

## What's at Stake in Medicare: A Voter Guide

Medicare guarantees access to health care for older adults and people with disabilities. Together with the Affordable Care Act (ACA) and Medicaid, Medicare helps to build health and economic security for Americans of all ages. The program has been a lifeline for millions since its inception in 1965, but threats and uncertainties persist.

To determine candidates' views on Medicare, voters should monitor their statements and the positions they have taken. This is especially important in the 2020 elections, as recent years have seen legislative and regulatory efforts to rework the program, often in ways that would undermine beneficiary protections. Further, decisions made this year will shape the future federal response to the coronavirus pandemic, which continues to put people with Medicare at risk. To help voters weigh in, below are a few proposals to keep an eye out for that would transform Medicare for the worse.

**Affordable Care Act (ACA) Invalidation:** From closing the donut hole to easing access to preventive services, the ACA greatly improved the Medicare program.<sup>1</sup> Troublingly, these coverage and sustainability advances are at risk. The U.S. Supreme Court is set to consider the health law's constitutionality this fall in *California v. Texas* (known as *Texas v. U.S.* in the lower courts).<sup>4</sup> The appeal before the Court stems from a Texas district court decision that held (1) the ACA's individual mandate is unconstitutional because Congress reduced the penalty to zero in the 2017 tax bill; and (2) therefore, the entire ACA is invalid. The plaintiffs—which include 18 Republican attorneys general and the Trump administration—maintain their support of the lawsuit and its goal of eliminating the entire ACA, despite the risks of tearing away coverage during a pandemic. The Supreme Court will hear the case on November 10. A decision would then be expected in 2021.<sup>5</sup>

**"Premium Support" or "Vouchers":** Currently, all people with Medicare are entitled to the same set of basic benefits. Some policymakers support replacing Medicare's defined benefit package with a fixed-dollar amount (often called a voucher) that beneficiaries would use to purchase health coverage through a private plan or Original Medicare. Converting Medicare to such a system, known as premium support, raises a number of beneficiary-related concerns:

- Under a premium support system, the voucher's value would be capped and unlikely to keep pace with inflation or rising health care costs—shifting significant costs to beneficiaries over time. While the voucher would help defray the cost of coverage, it would not cover the full cost of a comprehensive plan; beneficiaries would have to pay any costs or premiums above the voucher limit. Estimates

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<sup>1</sup> Medicare Rights Center, "The Affordable Care Act: Before and After" (June 13, 2013), <https://www.medicarerights.org/policy-documents/the-affordable-care-act-before-and-after>.

suggest at least six in ten people with Medicare could face higher premiums for the same coverage under a voucher system.<sup>2</sup>

- And some proposals would allow private plans to create their own list of covered benefits, leaving some people with Medicare without access to the coverage they have today. Most Americans—70%—prefer Medicare’s guaranteed benefits to vouchers.<sup>3</sup>

**“Private contracting,” “Balance billing,” “Allowing Physicians and Patients to Negotiate Prices,” or “Removing Unnecessary Barriers to Private Contracts”:** In the 1980’s, Congress prohibited Medicare-participating providers from charging beneficiaries more than the Medicare-allowed cost sharing.<sup>4</sup> Providers can choose not to participate in the Medicare program, but that makes them ineligible to receive any Medicare reimbursements. Most providers do participate and are therefore limited in what they can bill. Some policymakers endorse proposals to reverse these protections to allow providers to receive Medicare dollars and create private contracts. Under these arrangements, people with Medicare would face higher costs and reduced access to care:

- Medicare providers could require patients to negotiate a contract for the cost of their care, leaving people with Medicare with few choices but to accept additional costs on top of their premiums, copayments, and coinsurance.
- Providers could freely choose what to charge people with Medicare and refuse to see beneficiaries who are unable or unwilling to pay the price specified.
- This would essentially create two tiers of beneficiaries—those who can afford to access needed care and those who cannot.

**“Raising the Eligibility Age”:** Some lawmakers support increasing the Medicare eligibility age from 65 to 67 as way to reduce federal Medicare spending. The full cost of this change—including the financial and health implications for those who could lose Medicare coverage—must be considered:

- According to the Congressional Budget Office (CBO), this policy would leave many more 65- and 66-year olds uninsured and exposed to higher health costs and worse care.<sup>5</sup> Two-thirds of those losing Medicare coverage would face an average of \$2,200 each year in higher out-of-pocket health care costs.<sup>6</sup>

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<sup>2</sup> Kaiser Family Foundation, “Transforming Medicare into a Premium Support System: Implications for Beneficiary Premiums” (October 2012), <https://www.kff.org/medicare/report/transforming-medicare-into-premium-support/>.

<sup>3</sup> Mira Norton, et al., “Medicare and Medicaid at 50,” Kaiser Family Foundation (July 2015), <https://www.kff.org/medicaid/poll-finding/medicare-and-medicare-at-50/>.

<sup>4</sup> Cristina Boccuti, “Paying a Visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services,” Kaiser Family Foundation (November 2016), <https://www.kff.org/medicare/issue-brief/paying-a-visit-to-the-doctor-current-financial-protections-for-medicare-patients-when-receiving-physician-services/>.

<sup>5</sup> Congressional Budget Office, “Raise the Age of Eligibility to 67” (December 8, 2016), <https://www.cbo.gov/budget-options/2018/54733>.

<sup>6</sup> Kaiser Family Foundation, “Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform” (July 2011), <https://www.kff.org/medicare/report/raising-the-age-of-medicare-eligibility/>.

- Medicare beneficiaries over age 67 would also see increased costs. Their premiums would likely go up as the absence of younger, healthier 65- and 66-year-olds in the Medicare risk pool would leave an older, sicker, and more expensive group for the federal government to insure.<sup>7</sup>
- Increasing the Medicare eligibility age would be particularly punitive for low-income, older adults who perform physical labor, by impeding their ability to leave the labor market when no longer able to handle physically demanding work.<sup>8</sup>
- Diverse communities would also be among those hardest hit. People of color tend to be in poorer health at earlier ages, with lower incomes and less wealth. Access to Medicare at the earliest possible age is essential—if not life-saving—for diverse elders.<sup>9</sup>

Further, hiking the Medicare eligibility age would not save costs—it would simply transfer them from the federal government to individuals, employers, and states, increasing them along the way. CBO notes that beyond older adults paying more for care, “employers’ costs of providing group plans for their retirees would increase because those plans would remain the primary source of coverage until the retirees reached the new eligibility age for Medicare. In addition, states’ spending on Medicaid and the federal costs of subsidies for health insurance purchased through the marketplaces would increase.” And the impact of raising the eligibility age on “national health care spending is unclear because of the potential difference in costs borne by different payers to provide coverage for people between age 65 and the new eligibility age for Medicare.”<sup>10</sup> Other models support this conclusion, estimating that raising Medicare’s eligibility to 67 would generate one-year, \$5.7 billion in federal savings, but also result in increases of \$3.7 billion in out-of-pocket costs for 65- and 66-year-olds, and \$4.5 billion in employer retiree health-care costs.<sup>11</sup>

**“Increasing Competition,” “Expanding Consumer Choices,” or “Improving the Marketplace”:** Recent legislative and regulatory changes have increased flexibilities and reduced oversight for Medicare Advantage and Part D plans, giving insurers more leeway in how they design and offer their products. While this shift may yield plan options that work well for some beneficiaries, there are important considerations.

- For example, this approach can result in more plans with fewer discernible differences being available. Facing an overabundance of similar choices, consumers may become confused or overwhelmed, or may choose to stick with their current plan because it is an easier decision.<sup>12</sup> As a result, they may give up or choose a plan that does not meet their needs—e.g., because it is too restrictive, has incomplete

<sup>7</sup> Paul N. Van De Water, “Raising Medicare’s Eligibility Age Would Increase Overall Health Spending and Shift Costs to Seniors, States, and Employers,” Center on Budget and Policy Priorities (August 2011), <https://www.cbpp.org/research/raising-medicare-eligibility-age-would-increase-overall-health-spending-and-shift-costs-to>.

<sup>8</sup> Schwartz Center for Economic Policy Analysis (SCEPA), “Over Half of Low-Wage Older Workers Have Physically Demanding Jobs” (January 2017), <https://www.economicpolicyresearch.org/jobs-report/december-2016-unemployment-report-for-workers-over-55>.

<sup>9</sup> National Committee to Preserve Social Security and Medicare Foundation, “Impact of Raising Eligibility Age for Medicare” (January 2017), <http://socialsecurityspotlight.org/wp-content/uploads/2017/01/raising-medicare-age-research-full-report.pdf>.

<sup>10</sup> Congressional Budget Office, “Raise the Age of Eligibility to 67” (December 8, 2016), <https://www.cbo.gov/budget-options/2018/54733>.

<sup>11</sup> Kaiser Family Foundation, “Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform” (July 2011).

<sup>12</sup> Wyatt Koma, et al., “No Itch to Switch: Few Medicare Beneficiaries Switch Plans During the Open Enrollment Period,” Kaiser Family Foundation (December 2, 2019), <https://www.kff.org/medicare/issue-brief/no-itch-to-switch-few-medicare-beneficiaries-switch-plans-during-the-open-enrollment-period/>.

networks, or is not cost effective—ultimately compromising their access to care.<sup>13</sup> There can be no effective competition if there is no effective way to shop for coverage.

- Medicare Advantage plans can offer coverage that is not available to people with Original Medicare, leading to an unfair system where some people with Medicare have access to care that others cannot reach. By privileging Medicare Advantage in this way, Medicare administrators are tipping the scales toward private companies rather than allowing a fair choice between coverage options. There should be parity between Original Medicare and Medicare Advantage to prevent leaving any people with Medicare behind.
- The rise in Medicare Advantage means increasing privatization of the program, putting beneficiaries at the mercy of companies that routinely and inappropriately deny services and payment, according to government watchdogs.<sup>14</sup> There should be strict oversight of Medicare Advantage plans to ensure enrollees have appropriate coverage and care.
- Medicare Advantage plans are also overpaid. The Office of the Inspector General of the Department of Health and Human Services found that Medicare Advantage plans were regularly adding diagnoses to patient records without medical evidence then claiming increased payments.<sup>15</sup> These overpayments, which some estimates project could cost \$200 billion over 10 years, are problematic because they increase Medicare expenditures and decrease payment parity.<sup>16</sup>
- The freedom of Medicare Advantage plans to change benefit packages also comes at a time when there is too little oversight of the ways such plans are doing business. Data on possibly discriminatory plan benefits and practices, for example, are not available, which may mean that insurers are—intentionally or not—designing plans and networks that appeal to those who are healthier and therefore less expensive to cover. There is evidence this is happening:
  - People in poor health are more likely to abandon MA for Original Medicare than the other way around,<sup>17</sup> and MA enrollees with high needs, including dually eligible beneficiaries, are more likely than other enrollees to leave MA. Troublingly, this suggests something in MA plan design is not beneficial for those with complex health care needs.<sup>18</sup>
  - Beneficiaries who choose to enroll in MA plans have lower spending and use fewer services—before they sign up for coverage—than do people with similar health conditions in Original

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<sup>13</sup> Austin Frakt & Aaron Carroll, “Too many choices” (September 2013), <https://www.academyhealth.org/blog/2013-09/too-many-choices>.

<sup>14</sup> US Department of Health and Human Services, Office of Inspector General, “Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials (September 25, 2018), <https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp>.

<sup>15</sup> US Department of Health and Human Services, Office of Inspector General, “Billions in estimated Medicare Advantage Payments from Chart Reviews Raise Concerns” (December 2019), <https://oig.hhs.gov/oei/reports/oei-03-17-00470.pdf>.

<sup>16</sup> Richard Kronick, “Projected Coding Intensity in Medicare Advantage Could Increase Medicare Spending By \$200 Billion Over Ten Years,” Health Affairs (February 2017), <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0768>.

<sup>17</sup> United States Government Accountability Office, “Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight” (April 2017), <https://www.gao.gov/assets/690/684386.pdf>.

<sup>18</sup> David Meyers, et al., “Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries,” JAMA Internal Med. (February 2019), <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2725083>.

Medicare. This indicates that MA enrollees were healthier than their peers before joining a plan and raises further questions as to why beneficiaries who are higher utilizers are less likely to choose MA.<sup>19</sup>

- And other analysis shows that people in MA are less likely to choose higher-quality nursing homes, given the option, than are people with Original Medicare.<sup>20</sup> This indicates that MA plans may be influencing beneficiary decision making around nursing home selection and underscores the need for more data, reporting, and MA plan transparency.
- The decision-making landscape itself is also increasingly fraught, as deceptive plan marketing appears to be on the rise.<sup>21</sup> For example, some insurers have recently been offering inferior imitations or “look-alike” versions of specialized plans for dually eligible individuals, Dual Eligible Special Needs Plans (D-SNPs).<sup>22</sup> These D-SNP look-alikes are designed to appeal to this population, but they lack the extra benefits that come from true D-SNPs, such as care coordination. As a result, dually eligible enrollees can find themselves, often quite surprisingly, in plans that fail to meet their needs. CMS is taking steps to curtail such plans, but their proliferation to date indicates how little oversight there is for MA plan marketing, and how exposed this can leave beneficiaries.

**“Means Testing”:** Some policymakers support “means testing” the Medicare program—making higher income people pay more or get less—by raising premiums or cutting benefits for people above a certain income level. Such proposals threaten to undermine the Medicare guarantee: that those who contributed to the system will have access to high quality health care as they get older. They also fail to recognize that older adults with higher incomes already pay more for Medicare during their working lives and/or after retirement. Further means testing would jeopardize the integrity and universality of Medicare.

**Erosion of Special Enrollment Periods for Dually Eligible Individuals:** People who are dually eligible for Medicare and Medicaid have historically been able to switch plans whenever they need to do so. This ability has been sharply reduced in recent years.<sup>23</sup> However, complementary insurer flexibilities remain in place. As a result, plans may change their formularies and provider networks, leaving enrollees to scramble for care. This disconnect threatens beneficiary access and affordability and disproportionately affects those with limited resources and options.

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<sup>19</sup> Gretchen Jacobson, et al., “Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending?” Kaiser Family Foundation (May 7, 2019), <https://www.kff.org/report-section/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending-issue-brief/>.

<sup>20</sup> David Meyers, et al., “Medicare Advantage Enrollees More Likely To Enter Lower-Quality Nursing Homes Compared To Fee-For-Service Enrollees,” Health Affairs (January 2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5822393/>.

<sup>21</sup> Christopher Snowbeck, “State regulators warn of deceptive Medicare marketing” (October 31, 2018), <https://www.startribune.com/state-regulators-warn-of-deceptive-medicare-marketing-practices/499148241/>.

<sup>22</sup> Georgia Burke, et al., “Dual Eligible Special Needs Plan (D-SNP) Look-Alikes: A Primer,” Justice in Aging (July 2019), <https://www.justiceinaging.org/wp-content/uploads/2019/07/D-SNP-Look-Alikes-A-Primer.pdf>.

<sup>23</sup> Centers for Medicare & Medicaid Services, “Medicare-Medicaid Plan Enrollment and Disenrollment Guidance” (effective January 1, 2019), <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MMPEnrollmentNationalGuidance.pdf>.