Secure Retirement

SECURERET
SECURERET
SECURERET
SECURERET
SECURERETIREMENTSECURERETIREMEN
SECURERETIREMENTSECURERETIREMEN
SECURERETIREMENTSECURERETIREMEN
SECURERETIREMENTSECURERETIREMEN

SPRING 2010 A PUBLICATION OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE VOL II ISSUE 1

LETTER FROM BARBARA

Dear Friends,

A few weeks ago, Congress approved a historic health bill to reform and strengthen the health care system in America, including the Medicare program. Medicare will see its benefits improved and its finances strengthened.

As I wrote to you last fall in the special health care edition of *Secure Retirement,* the skyrocketing cost of health care for all Americans has been pushing Medicare's costs steadily higher. As a result, seniors are increasingly finding it harder to afford the health care they need, and the cost to the federal government will, over time, become unsustainable. The problem of affordability is not unique to Medicare, it is simply a reflection of uncontrolled inflation in health care overall.

As with any legislation that affects such a large part of the economy, health care reform is complex and imperfect. But the bills that were signed into law represent a good start toward reforming a health

*(continued on **3**)*

The Medicare Advantage Makeover

The new health care law includes important provisions to reduce wasteful Medicare spending. This will strengthen the solvency of the Medicare program and reduce the rate of increase in Part B premiums for all Medicare beneficiaries. The law also seeks to improve the care provided to Medicare Advantage enrollees and to limit their out-of-pocket costs.

Private Medicare Advantage (MA) plans are currently paid on average 13 percent more per enrollee than it costs to provide comparable care in traditional Medicare. These subsidies — which cost over $11 billion in 2009 — are paid for by taxpayers and by all beneficiaries, whether or not they are enrolled in a private plan.

It is estimated that every couple receiving Medicare, including the 75 percent in traditional Medicare, will pay about $90 in additional Part B premiums this year to subsidize those in the private MA plans.

The health care reform law phases down subsidies for MA plans over time so that on average plans will ultimately receive payments comparable to what it would cost traditional Medicare to cover the same seniors. These savings will be used to improve Medicare for everyone by improving prescription drug coverage — *i.e.*, closing the donut

*(continued on **2**)*

Is it really as bad as they say it is?

SENIORS AND HEALTH CARE REFORM

After a long year of debate and questions, health care reform legislation is now the law. The promise of universal health insurance that began with Medicare's creation in 1965 will now expand beyond seniors and the disabled to include all Americans.

At the same time, Medicare will become stronger and more affordable for both seniors and the federal government. Seniors will enjoy expanded benefits and better medical care. And the nation's health care system, formerly driven by insurance companies and their desire for greater profits, will truly become one where patients and their doctors can make the best informed decisions about their health care needs.

Despite the fear mongers' claims, Medicare benefits will not be cut to pay for covering the uninsured.

Before health care reform, the federal government was projected to spend about $6 trillion on the Medicare program over the next decade. After enactment of health care reform, Medicare is still projected to spend about $5.6 trillion. That means over the next 10 years about $450 billion less of American's money will be spent on wasteful tests, haphazard treatment options, wasteful subsidies to private insurance companies, and reimbursement policies that drive up costs without improving the quality of care seniors receive.

*(continued on **2**)*

Your Social Security COLA:

Luxury … or Necessity?

Social Security beneficiaries are going without a Cost-of-Living Adjustment (COLA) this year for the first time since the annual adjustments went into effect in 1975. And the Social Security trustees currently predict no COLA in 2011 as well.

Some people question whether Social Security beneficiaries really need a COLA. They argue that inflation has been low and should not be a concern for seniors. They ignore, however, the financial reality of millions

Some people question whether Social Security beneficiaries really need a COLA.

of American retirees facing multiple years of a shrinking Social Security check.

*(continued on **2**)*

PUBLISHER'S STATEMENT

Secure Retirement is published from time to time for the purpose of keeping members of the National Committee informed about important issues affecting their retirement. Future issues will be published on this same basis. The primary focus of this issue is the recent changes to health insurance enacted by Congress and how they will impact our members.

SENIORS AND HEALTH CARE REFORM

(continued from 1)

As a result, the lifespan of Medicare's Part A Trust Fund will more than double: its solvency will be extended from 2017 to about 2026. Medicare's growth will be trimmed by about 2 percent per capita annually — hardly the destruction of Medicare that opponents have claimed.

Medicare will continue to grow to meet the needs of an expanding older population, but it will grow at a slower rate that will more closely match the growth of the rest of the economy. And because health care reform is designed to slow the growth of costs in the entire health care system at the same time, seniors' out-of-pocket costs will be trimmed without driving providers out of the Medicare program or creating other barriers to care.

A wide range of benefit improvements for seniors

In a key improvement designed to help keep seniors healthy, preventive care will no longer require co-payments and for the first time, Medicare will cover an annual wellness visit and personalized prevention plan for every beneficiary. In addition, health care reform will protect seniors' access to doctors by making bonus payments to primary care providers and making new investments in training programs, scholarships, and tax incentives for doctors, nurses, and public health professionals who provide primary health services.

The Part D donut hole: Gone by 2020

In a dramatic reform to the Part D prescription drug program, seniors will no longer experience the coverage gap known as the donut hole. As a down payment on this important reform, any senior who enters the donut hole in 2010 will receive a payment of $250 to help cover the cost of his or her prescription drugs. Seniors will receive this rebate even if they have only entered the donut hole by a single dollar.

As a further improvement to the drug program, both the discount amounts and seniors' out-of-pocket drug costs will count toward reaching the threshold for catastrophic coverage.

Beginning in 2011, all seniors in the donut hole will receive a 50 percent discount on their brand-name drugs — a discount which will expand to 75 percent and will cover both brand-name and generic drugs by the end of the decade. This discount expansion effectively closes the donut hole for all beneficiaries. For a typical senior in the donut hole, this represents a savings of $250 in 2010, $700 in 2011, and over $3,000 by 2020.

The dollar amount of the threshold will also grow more slowly in the future. These two changes will allow seniors with high prescription drug expenses to more quickly reach the point at which the federal government picks up 95 percent of their drug costs.

Health care reform also makes it easier for low-income seniors to enroll in Part D plans without any premiums, and reduces the number of low-income seniors who are required to change plans each year to maintain their zero premiums. In addition, it will become easier for widows and widowers to keep their low-income eligibility after the death of a spouse.

Incentives to Reduce Readmissions

Health care reform rewards hospitals that reduce preventable readmissions. This change will

(continued on 3)

Social Security COLA

(continued from 1)

A zero COLA this year and next equates to an actual reduction in the buying power of Social Security benefits, as out-of-pocket health care cost are rising faster than general inflation. Since older Americans spend a considerably greater share of their income on health care, they face a steep climb to keep up with their expenses. Recently compiled data shows that people 65 and older spend twice as much as the overall population on health care.

People 65 and older spend twice as much as the overall population on health care.

Worse yet, seniors on fixed incomes have experienced significant drops in their retirement savings and home values over the past year. Without a COLA, the oldest seniors with the highest medical expenses and low-income seniors with few additional resources are the most likely to suffer. Surprisingly, one out of every five seniors has only Social Security to live on.

Representing millions of members and supporters, the National Committee is pressing Congress to pass COLA relief legislation this year. Senator Bernie Sanders and Representative Peter DeFazio introduced legislation to provide older Americans with a one-time $250 payment for 2010 in lieu of a COLA. President Obama included such a proposal among his legislative suggestions as an extension of last year's economic recovery payment.

One out of every five seniors has only Social Security to live on.

National Committee members sent thousands of petitions and emails to Congress in support of action on this issue. Despite a valiant attempt by Senator Sanders and others earlier this year, legislation has yet to be passed. The National Committee continues to press for COLA relief legislation this year.

Social Security beneficiaries cannot afford to lose their COLA for a second year. The average Social Security retirement benefit is only $13,800 a year; for many, that is all they have.

Unlike bailouts and bonuses for Wall Street, the annual Social Security COLA affects the personal financial well-being of millions of Americans by helping them maintain a modest and stable income in their older years.

The Medicare Advantage Makeover

(continued from 1)

hole — and covering preventive services with no out-of-pocket costs for beneficiaries.

Limiting Out-of-Pocket Costs for Medicare Advantage Enrollees

Health care reform does not eliminate Medicare Advantage plans or reduce the extra benefits they provide.

It is up to each private insurer to decide what extra benefits to offer; they are required to offer all benefits covered by traditional Medicare.

The health care reform law prohibits Medicare Advantage plans from charging seniors more than traditional Medicare for services such as chemotheraphy administration, skilled nursing home care, and other specialized services.

Often beneficiaries do not realize what their costs will be for these services until they need them.

Care vs. Profits

Health care reform requires Medicare Advantage plans to spend at least 85 percent of their revenue on senior care rather than profits or overhead.

Plans that do not spend at least 85 percent of their revenue on patient care will be required to return money to the government and could be suspended or terminated from the program if their spending on patient care remains below 85 percent for two or more years.

Bonus Payments for Improving Care

Health care reform creates an incentive system to increase payments by at least five percent to plans that provide high-quality care.

SENIORS AND HEALTH CARE REFORM

(continued from 2)

help ensure that seniors are not released from the hospital before they are healthy enough to leave, and will create incentives for hospitals to provide outpatient support once seniors have been released.

The current fee-for-service payment system rewards providers who order the most tests and procedures, not necessarily those who provide the best quality health care. We all know of seniors who have been subjected to unnecessary and potentially dangerous tests, not because they were needed but because they were profitable for the providers. This system not only puts seniors' health at risk from unneeded tests and procedures, it makes it hard to clamp down on rising costs.

Gaming the system

As Medicare reduces the amount it pays for each test, many providers simply increase the number of tests they order to maintain their profit margins, thus undermining previous efforts at cost containment.

Health care reform makes a number of changes to the way providers are paid. The goal is to realign the financial incentives built into the current system — and begin paying for quality rather than quantity. These changes include bundling payments to some providers; providing incentives to encourage the development of more coordinated models of health care delivery; and putting hospitals and other providers on the road toward value-based purchasing.

The law also establishes a new Center for Medicare & Medicaid Innovation to test new payment and service delivery models, restoring Medicare to the cutting edge of innovation in medical delivery.

New tools to crack down on Medicare fraud

By allowing the Department of Health and Human Services and the Internal Revenue Service to share information, Medicare payments to scam artists masquerading as legitimate providers will be easier to identify and prevent.

Fraud in the Medicare program hurts us all by increasing costs.

The new health care law also gives the agencies more time to verify that providers are legitimate and that they have actually provided seniors with the wheelchairs, hospital beds, oxygen tanks, and other supplied

(continued on 7)

Health Care Improvements for 50-64 Year Olds

The new health care reform law includes provisions that will help older Americans who are not yet eligible for Medicare have access to affordable health insurance coverage. In addition, it includes provisions to help employers with the costs of providing coverage to early-retirees and older workers.

Limiting Aging Rating of Health Insurance Premiums

The health care reform law establishes a 3:1 ratio for setting health insurance premiums based on age. Currently, older Americans buying health insurance in the individual or small group markets are likely to be charged much more than three times the cost for a younger person.

Reforming Private Insurance for All

The health care reform law includes many reforms to private health insurance that will benefit Americans of all ages, including older Americans. These reforms include prohibiting coverage denials for pre-existing conditions, banning caps on lifetime coverage, ending annual limits on coverage, and prohibiting insurers from dropping coverage when someone is sick. In addition, the law requires that parents be allowed to keep their unmarried adult children on their family health insurance plan until age 26.

Providing Immediate Assistance through a High-Risk Pool

The law establishes a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions who have been uninsured for at least six months. Premiums will be subsidized and cost-sharing will be limited.

(continued on 11)

LETTER

(continued from 1)

care system that for far too long has rewarded quantity over quality. In addition, if the cost containment envisioned by the new law is successful, much of the deficit spending projected in future decades will disappear.

Medicare is an important part of health care reform, whether you supported or opposed it. In this issue we have tried to help explain how the new law will affect you. In the lead article you will find an overview of the major impacts on Medicare beneficiaries, including how the new law will affect Medicare's finances. You can read more about the Part D coverage gap known as the "donut hole" and how it will be phased-out over time. This is a valuable benefit for seniors with high prescription drug costs. You will also get the real story about Medicare Advantage, and the protections the new law gives to seniors enrolled in these private plans. Finally, we have attempted to identify the questions most asked by National Committee members and provide clear answers.

While this edition of *Secure Retirement's* main focus is on the health care bill, we would be remiss if we did not include an update on the increasing threats to the Social Security system. The impact of deficit spending since the turn of the 21st Century and the current recession have dramatically increased our national debt, allowing supporters of cutting Social Security benefits to become more and more aggressive.

We all know that Social Security did not cause today's deficits, and in fact has been running surpluses that mask the size of the federal debt for decades. The baby boom generation has been paying higher payroll taxes to build up large reserves intended to help fund their own retirement as well as the retirements of earlier generations. But now that the baby boomers are approaching retirement age, many in Washington believe Social Security must be cut rather than repaying the bonds that represent the debt owed to these American workers.

In this edition of *Secure Retirement* you will also find information on the Fiscal Commission that has been appointed to find ways to reduce future deficits, including cutting Social Security benefits. As Fiscal Commission Co-Chair Erskine Bowles said, "We're gonna mess with Medicare, Medicaid, and Social Security."

We have also included an update on our effort to convince Congress to help seniors facing the prospect of a zero COLA two years in a row. We have been making headway on convincing lawmakers that seniors deserve a COLA because of the impact increasing health care costs and declining interest rates have had on their standard of living.

I hope you will find this issue of *Secure Retirement* informative and helpful in understanding the challenges facing Social Security and Medicare today and in the future.

Cordially,

Barbara B. Kennelly

Barbara B. Kennelly
President and CEO

The National Commission on Fiscal Responsibility and Reform: GUNNING FOR SOCIAL SECURITY?

Social Security is likely to be the main target of the newly-created National Commission on Fiscal Responsibility and Reform. The commission is charged with improving the nation's fiscal position for both the short-term and long-term. The new co-chairs of the commission have announced their intent to aim squarely at Social Security and Medicare.

"We're gonna stick with the big three. We're gonna stick with entitlements, Medicare, and Social Security."

Commission Co-Chair Alan Simpson

The co-chairs are former Republican Senator from Wyoming Alan Simpson and former Clinton Chief of Staff Erskine Bowles. In an interview on cable news station CNBC, Co-Chair Alan Simpson noted that the commission would be going after "the big three — Medicaid, Medicare, and Social Security." Likewise Co-Chair Erskine Bowles made it clear that Social Security topped his list for slashing benefits. "We're going to mess with Medicare, Medicaid, and Social Security because if you take those off the table, you can't get there," Bowles said in a speech to North Carolina bankers.

Why do these fiscal hawks want to "mess" with Social Security? Well, Chairman of the Federal Reserve Ben Bernanke didn't hesitate to reveal their real reason for wanting to cut Social Security benefits. Citing bank robber Willie Sutton's famous remark about why he stole from banks, Bernanke said Social Security, Medicare, and Medicaid should be cut because "that's where the money is." The hawks in charge of the new fiscal commission intend to cut Social Security benefits, not to strengthen Social Security, but to make the nation's fiscal situation look better.

Americans want fiscal sanity returned to Washington, but they know that Social Security is not responsible for our budget deficit. The real reasons for the budget imbalance are billions of dollars in tax cuts for the wealthy, a decade of borrow and spend policies and a recession driven by the excesses of Wall Street.

Medicare and Medicaid should be cut because "that's where the money is."

Federal Reserve Chairman Ben Bernanke

Social Security has not contributed one dime to our nation's deficit. The Social Security Trust Fund was built up in preparation for the Baby Boomers' retirement. In fact, the annual surpluses in Social Security have been used for years to help balance the federal budget.

Working Americans of all ages have contributed money to Social Security and that money belongs to them, not the government. That money is dedicated to paying promised benefits. Social Security should not be used as a piggy bank to pay for bad fiscal decisions of the past.

WHO'S WHO ON THE COMMISSION

The commission is made up of 18 members: Six appointed by the President — with no more than four from the same political party; six appointed from the U.S. Senate — three by the Majority Leader and three by the Minority Leader; and six appointed from the U.S House of Representatives — three by the Speaker of the House and three by the Minority Leader.

Purpose

The commission is charged with making recommendations to: (1) reduce annual deficits to 3 percent of the national economy by 2015 and (2) meaningfully improve the long-range fiscal outlook, including changes to address the growth in entitlement spending and the gap between the projected revenues and expenditures of the federal government.

Timeline

No later than December 1:
The final report of the commission must be approved by at least 14 of the commission's 18 members and submitted to Congress.

By end of 2010:
If a final report is adopted by the commission, Senate Majority Leader Reid has agreed to give the recommendations an up or down vote in the Senate by the end of 2010. House Speaker Nancy Pelosi has agreed that, if the Senate passes the recommendations, the House will then vote on them.

Members

- **Presidential Appointments:** Former White House Chief of Staff Erskine Bowles and former Senator Alan Simpson as co-chairs of the commission. The President also appointed to the panel: Andy Stern, President of the Service Employees International Union; Dave Cote, CEO of Honeywell; Alice Rivlin, former Vice-Chair of the Federal Reserve and Director of the Congressional Budget Office; and Ann Fudge, former CEO of Young and Rubicam Brands
- **Senate Majority Leader Harry Reid's Appointments:** Richard J. Durbin (IL); Max Baucus (MT); and Kent Conrad (ND)
- **Senate Minority Leader Mitch McConnell's Appointments:** Tom Coburn (OK); Judd Gregg (NH); and Michael Crapo (ID)
- **Speaker of the House Nancy Pelosi's Appointments:** John Spratt, Jr. (SC); Xavier Becerra (CA); and Jan Schakowsky (IL)
- **House Minority Leader John Boehner's Appointments:** Paul Ryan (WI); Dave Camp (MI); and Jeb Hensarling (TX)

Today Social Security is owed $2.6 trillion previously loaned to the federal government. Budget hawks are arguing that there is not enough money to pay this loan back, so their answer is to cut Social Security.

Health Care Reform At-A-Glance:

Strengthen Medicare by slowing growth in spending

- More than doubles the solvency of the Medicare Trust Fund, adding an additional decade (from current 2017 to about 2026.)
- Saves about $450 billion in the first decade, mostly through agreed-upon reductions in payment rates for inpatient hospitals, long-term care hospitals, home health services, skilled nursing facilities, insurance companies, and other providers. (Put in context, the government still is projected to spend $6 trillion on Medicare over that period.)
- Slows Medicare growth by about 2 percent per capita, annually. Medicare will still be growing faster than the overall economy.

Closes the "donut hole" in the Part D prescription drug program

- Provides a $250 rebate in 2010 for any senior who falls into the hole, regardless of their income — even those who enter the coverage gap by as little as one dollar will receive a check for the full $250.
- Provides a 50 percent discount for brand name drugs beginning in 2011 for seniors in the donut hole, regardless of income.
- Phases in additional discounts for both brand name and generic drugs until seniors' co-payments are reduced to 25 percent by 2020, regardless of income.
- Saves the typical senior who hits the donut hole $250 in 2010, over $700 in 2011, and over $3,000 by 2020.
- Counts both the seniors' out-of-pocket spending and the drug company discount as "True Out-of-Pocket Costs", helping seniors reach the catastrophic threshold more quickly.
- Slows the increase in the dollar amount where catastrophic coverage of drug costs begins.

Improves prescription drug coverage for low-income seniors

- Expands access to plans with zero premiums for low-income seniors.
- Reduces the number of seniors required to change plans each year to maintain their zero premiums.
- Allows widows and widowers to more easily retain their low-income eligibility.
- Improves outreach and information for low-income seniors and other Part D enrollees.
- Eliminates co-payments for seniors in home- and community-based settings that are eligible for both Medicaid and Medicare.

Improves the Part D program for all seniors

- Improves seniors' access to important classes of drugs.
- Creates new penalties for false or misleading marketing or enrollment of individuals in Part D plans.

Improves preventive health care services for seniors

- Eliminates cost-sharing for proven preventive services.
- Provides a comprehensive annual wellness visit and personalized prevention plan.

Improves overall health care services for seniors

- Improves senior's access to primary care by providing bonus payments to primary care providers.
- Establishes initiatives to encourage the development of a more efficient health care delivery, especially for seniors with multiple chronic conditions.
- Provides transition services to high-risk Medicare beneficiaries when they are discharged from the hospital.
- Encourages hospitals to reduce avoidable readmissions and hospital-acquired infections.
- Increases funds for Community Health Centers (especially critical to minorities) to allow for nearly a doubling of the number of patients seen over the next 5 years.
- Establishes a new Center for Medicare & Medicaid Innovation to test new ways of reducing costs while improving the quality of health care.
- Helps seniors living in rural area by making sure their physicians are adequately paid.
- Extends the special appeals process for added physical therapy until December 31, 2010.

*(continued on **6**)*


Erskine Bowles, Co-Chair


Sen. Alan Simpson, Co-Chair


Sen. Max Baucus


Rep. Xavier Becerra


Rep. Dave Camp


Sen. Tom Coburn


Sen. Kent Conrad


Dave Cote


Rep. Mike Crapo


Sen. Dick Durbin


Ann Fudge


Sen. Judd Gregg


Rep. Jeb Hensarling


Alice Rivlin


Rep. Paul Ryan


Rep. Jan Schakowsky


Rep. John Spratt


Andy Stern

Q&A on Health Care Reform

Q My out-of-pocket costs are expensive enough as it is. Why should I support cutting Medicare to pay for covering the uninsured?

A Despite the rumors you may have heard, health care reform does not cut Medicare's traditional, guaranteed benefits. Quite the opposite: the new law explicitly prohibits such cuts. There are significant Medicare savings in the bill, but the money does not go to pay for covering the uninsured — it just looks that way because of our government's budget and accounting rules.

In fact, the Medicare savings stay in the Medicare program — which is why the Part A Trust Fund will stay solvent at least another decade beyond what we expected before health care reform, and premiums and other out-of-pocket costs will grow more slowly in the future. Most of the savings were voluntarily agreed to by hospitals and other affected provider groups because they believe the additional insured patients and efficiencies included in the law will save them money. They contributed part of these savings back to the Medicare program by agreeing to slower rates of growth in future payments.

Q Is there anything good for seniors in the new law? What's in it for me?

A Over time, the overwhelming majority of seniors in the United States will have lower out-of-pocket costs and better coverage as a result of the enactment of health care reform.

The biggest immediate improvement for Medicare is in its drug coverage. The law finally phases out the donut hole in the Part D prescription drug program. The donut hole is the gap in coverage where seniors continue to pay full premiums, but also pay 100 percent of the cost of their drugs — a gap that does not exist in other health insurance programs. As a first step to help seniors struggling with the high cost of prescription drugs today, anyone who falls into the donut hole in 2010 will receive a $250 payment from the government. In future years, deep discounts in drug prices will close the gap for seniors.

The new law also includes significant benefit improvements to keep seniors healthy by eliminating co-payments and deductibles for preventive care and providing coverage for an annual wellness visit and personalized plan.

Finally, many of the payment reforms that will save money for Medicare are also designed to provide better quality health care for seniors. For example, hospitals will be encouraged to implement programs that prevent hospital acquired infections and unnecessary readmissions, while doctors will receive bonus payments to improve access for seniors. In future years, the entire health care system will be redirected away from a model that pays based on the number of procedures and tests that are ordered and focuses more on rewarding providers based on the quality of the health care they provide.

Q I still don't understand how you can cut Medicare by over $400 billion and not hurt seniors. Where does the money come from?

A Most of the savings come from reducing the annual increase in Medicare payments to hospitals, skilled nursing facilities, and home health agencies. They will continue

*(continued on **8**)*

Health Care Reform At-A-Glance:

*(continued from **5**)*

Makes necessary changes to Medicare Advantage plans

- Phases down subsidies for Medicare Advantage plans over time so that, on average, plans will ultimately receive payments comparable to what it would cost traditional Medicare to cover the same seniors.
- Savings will be used to improve Medicare for all seniors.
- Reduces Part B premiums for the 75 percent of seniors in traditional Medicare who help finance the subsidies.
- Provides bonus payments to Medicare Advantage plans providing high-quality care.
- Prohibits Medicare Advantage plans from charging seniors more than traditional Medicare for services such as chemotheraphy administration, skilled nursing home care, and other specialized services.
- Requires all Medicare Advantage plans to spend at least 85% of revenue on senior care rather than profits or overhead.

Expands protections for vulnerable seniors

- Requires disclosure of information about nursing facilities ownership, accountability requirements and expenditures.
- Requires publishing standardized information on a website so Medicare enrollees can compare facilities.
- Provides for background checks of employees with direct access to patients of long-term care facilities or providers.
- Enacts the Elder Justice Act to help prevent and eliminate elder abuse, neglect, and exploitation.

Cracks down on Medicare fraud

- Establishes new requirements for community mental health centers that provide Medicare partial hospitalization services.
- Allows the Department of Health and Human Services to share IRS data to help screen and identify fraudulent providers.
- Strengthens oversight of Durable Medical Equipment providers.
- Increases funding for the Health Care Fraud & Abuse Control Fund by $250 million over the next decade.

Creates Independent Payment Advisory Board (IPAB)

- Establishes IPAB and requires the Board to propose recommendations for reducing Medicare spending, while maintaining quality and access, if Medicare per capita growth rates exceed targets, beginning in January 2014.
- Requires IPAB to submit an advisory report for years it does not submit a proposal.
- Requires proposals to be automatically implemented unless Congress enacts alternative proposals that achieve the same savings, or unless the Secretary implemented recommendations in the prior year.
- Prohibits IPAB from recommending changes that would ration care or modify benefits, eligibility, premiums, or taxes.
- Exempts certain providers, such as hospitals, from recommendations prior to 2019.
- Requires IPAB to submit recommendations every two years on slowing the growth in national health expenditures, beginning 2015.
- Requires the Board to submit an annual report on system-wide health care costs, access, utilization, and quality of care, beginning July 1, 2014.

Improves health coverage for those ages 50 - 64

- Creates a temporary reinsurance pool (until the Exchanges are available) to help offset the costs of expensive health claims for employers providing health benefits for retirees aged 55-64.
- Postpones elimination of deduction for employers receiving a subsidy for maintaining a prescription

*(continued on **7**)*

SENIORS AND HEALTH CARE REFORM

(continued from 3)
equipment that they are billing to the Medicare program.

Making changes in the Medicare Advantage program is another way of restoring the integrity of Medicare by reducing wasteful spending.

Medicare Advantage is the privatized part of Medicare, whose growth has been fueled by the massive subsidies enacted in the Medicare Modernization Act of 2003.

Medicare Advantage plans are paid on average 13 percent more per enrollee than it costs to provide comparable care in traditional Medicare. These subsidies, which cost over $11 billion in 2009 alone, are paid for by taxpayers and by all beneficiaries, whether or not they are enrolled in a private plan.

It is estimated that every couple receiving Medicare, including the 75 percent in traditional Medicare, will pay about $90 in additional Part B premiums this year to subsidize those in the private Medicare Advantage plans. Although these plans provide some additional benefits, many require much higher cost-sharing from seniors for expensive services such as chemotherapy, extended hospital stays, and skilled nursing home care — a shortcoming few seniors realize until they find themselves needing the service.

Health care reform phases down the exorbitant subsidies currently going to Medicare Advantage plans. In this way, the government's costs for Medicare Advantage end up being more in line with what it would cost to cover the same seniors in traditional Medicare. Each private insurer must decide how to absorb the reduced payments and whether to continue providing extra benefits. At the same time, Medicare Advantage insurers cannot cut guaranteed benefits; they are required to offer all benefits covered by traditional Medicare. And, under the health care reform law, they are prohibited from charging more than traditional Medicare for certain expensive services. They are also, for the first time, required to spend at least 85 percent of their revenue on patient care rather than profits or overhead. Finally, the law rewards Medicare Advantage plans that are providing high-quality care by giving them bonus payments.

Health care reform does not eliminate Medicare Advantage plans or reduce the extra benefits they provide.

The most vulnerable seniors are now better protected.

The health care reform law enacts the Elder Justice Act to help prevent elder abuse, neglect, and exploitation. It expands protections and improves the quality of care for those in nursing homes through increased transparency and accountability. It creates a national program of criminal background checks of workers who provide long-term care services in both facilities and private homes. The law also increases funds for Community Health Centers to allow for nearly doubling the number of patients seen over the next five years.

Numerous benefits for near-retirees

Although these benefits do not affect those over age 65 directly, they do provide indirect benefits to the Medicare program because older workers who have insurance coverage tend to be healthier than those without insurance. Healthier older workers can stay on the job longer, and they have fewer health care expenses after they turn 65 and become eligible for Medicare because they have not postponed needed care. This saves Medicare money, which reduces costs for both seniors and taxpayers.

Benefits for near-retirees include:

- the creation of a temporary reinsurance pool, which is designed to help offset the costs of expensive health care claims for employers that provide benefits to their retirees while the health insurance Exchanges are being established;
- limits on how much insurance companies can charge older workers for coverage;
- more flexibility in applying the excise tax for employers with an older workforce;
- the creation of a new, voluntary self-funded long-term care insurance program that will help people with severe disabilities stay in their homes and communities (CLASS Act).

Health Care Reform At-A-Glance:

(continued from 6)
drug plan for their Medicare Part D eligible retirees until 2013.

- Limits age rating of premiums to no more than 3:1.
- Provides higher thresholds for the excise tax applying to high cost employer provided plans for retirees (*e.g.* limits of $10,200 for single coverage and $27,500 for family coverage before tax applies are increased to $11,850 and $30,950 respectively for retirees.) The dollar thresholds are indexed with inflation, and employers with higher costs due to the age demographics of their employees may use national data to value their coverage

Expands benefits for Long-Term Care

- Creates a new, voluntary self-funded long-term care insurance program, provided through the workplace, to help people with severe disabilities remain in their homes and communities (CLASS Act).

Provides incentives to expand the health care workforce

- Invests in training programs to increase the number of primary care doctors, nurses, and public health professionals.
- Expands funding for scholarships, loan repayments, and tax incentives for primary care practitioners working in underserved areas.

Expands income-related provisions in Medicare

- Freezes the threshold for "means tested" (*i.e.* based on income) Medicare Part B premiums through 2019; the threshold will no longer move up with inflation.
- Requires higher Medicare Part D premiums for beneficiaries with incomes above $85,000 for individuals and $170,000 for couples, similar to Part B.

Increases Medicare taxes for high-income individuals

- Increases the Medicare payroll tax by 0.9 percent for individuals earning over $200,000 ($250,000 for those who are married and file a joint return). The law also applies the Medicare tax to some investment income for the first time. (Income from retirement plans, such as pensions, 401(K), and IRAs, is not included.) The money raised by the additional tax on wages will be credited to the Medicare Part A Trust Fund that pays hospital costs.

Miscellaneous

- Allows individuals over age 65 to continue claiming the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016. The floor then rises to 10 percent thereafter (floor rises to 10 percent for those under age 65 beginning in 2013).

Q&A on Health Care Reform

(continued from 6)

to get larger payments every year; those payments will simply get smaller inflation increases in the future. Hospitals will also see gradual reductions in the payments they receive to help cover the cost of uncompensated care because they will have fewer uninsured patients to treat.

Additional savings come from bringing Medicare Advantage payments inline with traditional Medicare. Medicare Advantage is the privatized portion of Medicare. In order to entice private insurers to cover seniors, Congress has been subsidizing these plans — at a cost of $11 billion in 2009 alone. This raises the government's costs and shortens the solvency of the Part A Trust Fund. Seniors are also subsidizing these plans.

Whether they are enrolled in a Medicare Advantage plan or not, seniors will pay about $90 extra per couple this year to help cover the excess payments to the private plans. The new law does not cut the benefits Medicare Advantage plans offer — they slowly reduce reimbursements to the private insurance plans over time so they are closer to the amounts traditional Medicare would pay to cover the same seniors. The new law also includes significant new protections for those enrolled in the plans.

Finally, the new law strengthens efforts to reduce waste and fraud in the Medicare program, and put in place the building blocks for significant new cost savings in the future through changes in our health care delivery system.

While the dollar value of these savings is a lot of money, it's important to remember it represents just a small percentage of Medicare spending. The government is projected to spend about $6 trillion on Medicare during the next decade. The non-partisan Congressional Budget Office has estimated the savings in the new law will trim the growth of Medicare spending by about 2 percent a year.

Q If Medicare is still going to be growing faster than the rest of the economy, why didn't Congress focus more on cost containment? I'm barely keeping up with the rising costs of health care as it is.

A Our health care system is large and complicated — in fact, it involves about one-fifth of our economy. Implementing the wrong kind of reforms could not only damage the economy, but it obviously puts the health and lives of millions of Americans at risk. Because of this risk, Congress was very cautious in how the new law implements changes, which is why some argue they impose too little cost containment.

In fact, the new law incorporates virtually every major cost cutting idea proposed for health care by non-partisan experts over the last 10 years. But the changes are implemented slowly, with a combination of "carrots and sticks," in many cases through pilot projects that can be tested first to make sure they both save money and improve the quality of care. If they work as expected, systems and incentives are in place to allow them to be quickly expanded to cover a broader group of people. Because so many of these new initiatives are untested, the Congressional Budget Office was unwilling to attribute any significant savings to them in the budget process. Many experts believe that the new law will save more money over time than what shows up on paper today, while providing Americans with a better quality health care system.

Q On the other hand, could the savings be too drastic? What if Congress is wrong and hospitals discover they can't afford to continue treating Medicare patients?

A The major hospital associations have supported health care reform, as have most other health provider groups. But their support depends on the law being successful in covering most of the people who are uninsured today. People who don't have health insurance tend to wait until they are very sick to receive treatment, and then go to hospital emergency rooms where they cannot be turned away. Emergency room treatment is the most expensive kind of health service there is, and it is in short supply — in part because emergency rooms are packed with sick people who could have been treated sooner and at much lower cost if they had insurance.

It is true that Medicare's independent actuaries have expressed concern that providers won't be able to meet the productivity target and that people with Medicare might see reduced access to services. But the Medicare savings are slowly phased-in over ten years, giving Congress plenty of time to re-visit the payment rates if access problems begin to surface. This has happened in the past. One example is the Medicare spending reductions imposed in 1997 — savings that were much deeper than those in this year's bill. When it became clear that the 1997 bill had over-reached, Congress passed subsequent bill to moderate the provisions it had enacted earlier.

Q If millions more people have insurance because of health care reform, won't it be harder for me to find a doctor if I need one?

A Even if health care reform had not passed, we know that we will need more primary care doctors in the future as the baby boom generation ages and requires more health care services. That's why the new law includes significant investments in training for doctors and nurses, including expansions of student loan programs and forgiveness of loans for primary care providers who are willing to serve in medically-underserved areas. In addition, health care reform will give primary care providers bonus Medicare payments to encourage more family doctors to provide services to Medicare patients,

(continued on 9)

Q&A on Health Care Reform

(continued from 8)

which will help seniors keep up with those newly insured because of the legislation. Finally, many of the efficiencies included in the new law should free up time for doctors to spend seeing patients rather than ordering overlapping tests and filling out paperwork.

Q What about this 21 percent cut in doctor's pay I keep hearing about?

A There is no cut in payment for doctors in the health care reform bill just signed into law — the 21 percent cut doctors are facing is the result of a payment formula that was enacted in the late 1990s and would have been a problem whether health care reform had passed or not. Congress has passed a bill to override the cuts in past years, but always on a short-term basis. No matter which political party was in control, Congress has not been able to completely repeal the formula, and this has resulted in both the cost and the amount of the payment cut growing bigger every year. President Obama, at least, has proposed to repeal the formula and to accurately account for the costs of repeal in his budget. The original House health care reform bill included a permanent repeal of the old formula so annual cuts would no longer be required, and the House also passed a separate, free-standing bill that would do the same thing. But to date the Senate has been unable to come up with the votes to pass the House bill without paying for it, and the cost of the permanent repeal of the old formula is now so high there is no easy way to find offsets.

Congressional leaders have assured the National Committee that they will find a way to prevent the reimbursement cuts from going into effect, even if it is again only done for a short period of time. Hopefully, this will give Congress time to find a permanent solution, which is absolutely essential to protect seniors from the devastating impact of cutting physician reimbursement levels so deeply. Medicare already pays doctors about 80 percent of what private insurance pays for the same services. Although seniors report occasional problems finding doctors who will take Medicare patients in certain areas of the country, the many benefits Medicare provides has kept the lower reimbursements from being a serious problem. This would not be the case if Congress allowed an additional 21 percent cut in payments to take effect.

On the positive side, primary care physicians will get a 10 percent Medicare pay increase for many of the services they provide as a result of health care reform. In addition, general surgeons practicing in underserved areas will be eligible for bonus payments.

Q My Medicare Advantage plan says my premiums will go up and my benefits will be cut. I like my plan and the President said anyone who likes their plan can keep it without anything changing. Was he talking about everybody but me?

A There is nothing in the new law that requires Medicare Advantage plans to increase your costs or cut your benefits. Many plans change the benefits they offer and the cost-sharing they provide on a yearly basis, even without changes in payments. In fact, many seniors reported changes in their plans this year, well before health care reform was signed into law.
Today private insurers are paid an average of 13 percent more than it costs Medicare to cover the same senior. The new health care reform law is a move back toward a fairer reimbursement system. First, it freezes payments to Medicare Advantage plans in 2011 to give the plans time to adjust to the upcoming changes. In future years, the subsidies will slowly be phased down so most plans are paid amounts closer to what it costs traditional Medicare to cover the same seniors. There will still be areas where higher payments are allowed — especially in areas with lower overall costs. The law provides for bonus payments for plans that deliver high-quality health services to their enrollees.

The new law also includes significant new protections for seniors enrolled in the private plans. For example, plans will no longer be allowed to charge more for certain expensive services than traditional Medicare. They will also be required to spend 85 percent of their revenues on patient care rather than overhead or profits. If a private insurer reduces any of its additional benefits or raises costs, that is purely a business decision the insurance company has made on its own — putting profits ahead of seniors. Any senior who sees a premium increase or benefit cut in their Medicare Advantage plan can change to another plan or return to traditional Medicare.

Q I hear Congress exempted itself from the new law. If it's good enough for average Americans, why isn't it good enough for them?

A This claim appears to be an Internet rumor that is completely false. The truth is that Congress specifically included itself and members of Congressional staff in the new law. The provision explicitly states that the only health plans the federal government can offer to members of Congress and their office staffs are plans "created under this Act," or "offered through an Exchange established under this Act." This will require the Federal Employees Health Benefits Program (FEHBP), which is available to all government employees, to only be available to members of Congress and their staffs through the new Exchange that is created by the health care reform law.

Q Isn't this just a government takeover of the health care system?

A The legislation that was signed into law is nothing like a government takeover of health care. It does not create a "single-payer" system like Canada's, or government-owned and run health care like Great Britain or the Veterans Administration here in the United States. As President Obama has said, the new law is a "uniquely American" response to health care — providing a combination of pilot projects, financial incentives and penalties, and changes in federal programs — all designed to encourage our health providers toward a system that costs less while providing better care. By any objective measure, America has a very expensive health care system and this is a big part of the dramatic deficits economists are predicting for the future. If the new law is successful at slowing the rate of cost growth while improving quality, much of the skyrocketing debt predicted for the future will disappear.

Q So how does all this get paid for? I don't want to leave the bill to my grandchildren.

A The Congressional Budget Office (CBO) estimates that the combination of Medicare savings and increased revenues in the bill reduces the deficit, both over the first ten years as well as over the longer term. And this estimate uses extremely conservative cost estimates, as CBO economists refused to "score" as savings any part of the bill that could not be verified through their economic models. Many of the savings health experts expect from changes such as payment reforms and coordination of care models were not counted because CBO considered them "too

(continued on 10)

Q&A on Health Care Reform

(continued from 9)
speculative." For this reason, many experts believe much greater savings will result from enactment of health care reform than is currently estimated.

Q I get my health care coverage through my employer and he says his costs for providing prescription drug coverage are going up. Is this true?

A Prior to enactment of the Medicare Modernization Act (MMA) of 2003, some employers were providing health insurance to their retirees which included prescription drug coverage. As an incentive to keep them from dropping that coverage, MMA provided a double benefit. First, the MMA gave employers a 28 percent subsidy for continuing to offer prescription drug coverage to their retirees, and provided an exemption so the subsidy is not considered taxable income to the company. In addition, it then allowed the companies to deduct the federal money from their corporate taxes as if it was their own spending. So, for example, for every $100 a company spends on retiree drug benefits, Medicare sends it a subsidy payment of $28. This effectively leaves the company with a cost of $72 for every $100 in benefits. The companies do not have to count the $28 subsidy as income to the company, and in addition they are allowed to deduct the entire $100 — which includes the $28 contributed by the federal government — from their corporate income taxes as though the entire amount came from their own treasuries.

Health care reform left the 28 percent subsidy in place and continued to exempt it from taxation. But companies will no longer be allowed to deduct the subsidy from their corporate taxes as if it were their own spending on benefits.

The remaining subsidy is substantial and many companies and their workers value the retiree drug benefit, so we hope the number of companies that use the elimination of the double benefit as an excuse to drop their retiree drug coverage will be small. If some retirees do lose their company drug benefits, they can opt into Medicare's Part D prescription drug program which will improve significantly as a result of changes in the health care reform law.

Q Medical malpractice is the biggest driver of health care spending. Why isn't it included in the new law?

A Economic studies simply do not support this claim, according to the independent FactCheck.org. There is a great deal of support for limiting liability awards in medical malpractice cases, and it's true that doing so would save money. The Congressional Budget Office has estimated medical malpractice measures proposed by some members of Congress would save $54 billion over 10 years and "reduce total U.S. health care spending by about 0.5 percent." That's real money, but it's only a tiny part of the more than $2 trillion spent on health care every year in the United States. While there's disagreement over what exactly the biggest drivers of health care spending are, it is clear medical malpractice is nowhere near the top of the list. About 75 percent of spending, for instance, goes to taking care of people with multiple chronic diseases.

Q I hear the law will require the hiring of up to 16,500 new IRS agents, who will be armed and charged with collecting the new taxes mandated by the new law. The IRS will hound taxpayers, confiscate property, or put you in jail if you don't have health insurance. Is this true?

A None of these statements is true. The law specifically prohibits the IRS from confiscating taxpayer assets, from using liens or levies, or imposing criminal penalties of any kind — including jail time — because of a lack of health care coverage. The Commissioner of IRS explained during a recent hearing before the Ways and Means Committee that he expected the coverage information to become standardized in a form — much like the 1099 form currently received from banks and other financial institutions outlining the amount of mortgage interest or real estate taxes a homeowner has paid. According to his testimony, "We expect to get a simple form, that we won't look behind, that says this person has acceptable health care coverage."

The supposed number of new agents is very misleading and was generated by those opposed to health care reform using dubious methodologies and highly questionable assumptions. While it is clear the IRS will have a heavier workload as a result of health care reform and will therefore likely need to hire new staff, many will be hired to make sure individuals and businesses are educated about their rights and benefits under the new law. This will be especially important to ensure that both individuals and businesses are aware of the new tax credits designed to help them pay for their health care.

Q You talk a lot about the good things in health reform. Is there anything you don't like about the new law?

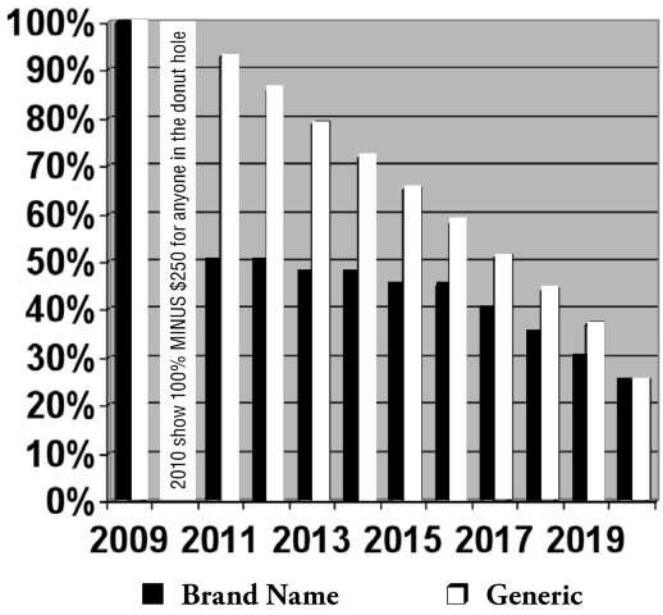
A No bill is perfect, and the National Committee advocated for numerous other improvements to Medicare such as expanded benefits and caps on out-of-pocket spending. These improvements are still on our agenda and we intend to continue educating Congress about their importance in the coming months and years.

For the immediate future, however, we are very concerned that the law creates an independent board that has the power to limit spending growth in Medicare. The Independent Payment Advisory Board (IPAB) has been given broad new powers to further reduce Medicare spending beginning in 2014. Its recommendations will go into effect automatically unless Congress passes legislation to make changes. The changes can redistribute how the payment cuts are allocated, but Congress does not have the ability to change the target limits themselves. The IPAB does not begin operating until 2014 so there is time for Congress to address the issues it raises.

The new law also increases the premiums for Part D coverage for higher-income beneficiaries and freezes the threshold for Part B premiums for 10 years. We opposed this means-test when it was first applied to Part B premiums and continue to believe neither Part B nor Part D should be structured this way. Higher-income workers already pay more money into Medicare during their working lives; we do not believe they should be charged more after retirement too.

CLOSING THE DONUT HOLE AND OTHER IMPROVEMENTS

The health care overhaul has added important improvements to Medicare prescription drug coverage for seniors. In 2010, the new health care reform law helps cover expenses for victims of the "donut hole" coverage gap, and the hole in coverage is eliminated altogether by 2020. The law also provides for additional assistance for low-income beneficiaries.



The Donut Hole: Immediate relief for seniors now, completely gone by 2020

Currently, the standard Part D drug benefit contains a "donut hole," a gap in coverage where beneficiaries must cover the full cost of their medications even while they continue to pay premiums. In 2010, this occurs when the total costs of a beneficiary's prescription drugs reaches $2,830 — requiring the beneficiary to cover the next $3,610 in drug costs.

The new law provides assistance to help seniors bridge this donut hole until it is closed entirely in 2020.

2010 $250 rebate to every senior who falls into the donut hole.

2011 A 50% rebate will be applied at the pharmacy for brand name medications, saving the typical senior over $700. Part D co-payments for generic drugs will be reduced by 7% each year until the coverage gap is eliminated for these drugs as well. For brand-name drugs, manufacturers will increase their discounts each year to erase the coverage gap.

2014 The dollar amount of the catastrophic threshold, where seniors' co-payments are dropped to 5% of drug costs, will be more slowly increased from year to year at this point.

2020 Co-payments required for brand-name and generic drugs will be phased down to the standard 25% by 2020, thus entirely eliminating the donut hole and saving the typical senior over $3,000.

Health Care Improvements for 50-64 Year Olds

(continued from 3)

Providing Affordable Private Insurance Choices through Exchanges

A major provision of the health care reform law is to create state-based American Health Benefit Exchanges through which individuals can purchase coverage. Subsidies will be available to help individuals and families with income between 133-400 percent of the federal poverty level afford insurance. U.S. citizens and legal residents will be required to have qualifying health care coverage individually or through an employer.

Creating a Program to Help Employers Cover Retirees Age 55-64

The health care reform law creates a temporary $5 billion reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program, which is designed to encourage former employers to maintain retiree health care coverage, will reimburse employers or insurers for 80 percent of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan.

Increasing the Thresholds for the Excise Tax Based on Age

The health care reform law imposes an excise tax on high-cost insurance plans beginning in 2018. However, the threshold amounts for imposing the tax will be increased for retired individuals age 55 and older who are not eligible for Medicare, and they will also be increased for employers who may have higher health care costs because of the age or gender of their workers. This will make it less expensive for employers with an older workforce to continue providing health insurance.

Assistance for Low-Income Seniors

Eligibility and coverage for low-income Medicare beneficiaries is also improved:

- Co-payments are eliminated for many beneficiaries receiving home- and community-based services who are eligible for both Medicare and Medicaid.
- The number of low-income beneficiaries required to change plans each year to maintain zero premiums is reduced.
- Widows and widowers can more easily retain their low-income eligibility.
- Outreach programs are enhanced to ensure more beneficiaries who are eligible for the Low-Income Subsidy know about the benefit and sign up for it.

Senior Co-pays

	Deductible	Basic Benefit	Donut Hole	Catastrophic
Pre-reform co-pays	100%	25%	100%	5%
Post-reform co-pays (fully phased-in)	100%	25%	25%	5%

What Begins When

2010

- $250 to every senior entering the donut hole (2010 only)
- Temporary high-risk insurance pool for early retirees
- Background checks on long-term care employees
- Nursing homes required to disclose ownership information
- Student loan programs to boost primary care workforce
- Initiatives to root out waste, fraud, and abuse

2011

- Part D prescription drug discounts for seniors in donut hole (50 percent for brand-name drugs and 7 percent for generics)
- Free annual wellness visits and personalized prevention plans
- Preventive care deductibles and copayments eliminated
- Medicare Advantage plan reimbursements frozen
- Medicare Advantage plans prohibited from charging enrollees more than traditional Medicare for chemotherapy administration, skilled nursing home care, and other specialized services
- Creation of new Centers for Medicare and Medicaid Services (CMS) Innovation Center
- Means-tested Part D premiums begin; Part B means-tested income thresholds frozen for 10 years
- 10% bonus payments to Medicare primary care practitioners
- New, voluntary long-term care insurance program (CLASS ACT)

2012

- Phase-down of Medicare Advantage plan subsidies
- Bonus payments to high-quality Medicare Advantage plans
- Incentives for hospitals to reduce preventable readmissions
- Data collection and reporting improvements to CMS' Nursing Home Compare (NHC) Website
- Elder Justice Coordinating Council required to make recommendations to the Secretary of Health and Human Services on the coordination of federal, state, local and private agencies'/entities' activities relating to elder abuse, neglect, and exploitation

2013

- Pilot program to test bundled payments for a single episode of care
- Double-deduction for employer Part D subsidies eliminated
- Additional hospital insurance tax for high-income workers
- Nursing homes required to have effective compliance and ethics programs

2014 and beyond

- Part D donut hole phases down to complete closure by 2020
- Medicare Advantage plans must limit profits and expenses to 15 percent of Medicare payments
- Independent Payment Advisory Board established

Report Medicare waste, fraud, and abuse!

If you see suspicious charges for health care services you've received, first contact the physician or provider. If the problem is not resolved, please report it by calling 1-800-HHS-TIPS.

GET THE WORD OUT

Share this newsletter
with a friend.
For additional copies,
please call
1-800-966-1935,
or go online to

www.mycommittee.org/secure-retirement

to forward this to a
friend electronically.

YOU CAN FIND THE NATIONAL COMMITTEE ON THE WEB

NCPSSM
National Committee to Preserve Social Security and Medicare

Our website:
www.ncpssm.org

Our Blog:
www.entitledtoknow.org

YouTube:
www.youtube.com/NationalCommittee

Facebook:
facebook.com/NationalCommittee