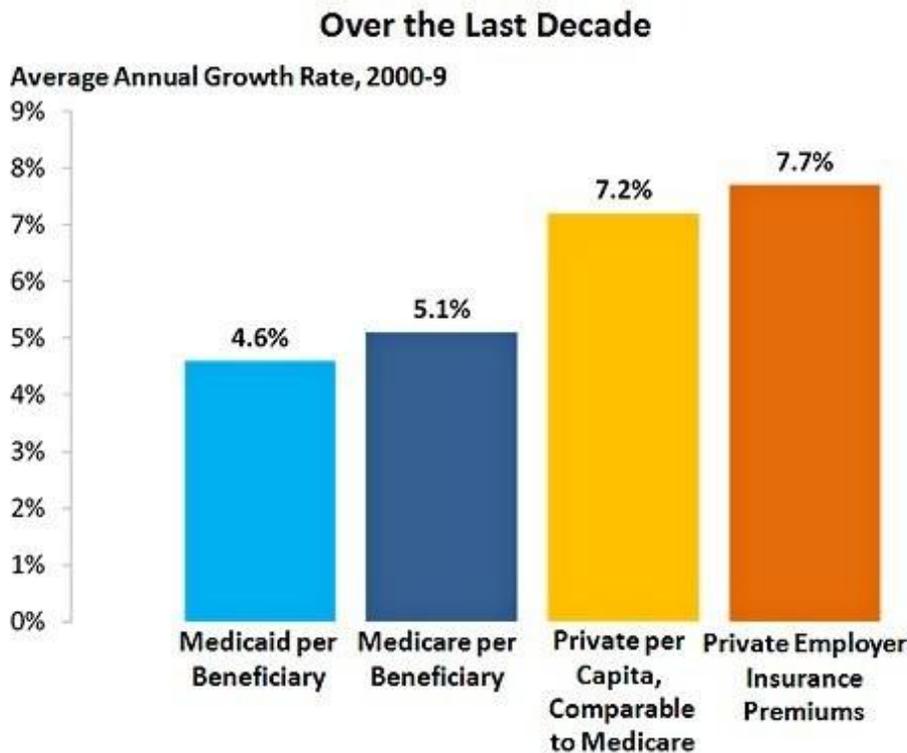
² “Medicaid Primer 2010,” Kaiser Family Foundation.

³ “Medicare’s Role for Dual Eligible Beneficiaries,” Kaiser Family Foundation, April 2012.

⁴ “Medicare Benefit Redesign Proposals that Would Shift Costs to People with Medicare,” MRC President Joe Baker statement, Medicare Rights Center, 2011.

Seniors and Cost-sharing— While living on fixed incomes, seniors pay three times as much of their incomes for medical care as non-seniors. Median costs as a percentage of income have risen from 12% in 1997 to 19% in 2011 and are expected to increase to 26% by 2020. One in four seniors pays more than 30% of her or his income on medical care.⁵

Medicare and Medicaid Are More Efficient than Private Insurance — Medicare has lower administrative costs than private insurance (less than 3% compared to an average 15% for private insurers) and has also lower per capita (per person) spending increases. Over the last decade, Medicare spending grew at a rate of 5.1% and Medicaid’s grew at a 4.6% rate, while private insurance per capita spending grew at a rate of 7.7%.⁶ Over the next decade, Medicare per capita spending is projected to increase by 3.1% and Medicaid by 3.6%, compared to 5% for private insurance.⁷



⁵ “The Facts about Medicare Beneficiary Out-of-Pocket Costs,” National Council on Aging, March 2012.

⁶ “Medicare vs. Private Insurance in one graph,” *The Washington Post*, August 25, 2011.

⁷ “Medicare and Medicaid Spending Trends and the Deficit Debate,” *New England Journal of Medicine*, August 2, 2012.

OBAMACARE AND SENIORS

The Affordable Care Act “strengthens Medicare by protecting and improving your guaranteed benefits and cracking down on waste, fraud and inefficiency.”

AARP, July 2012

“The Affordable Care Act includes important provisions already in effect that are improving health care and saving money for millions of Medicare beneficiaries.”

National Committee to Preserve Social Security and Medicare, July 2012

The Patient Protection and Affordable Care Act, also known as Obamacare, was signed into law on March 23, 2010. The law improves health care for all Americans – eliminating pre-existing condition exclusions, as well as lifetime and annual limits; preventing private insurers from denying coverage or charging higher premiums because of gender or health status; and providing coverage to 30 million Americans who would otherwise be uninsured.

It also makes significant improvements to Medicare and Medicaid, adding new benefits and strengthening their financial position. Here are some of the highlights of those improvements.

NEW HEALTH BENEFITS

Free Preventive Services— Prevention, like cholesterol checks and diabetes screenings, help catch problems early when they are treatable and less costly. Vaccinations help prevent illness. Yet, deductibles and coinsurance kept many seniors on Medicare from taking advantage of these potentially lifesaving services. For example, in 2008, 17% of women over age 65 hadn’t received a mammogram for two years and one-third hadn’t gotten a colorectal screening.⁸

Under Obamacare, Americans have greater access to preventative services. Since January 2011, seniors on Medicare have been able to get a range of preventive services and screenings, without having to pay a deductible or co-insurance. In the first 7 months of 2012, 18 million seniors and persons with disabilities on Medicare – including over 854,000 in Illinois -- have received at least one free preventive service.⁹

⁸ “Enhancing Use of Clinical Preventive Services among Older Adults: Closing the Gap,” Department of Health and Human Services, 2011.

⁹ “People with Medicare Save Over \$4.1 Billion on Prescription Drugs Thanks to the Health Care Law,” Centers for Medicare & Medicaid Services, August 20, 2012.

Free Wellness Exams— Obamacare provides a new annual wellness exam, where seniors can meet with their doctor and create a personalized prevention plan to improve their health. In the first 7 months of 2012, 1.6 million seniors and people with disabilities on Medicare – including nearly 66,000 in Illinois -- took advantage of this new benefit, including 65,957 in Illinois.¹⁰

Managing Multiple Medications— According to the American Society of Consultant Pharmacists, 65-69 year-olds take an average of 14 prescriptions a year, while 80-84 year olds take an average of 18 prescriptions. Taking multiple medications can result in adverse drug reactions, estimated to cause 28% of senior hospitalizations and 32,000 hip fractures each year. Under Obamacare, all Part D plans must offer medication therapy management services to seniors most likely to experience problems.¹¹

Help for Low-Income Seniors— Over 9 million low-income seniors and persons with disabilities are covered through both Medicare and Medicaid. Obamacare provides additional assistance to them by, for example, eliminating Part D Prescription Drug cost-sharing for those receiving home- and community-based care (low-income nursing home residents were already protected under the law). Low-income seniors living with multiple chronic conditions will get new help through health homes designed to help them coordinate their care, and there will be additional long-term care options available to help them stay in their homes. A new Federal Coordinated Health Care Office is already working to help low-income seniors obtain all their eligible benefits – including new preventive services and wellness exams.

Protecting and Improving Guaranteed Medicare Benefits— Obamacare does a lot to lower costs while adding to – not reducing – guaranteed benefits. The law states emphatically that any savings obtained through its provisions must be used to reduce premiums and cost-sharing, improve benefits, protect access to services or extend the life of the Medicare Trust Fund. Private Medicare Advantage plans are also prohibited from making any cuts to guaranteed benefits. The savings achieved by eliminating fraud and waste, reducing overpayments, and promoting prevention will extend the solvency of Medicare by eight years, to 2024.

LOWER HEALTH CARE COSTS

Lower Prescription Drug Costs— 25.4 million senior citizens are voluntarily enrolled in the Part D prescription drug benefit created through the 2003 Medicare Modernization Act.¹² Under that Act, the standard benefit includes a deductible, coinsurance and then a gap in coverage during which the enrollee is responsible for the full cost of the drugs (often called the donut hole) until a catastrophic threshold is reached. Once that threshold is reached, the Part D plan pays 95% of the cost.

¹⁰ Ibid.

¹¹ ASCP (American Society of Consultant Pharmacists) Fact Sheet, ascp.com/print/105

¹² “Medicare Part D: Important Considerations for Health-System Pharmacists,” California Journal of Health System Pharmacy, 2009.

In 2010, when Obamacare was enacted, a senior with a standard benefit would have been responsible for a \$310 deductible, 25% of the next \$2520 in drug costs, 100% of the next \$3570 in drug costs, and then 5% of any additional costs.¹³ In 2010, about 4 million seniors and people with disabilities had large enough drug costs to fall into the donut hole.

Obamacare began eliminating the donut hole in 2011 and will completely end the gap in coverage by 2020. Already, seniors and people with disabilities have saved \$4.1 billion (an average of \$768 for every person who enters the donut hole) because of this change – and seniors are expected to save between \$3,000 and \$16,000 in drug costs through 2021 depending on the number of prescriptions they take. In Illinois, over 52,000 seniors and people with disabilities have already saved more than \$32 million this year, an average of \$614 per person.¹⁴

Eliminating Overpayments to and Improving Medicare Advantage plans— Private insurers argued that they would be able to provide the same benefits as traditional Medicare at less cost. Once they were allowed into Medicare, however, the results proved quite different. Instead of costing less, private Medicare Advantage plans cost more than traditional Medicare. In 2009, the year before Obamacare was enacted, it was estimated that Medicare paid Medicare Advantage plans \$14 billion more (\$1,000 more for each person they enrolled) than if care had been provided through traditional Medicare – and about one-sixth (16.7%) of total payments went to profits and administration.¹⁵ Even seniors who didn't enroll in MA plans paid more as a result because Part B premiums are based on total Medicare costs, which include those overpayments.

Since Obamacare was enacted in 2010, Medicare Advantage premiums have dropped by 16% while enrollment is up by 17%.

One in 4 seniors is enrolled in private Medicare Advantage plans that, until Obamacare, had been allowed to charge higher cost-sharing for Medicare guaranteed benefits. Under the new law, MA plans will be prohibited from charging higher cost-sharing requirements for renal dialysis, chemotherapy, skilled nursing facility care, and other services

Under Obamacare, beginning in 2014, private Medicare Advantage plans will be required to spend at least 85% of premium dollars on medical costs – not bureaucracy, marketing or CEO salaries. In addition, Obamacare gives HHS the authority to negotiate with private Medicare Advantage plans and to reject premiums that are excessive. In 2011, HHS Secretary Sebelius used that new authority to reduce premiums by \$150 million – an average of \$155 per member per year. In 2012, premiums were 4% lower than in 2011 – 11.5% below 2010 premiums.

Reducing Medicare and Medicaid Fraud and Abuse— Obamacare includes unprecedented new tools to eliminate fraud and abuse in Medicare and Medicaid. In May 2009, the Health Care Fraud Prevention and Enforcement Team (HEAT) was created to coordinate

¹³ Congressional Research Service (CRS), “Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline,” June 30, 2010.

¹⁴ “People with Medicare Save over \$4.1 billion on Prescription Drugs Thanks to the Health Care Law,” CMS Press release, 8/20/12.

¹⁵ “Report to the Congress: Medicare Payment Policy,” Medicare Payment Advisory Commission, March 2010.

anti-fraud activities at the Department of Justice and the Department of Health and Human Services. Obamacare doesn't just provide new tools to find those who commit fraud, it is designed to keep fraudulent providers from participating in Medicare and Medicaid. New requirements will allow CMS to identify fraudsters through enhanced background checks and on-site visits, to keep them from preying on seniors, people with disabilities and others. A new national health care fraud and abuse database will make it harder for fraudsters to move from one state to another or from Medicare to Medicaid in order to avoid detection. Obamacare also increases penalties on those who cheat taxpayers and seniors by defrauding Medicare and Medicaid or by making false statements, and increases the funding for the government to prosecute those who commit Medicare fraud.

In FY2011, the Obama Administration's anti-fraud efforts recovered nearly \$4.1 billion in Medicare fraud, the highest annual amount ever. That money was returned to the Medicare Trust Funds. As a result of the strike force action team, 175 defendants were sentenced to prison.¹⁶ Estimates are that every \$1 in fraud prevention results in \$4 in recoveries.

QUALITY IMPROVEMENTS

Increased Payments to Hospitals and Health Providers that Improve Quality—

Under the new law, a percentage of a hospital's payment from Medicare will be linked to the hospital's performance in improving quality. A hospital's performance will be based on quality measures that are related to common and high-cost conditions such as cardiac, surgical and pneumonia care. Medicare payments to doctors will be adjusted based on the quality and cost of care they deliver. This will reward physicians that provide high quality care for lower costs. Other providers – like hospice and rehabilitation hospitals – will also be required to report on quality.

New Incentives for Hospitals and Medicare Advantage Plans to Improve Care—

Nearly 1 in 5 seniors and people with disabilities on Medicare are readmitted to hospitals within 30 days of their initial discharge – 19.7% of heart attack patients, 24.7% of those with heart failure and 18.5% of those with pneumonia. Medicare will impose penalties on hospitals that don't take steps to avoid preventable readmissions, through better discharge planning and followup care for example. Those hospitals with high-levels of hospital-acquired infections will also face payment penalties, providing financial incentives for them to improve patient care.

Beginning in 2012, Medicare Advantage plans – which now provides coverage for 1 in 4 seniors and people with disabilities on Medicare – will get a 5% increase in payments if they hit quality targets.

Comparative Effectiveness Research— There is a lot left to learn about which treatments and prescriptions provide the best care to deal with specific conditions. While doctors will still be free to prescribe whatever they believe is best for their patients, Obamacare increases

¹⁶ "Health Care Fraud Prevention and Enforcement Efforts Result in Record-Breaking Recoveries Totaling Nearly \$4.1 billion," HHS/Dept. of Justice news release, February 14, 2012.

research so that doctors, health care professionals and patients will have more accurate information to help them make the best decisions.

Coordinated medical care— Anyone who has had to navigate the U.S. health care “system” knows that it can be confusing and costly – with multiple visits to specialists, each of whom may order the same tests and treat only one symptom or problem at a time. Obamacare establishes demonstration programs like medical homes and accountable care organizations, where teams of doctors and health care professionals will be responsible for maintaining and improving the overall health of patients. Through new access to health information technology, tests will not have to be repeated, avoiding duplicative that increases costs and exposes patients to unnecessary risks.

Access to Doctors, Health Professionals of Your Choice— Access to health care depends on having a well-trained, adequate number of doctors, nurses, and health care workers to provide quality care in a timely fashion. We know that we face future shortages unless we act now, and Obamacare includes many new mechanisms to expand the health care workforce, particularly focusing on the need for primary care providers and experts in geriatrics and long-term care.

There are new measures to expand access to doctors, providers and hospitals for all Americans, and particular attention is paid to meeting the needs of seniors. For example, there are new grants to train direct care workers who provide long-term care in homes, community settings, and nursing homes. Recognizing the shortage of primary care providers, there are new student loans available and a 10% payment bonus for the next 5 years for primary care doctors, geriatricians and general surgeons who serve people covered through Medicare and Medicaid. Obamacare also includes expanded loan and scholarship programs for nurses and grants to help improve access to care in underserved urban and rural areas.

There is a serious shortage of healthcare doctors and nurses trained to care for the special needs of seniors. With 10,000 Americans turning 65 every day and seniors expected to account for almost 20% of the population by 2030, we need health care professionals trained in geriatric medicine. Projections are that the number of geriatricians serving those over 75 years of age will drop from 1 to 2,551 today to 1 in 3,798 by 2030 if we don't act.¹⁷ In addition to providing more funding for medical education and increasing payments to geriatricians, Obamacare creates new Geriatric Education Centers to promote training in chronic care management and long-term care.

IMPROVING SAFETY

Preventing Elder Abuse— Adult Protective Services (APS) received 565,747 reports of elder abuse in 2004, a 19.7% increase from 2000.¹⁸ Seniors citizens – particularly those who are

¹⁷ “The Demand for Geriatric Care and the Evident Shortage of Geriatrics Healthcare Providers,” The American Geriatrics Society, June 2012.

¹⁸ “The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older,” The National Center for the Prevention of Elder Abuse and the National Adult Protective Services Association, February 14, 2006.

frail or suffering from cognitive problems or dementia – are easy targets for physical abuse or financial exploitation.

To help prevent elder abuse, neglect and exploitation, Obamacare provides grants to establish up to 10 elder abuse, neglect and exploitation centers to research signs of abuse and how to prevent it, working with health care, social and law enforcement personnel. Grants are also created to help long-term care facilities to train workers, help adult protective services improve investigatory methods, and aid long-term care ombudsmen in responding to complaints.

Obamacare also establishes the Elder Justice Coordinating Council and Advisory Board to coordinate research, training and data collection about elder abuse, neglect and exploitation. Based on that information, the board will make recommendations on how to best prevent, detect, treat, intervene and prosecute abusers of the elderly.

Required Dementia and Abuse Prevention Training— 1 in 8 older Americans – 5.4 million people – are living with Alzheimer’s, a number expected to triple by 2050.¹⁹ Obamacare requires dementia and abuse prevention training in skilled nursing facilities and nursing homes *before* they are hired.

Improved Nursing Home Care— Over 3 million seniors and people with disabilities are currently being cared for in nursing homes. To make sure that they are safe and receive quality care, Obamacare requires criminal background checks of employees and includes a pilot program to provide independent oversight of large nursing home chains to prevent abuse and improve care. It also includes new ownership disclosure so that those who own nursing homes that jeopardize resident safety can be identified and held accountable.

BETTER LONG-TERM CARE OPTIONS

Home and Community-Based Services— Over 5 million seniors need some level of long-term care services, a number that is projected to rise to 13.8 million by 2030. The cost of nursing home care now averages about \$80,000 a year, and home- and community-based care would be less expensive and preferable for many seniors. Obamacare removes barriers by making it easier for states to provide home- and community-based services as an alternative to nursing home care and provides bonus payments to states that do. State Balancing Incentive Payments Programs and the new Community First Choice are available to states to pay the costs of moving seniors and people with disabilities out of nursing homes when appropriate and into home- and community based care, and to provide community-based attendant services. State Aging and Disability Resource Centers – which help seniors and their family understand their long-term care options – would receive \$10 million in new funding.

To encourage home- and community-based care, the new law also creates an Independence at Home Demonstration Program, to help chronically ill seniors on Medicare get primary care services at home and allow states to provide them with full Medicaid benefits.

¹⁹ Alzheimer’s Association Factsheet, March 2012.

Protection Against Spousal Impoverishment— Many middle-class seniors do not have enough savings to pay for their long-term care needs, and they can turn to Medicaid for help when their resources are gone. Medicaid ensures that, when a husband or wife needs assistance for nursing home care, their spouse can keep enough income and assets to live at home, without becoming impoverished. Obamacare extends those protections to cover home- and community-based services, ensuring that no one will be forced into poverty so that their ill husband or wife can qualify for home care.

More information on nursing homes— Choosing a nursing home is a difficult decision. To help individuals and families get more information, Obamacare requires public reporting of quality measures, the number of types of staff available to care for residents, and information on substantiated complaints through the Nursing Home Compare Medicare Website. With changes in and greater consolidation of the nursing home industry, it is often difficult to determine who is in charge of decisionmaking and who is accountable for nursing home quality. The new law requires disclosure of ownership.

LOWERING MEDICARE COSTS BY INSURING THE NEAR-ELDERLY

Nearly 1 in 6 Americans between the ages of 45 and 64 (16.3%) are uninsured;²⁰ often because they've hit lifetime caps on benefits, have pre-existing conditions, or face higher premiums based on age-rating. All of us know individuals who are just hanging on until they reach age 65 and can qualify for Medicare in order to get the care they need. In the meantime, they go to the doctor less often and are more likely to suffer from hypertension, diabetes, heart disease or stroke before age 65.²¹ In their first year of Medicare coverage, they spend an average of \$1,023 more than those seniors who had been previously insured. It has been estimated that Medicare could save \$98 billion over 10 years by insuring pre-65 year olds.²²

Obamacare takes a number of steps to insure the near-elderly, improving their health and lowering Medicare costs for all seniors. The Early Retiree Reinsurance Program has provided \$5 billion to help employers and union plans pay the costs for individuals with costly medical claims, assistance that allows them to avoid dropping coverage altogether. Until 2014, older, uninsured Americans with pre-existing conditions can receive coverage through new state Pre-existing Condition Insurance Pools.

In 2014, barriers like pre-existing condition exclusions and lifetime and annual caps will be eliminated and all individuals will be able to obtain coverage through new state-based Exchanges at group rates that limit the ability to charge higher premiums based on age and prohibit higher rates based on health status.

²⁰ ASPE Issue Brief, "Overview of the Uninsured in the United States: A Summary of the 2011 Current Population Survey," HHS, September 2011.

²¹ "Use of Health Services by Previously Uninsured Medicare Beneficiaries," J. Michael McWilliams, M.D. et al, *New England Journal of Medicine*, July 12, 2007.

²² "Insuring the Near-Elderly: How Much would Medicare Save?," *Annals of Internal Medicine*, December 1, 2009.

THE RYAN BUDGET IS BAD FOR MEDICARE, AND BAD FOR SENIORS

“The Ryan Republican budget ends Medicare as we know it and leaves in its place a two-tiered health system designed to leave Medicare withering on the vine....Because the value of these vouchers would not be tied to actual health costs, its purchasing power would shrink over time, leaving seniors spending out-of-pocket funds to make up the difference.”

Alliance for Retired Americans, 3/28/12

“Under the GOP/Ryan (Medicare) plan, if seniors want the same level of coverage and access to health providers that they’ve had in the past, they’ll have to pay more. If they can’t pay more, they’ll have to settle for less.”

National Committee to Preserve Social Security and Medicare, 3/20/12

“The proposal is likely to simply increase costs for beneficiaries while removing Medicare’s promise of secure health coverage – a guarantee that future seniors have contributed to through a lifetime of hard work...The premium support method described in the proposal –unlike private plan options that currently exist in Medicare -- would likely ‘price out’ traditional Medicare as a viable option, thus rendering the choice of traditional Medicare as a false promise....Converting Medicare to a series of private options would undermine the market power of Medicare and could lead to higher costs for seniors....”

AARP, 3/21/12

In 2011 and 2012, Republican Budget Chair Paul Ryan offered two budget proposals-- both of which would include significant changes for seniors and both of which passed the House of Representatives along party lines. Both versions would:

Repeal Obamacare’s Many Benefits— The Ryan Republican budgets would repeal all the benefits outlined in the preceding pages. Seniors would see higher drug costs, lose new preventive benefits and new long-term care options, and face shortages of doctors and nurses.

End Medicare as We Know It– Raising costs to Seniors and Jeopardizing The Ability to Choose your Own Doctors. Instead of traditional Medicare, seniors and people with disabilities would be given a voucher or coupon worth a set amount (pegged initially at the cost of the second cheapest plan in an area and then rising by the rate of general inflation, which has historically been less than medical inflation). The value of the coupon will not rise along with health costs, leaving seniors to pay a greater and greater share of costs, settle for a plan that doesn’t meet their needs or allow them to pick their own doctor, or, perhaps, be uninsured altogether. According to the nonpartisan Congressional Budget Office, seniors would face an

average \$6,400 in additional costs. As the independent Center on Budget and Policy Priorities concluded, "...the vouchers would purchase less coverage with each passing year, pushing more costs on to beneficiaries. Over time, seniors would have to pay more to keep the health plans and the doctors they like, or they would get fewer benefits."²³

Under the Ryan Republican proposal, private insurance companies could limit choice of doctors and manipulate benefits, meaning they would be able to cherry pick the youngest and healthiest people. That would leave traditional Medicare with a smaller, older and sicker pool and raise Medicare Part B premiums not just for seniors who enroll in Medicare for the first time after 2023 but for seniors who are currently in Medicare.²⁴

Raise the Age of Eligibility from 65 to 67— Raising the Medicare eligibility age would make it extremely difficult for people 65 to 67 to find health coverage and would increase costs to employers, seniors, and state governments. According to one study, raising the age of eligibility to 67 in 2014 would cost employers \$4.5 billion in retiree benefits and increase out-of-pocket costs for seniors by \$3.7 billion.²⁵ Moreover, it is not true that everyone in America is living longer. Researchers have found that "alarming disparities" in life expectancy exist and that, "in 2008 US adult men and women with fewer than twelve years of education had life expectancies not much better than those of all adults in the 1950s and 1960s."²⁶ At the same time that the Ryan Republican plan makes seniors wait longer to get Medicare, it would repeal Obamacare and the new mechanisms to provide affordable coverage to the near elderly (the elimination of pre-existing condition exclusions and access to group-related coverage).

Threatens Medicare financially— The savings that Obamacare achieves by improving efficiency, eliminating fraud and waste, and promoting prevention are used to both to improve benefits and improve Medicare's solvency, extending the life of the Medicare Hospital Trust Fund through 2024. Under the Ryan Republican budget proposal, those savings would be lost and the Trust Fund would face solvency problems beginning in 2016.

Medicaid Funding would be Slashed – Threatening Long-Term Care Services, Help for Low-income Seniors. The Ryan Republican budget would cut federal Medicaid funding by \$810 billion over the next 10 years (in addition to repealing the \$1.6 trillion dedicated by Obamacare to expanding Medicaid and its long-term care options) and turn it into a block grant. This would be a 34% cut in funding by 2022 and a 49% cut by 2050. Medicaid already has lower administrative costs, per capita funding increases and payment rates than private insurers. Yet, the Ryan Republican budget would drastically cut federal funding just as the baby boom generation retires and begins to turn to Medicaid for long-term care services.²⁷

²³ "Medicare in the Ryan Budget," Center on Budget and Policy Priorities, March 28, 2012.

²⁴ "Why the Medicare Fight Matters to Americans Over 55," Henry Aaron, Brookings Institution, August 20, 2012.

²⁵ "Raising the Age of Medicare Eligibility," Kaiser Family Foundation, July 2011.

²⁶ "Differences in Life Expectancy Due to Race and Education Differences Are Widening, and Many May not Catch Up," Health Affairs, August 2012.

²⁷ "Ryan Medicaid Block Grant Proposal Would Cut Medicaid by One-Third by 2022 and More After That," Center on Budget and Policy Priorities, March 27, 2012

Cuts of this magnitude would make it virtually impossible to continue the guarantee of existing benefits – let alone add new home and community-based long-term care options. In fact, some experts have suggested that cuts of this magnitude would have to be coupled with the elimination of guaranteed nursing home coverage for seniors who have exhausted their benefits – and spousal impoverishment protections for husbands and wives whose spouses need nursing home care.²⁸

²⁸ “Spousal impoverishment: Romney-Ryan Plan would Repeal Reagan’s Spousal Safety Net,” Scott Lilly, Aug 13, 2012.

MYTHS AND FACTS

- MYTH: Most seniors are wealthy and can afford to pay higher premiums.
FACT: The median senior household income is \$22,000 – less than 1% have incomes over \$250,000. Half of all people on Medicare have retirement account savings less than \$2,100 and less than \$31,000 in other financial assets. The average person on Medicare spends 16.6% percent of their income on health care and that percentage rises with age.
- MYTH: Obamacare cuts Medicare benefits.
FACT: Not only are no guaranteed benefits cut – we add benefits, such as free preventive services and the annual wellness visit. 32 million seniors and people with disabilities on Medicare have already used at least one free preventive service.
- MYTH: Obamacare raises premiums. In fact, there’s even a viral email – supposedly from Blue Cross Blue Shield Alabama that falsely says the Medicare monthly premium will be \$247 in 2014.
FACT: BCBS –Alabama states the information is “inaccurate” and “erroneous” and is “NOT” their position. On page 218 of this year’s Trustees Report, the projection is that premiums will be \$115.80 in 2014. That Part B deductible actually decreased by \$22 in 2012, and the premium rose only \$3.50 over the last two years, from \$96.40 in 2010 to \$99.90 in 2012.
- MYTH: Seniors and people with disabilities would be better off with private insurance and with the vouchers provided in the Republican budget.
FACT: According to a recent Commonwealth Fund report, seniors and people with disabilities on Medicare are more satisfied, report fewer access problems, and fewer financial burdens than those on private insurance. Medicare is more efficient and has lower administrative costs (3% compared to 15-20%). Medicare per capita growth rates have been lower – and are projected to remain below – those of private insurance companies.
- MYTH: Seniors are denied access to care – one viral email says anyone over 76 years old can’t get cancer care because of Obamacare.
FACT: There is no rationing in Medicare or Obamacare – in fact, by eliminating cost-sharing for many screenings, we will be able to get care to seniors and people with disabilities sooner.
- MYTH: Obamacare weakens Medicare by cutting \$716 billion in spending.
FACT: Obamacare doesn’t cut any Medicare guaranteed benefits or increase anybody’s cost-sharing. It does slow future growth rates (from 8% a year to 6% over the next 20 years) by cutting \$160 billion in excess payments to private insurers and creating new tools to reduce waste and fraud. And, it uses the savings to improve Medicare by closing the donut hole (5.3 million seniors have already saved \$3.7 billion) and improving benefits. And it adds 8 years of solvency.

- MYTH: The Republican voucher plan to turn seniors and people with disabilities over to private insurance will work.
- FACT: The Republican plan doesn't lower costs – it simply shifts them onto the backs of seniors and people with disabilities. It will double out-of-pocket costs and leave people to the mercy of private insurers who didn't want them in the first place – that's why Medicare was created
- MYTH: New health care law will bankrupt Medicare.
- FACT: According to the 2012 Medicare Trustees report, Obamacare actually extends the life of the Hospital Insurance Trust Fund through 2024 – providing 8 more years of solvency.

NOTE: This is a sampling of some of the myths and mistruths that have been circulating about Obamacare. If you hear something that sounds like another “myth” to you and would like me to help check it out, please don't hesitate to contact me at jan.schakowsky@mail.house.gov.

SUMMARY OF OBAMACARE BENEFITS FOR SENIORS

NEW BENEFITS

- Free preventive services, like mammograms, diabetes screenings and flu shots
- Free wellness exams with personalized prevention plans
- Medication therapy management to avoid dangerous drug interactions

LOWER COSTS

- Lower drug costs by eliminating the “donut hole” gap in coverage
- Eliminating excess payments to private Medicare Advantage plans and reducing fraud and abuse
- Limiting cost-sharing in private Medicare Advantage Plan

BETTER QUALITY

- Quality bonuses to doctors and hospitals that improve quality
- Preventing hospital-acquired infections
- Coordinating care to improve overall patient care

ACCESS TO MORE DOCTORS AND HEALTH CARE PROVIDERS

- Providing bonus payments to primary care doctors, geriatricians and general surgeons
- New loan and scholarship options for nurses and doctors
- Training direct care workers and long-term care specialists

ENHANCED SAFETY

- New Elder Justice grants to prevent abuse against seniors
- Required criminal background checks (prior to hiring) for nursing home and home care workers
- Mandatory training to improve care of patients with dementia and to stop patient abuse

MORE LONG-TERM CARE OPTIONS

- New options for home- and community-based care
- More information to help select quality nursing homes

FIVE BIG DIFFERENCES BETWEEN OBAMACARE AND RYAN REPUBLICAN PLAN

	Obamacare	Ryan Republican Plan
Does it Lower Drug Prices by Closing the Donut Hole?	Yes. \$4.1 billion in savings already – donut hole closes in 2020.	No. Reopens and maintains the donut hole, leaving millions of seniors each year with a gap in drug coverage.
Does it Provides Free Preventive Services and a New Wellness Exam?	Yes. Medicare covers mammograms, prostate tests, diabetes screenings, immunizations, and other preventive services without cost-sharing.	No.
Does it Give More Options for Quality Long-term Care Services?	Yes. Encourages access to home- and community-based services, improves nursing home quality.	No. Threatens access to all long-term services because cuts Medicaid by \$810 billion and turns it into a block grant.
Does it Maintain Traditional Medicare?	Yes. Strengthens traditional Medicare – maintaining the ability to choose your own doctor – by cutting waste, improving efficiency, and extending the life of the Trust Fund by 8 years.	No. Threatens traditional Medicare by turning Medicare into a voucher plan and allowing private insurance companies to manipulate benefits – driving up traditional Medicare premiums. Only those who could afford to pay more would be able to keep it.
Does it End Overpayments to Private Medicare Advantage Plans?	Yes. Eliminates overpayments that raise costs to all seniors, requires plans spend at least 85% of premiums on medical care, and prohibits plans from charging cost-sharing higher than limits in traditional Medicare.	No. Restores overpayments to private Medicare Advantage plans and repeals protections included in Obamacare.

FOR MORE INFORMATION:

Please contact my office at jan.schakowsky@mail.house.gov if you have questions about Obamacare, the Ryan Republican plan or any other issues regarding Medicare, Medicaid and seniors.

If you want to know more about these issues, here are some additional sources.

AARP Factsheets on Obamacare are available at: http://www.aarp.org/health/health-care-reform/health_reform_factsheets/

Alliance for Retired Americans, www.retiredamericans.org: Materials on Obamacare are available at: <http://www.retiredamericans.org/issues/health-care-reform>.

Center for Budget and Policy Priorities, www.cbpp.org: Provides analyses of budget proposals, Medicare and Medicaid issues.

Center for Medicare Advocacy, www.medicareadvocacy.org: provides factsheets on Medicare and Medicaid, including a “facts and fiction” report at available at: <http://www.medicareadvocacy.org/medicare-facts-fiction-quick-lessons-to-combat-medicare-spin/>.

Families USA, www.familiesusa.org: Information on Obamacare, Medicare, Medicaid and Long-Term Care issues are available.

Health Care for America Now: www.hcan.org

Kaiser Family Foundation, www.kff.org: A summary of Obamacare is available at <http://www.kff.org/healthreform/8061.cfm?source=QL>, in addition to other information on seniors, Medicare, Medicaid and long-term care.

Medicare Rights Center, www.medicarerights.org: Provides analysis on Medicare issue and also provides free independent counseling to help resolve Medicare questions at 1-800-333-4114.

National Committee to Preserve Social Security and Medicare, www.ncpssm.org: Has information available on Social Security, Medicare and seniors. An analysis of Obamacare can be found at <http://www.ncpssm.org/PublicPolicy/Medicare/Documents/ArticleID/216/How-the-Affordable-Care-Act-Helps-Seniors>.

The SCAN Foundation, www.thescanfoundation.org: A summary of Obamacare is available at <http://www.thescanfoundation.org/health-care-reform-bill-and-reconciliation-side-side-0>.