

— **SPECIAL REPORT** —

**MEDICARE: TIME TO RENEW NOT RETREAT**

Medicare Matters. It opened doors to health care by providing coverage the private market didn't want to offer. Today, 55 million older people and people with disabilities have health care because of Medicare. It relieves families of worry and enhances their quality of life, peace-of-mind, health and economic security. But, in 2017 all this is in jeopardy.

We need to keep Medicare current, with oral health, audiology and vision coverage. We need to pay only the best price for prescription drugs, and interrupt the wasteful flow of Medicare dollars to insurance company profits. Medicare needs to stay vital and relevant. But that can be done by renewing Medicare, not retreating from its promise.

Unfortunately, many incoming policy-makers are committed to converting Medicare from a defined benefit program to a defined contribution that would help pay for individual private insurance premiums. This would end Medicare as we know it, with its community of interest in top-quality, best-value coverage. Instead, each individual would receive a voucher as partial payment to shop for insurance in the private market.

Medicare's 50<sup>th</sup> anniversary in 2015 gave us an opportunity to reflect on all it has accomplished and what it has meant to the country, to individuals, and to families. The Center for Medicare Advocacy collected 50 Insights about Medicare to honor its 50 years. We solicited ideas and stories from experts and individuals who rely on Medicare. They responded generously with their own experiences and knowledge about what Medicare has done to advance the health and well-being of families throughout the country. They also reminded us what could have been better and what could be improved to create an even stronger program for the 21<sup>st</sup> century. We re-publish the Insights here, *along with brand-new stories*, to remind policy-makers and citizens what would be lost when they consider privatizing the Medicare program.

Medicare has met the needs of individual families for over 50 years while also helping to unite our national family. The enclosed information, Insights and real stories illustrate what's at stake if we unravel this national treasure – and how to renew it for generations to come.

“Before we were eligible for Medicare our finances were almost ruined by high health insurance premiums. ... Medicare has made a huge difference in our ability to remain adequately covered, particularly since the Recession left our retirement funds badly diminished.”

*K.M., Medicare Beneficiary, Minnesota*



## The Value of Medicare

“I am 80 years old. I have had Medicare since I was 65. That is regular Medicare. My wife has had the same as I have. I have had two mini strokes, implants where needed, open heart surgery and many Dr. visits. I have never, that is never had a problem with Medicare like it is. Please just leave it alone. Do not mess with it. It is better than Medicare Advantage and is better than any private insurance would be. If you don't have it you have no idea. You just think you do.”

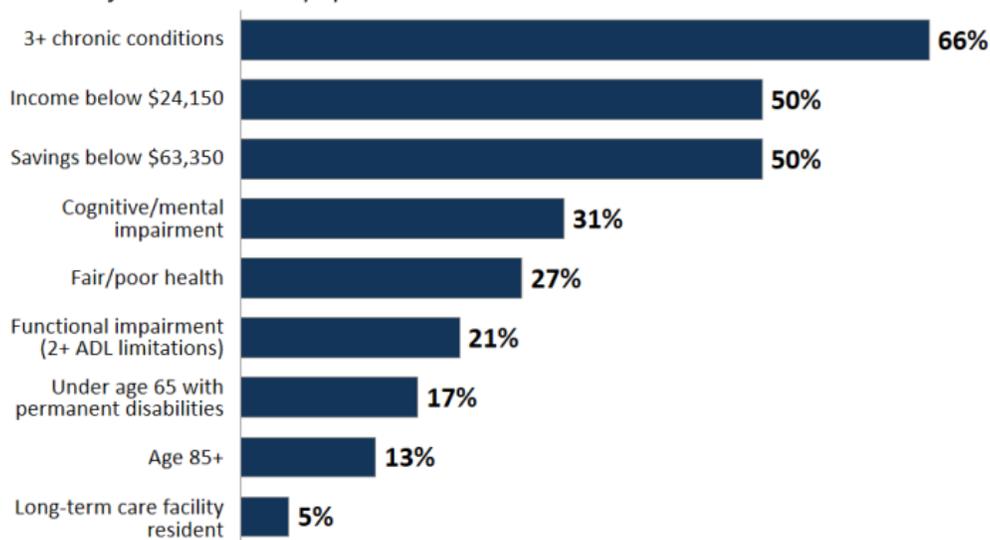
*M.B., Medicare Beneficiary, Tennessee*

## Characteristics of People on Medicare (From Kaiser Family Foundation)

Many people on Medicare live with health problems including multiple chronic conditions, cognitive impairments, and limitations in their activities of daily living, and many beneficiaries live on modest incomes. In 2011, two-thirds of beneficiaries (66%) had three or more chronic conditions, more than one quarter of all beneficiaries (27%) reported being in fair or poor health, and just over 3 in 10 (31%) had a cognitive or mental impairment. Nearly one in six beneficiaries (17%) were under age 65 and living with permanent disabilities and 13 percent were ages 85 and over. Two million beneficiaries (5%) lived in a long-term care facility. In 2014, half of all people on Medicare had incomes below \$24,150 per person and savings below \$63,350.

### Characteristics of the Medicare Population

*Percent of total Medicare population:*



NOTE: ADL is activity of daily living.

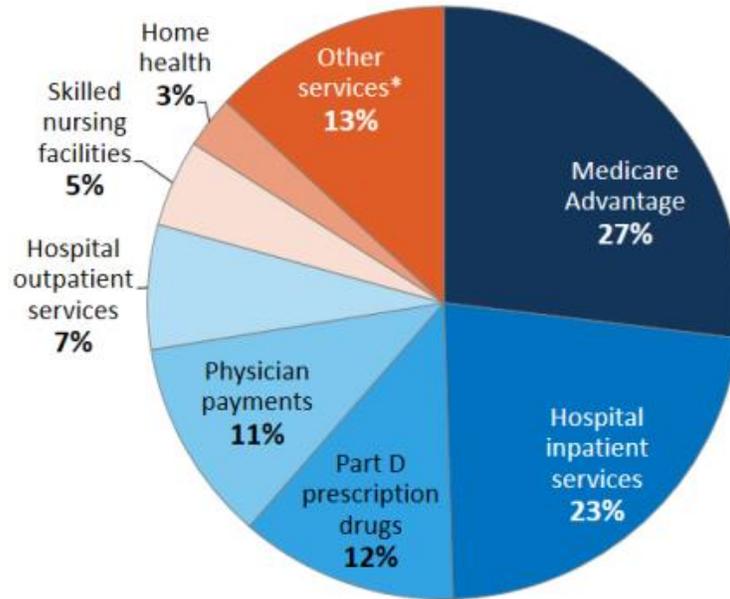
SOURCE: Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary 2011 Cost and Use file.; Urban Institute and Kaiser Family Foundation analysis, 2015 (for income and savings).



## What Medicare Covers (From Kaiser Family Foundation)

Medicare covers many basic health services, including hospital stays, physician services, and prescription drugs.

### Medicare Benefit Payments by Type of Service, 2015



**Total Medicare Benefit Payments, 2015: \$632 billion**

NOTE: \*Consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services; also includes the effect of sequestration on spending for Medicare benefits and amounts paid to providers and recovered.

SOURCE: Congressional Budget Office, 2016 Medicare Baseline (March 2016).



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“Without Medicare my wife and I would be impoverished or dead.”

*J.E. Medicare Beneficiary, Texas*

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“Medicare is the only medical coverage and prescription coverage I have. Without it I would never be able to see a doctor which means they would not be able to prescribe my blood pressure medication and other medications I need. I will be 78 in 2 weeks and have no other way to pay for these necessities I worked until I was 72 and have no family to help me. Medicare is vital to me.

*L.L.B., Medicare Beneficiary, Nevada*

“Although I have Medicare and am very satisfied with it, my Medicare story is about my mother. During her last year she had to come to live with me and my husband. She ultimately needed a variety of prescriptions, a hospital bed in our home, a wheelchair and a hospice nurse who came in once a week to talk with her and evaluate her health. Services were also available for an aide to come in and help her with bathing, but we did not require assistance with this function. Medicare covered all of these expenses. Medicare was a life line to us. At the end she was hospitalized for 3 days and those costs were also covered by Medicare.”

*L.H., Medicare Beneficiary, North Carolina*

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“My husband just passed away in September. I no longer get his pension and only get social security with just a small savings. Without Medicare...wow, do I eat or pay for medical care and prescriptions. I'm so worried....maybe death would be easier.”

*S.M., Medicare Beneficiary, Florida*

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“I am a senior with several serious illnesses and can't afford to see a doctor without Medicare and state aid! Also social security is my only source of income.”

*P.M.W., Medicare Beneficiary, Arizona*

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“Medicare saved my life. Without this program, I would be dead. I'm not exaggerating; it's no hyperbole when I say Medicare saved my life. I have a life threatening illness and if I had no access to doctors or medicines, I wouldn't be here. A few years ago, I had been prescribed Bactrim, which caused crystals to build up in my kidneys. I went into kidney failure, and because I have Medicare, I was able to go into the hospital and have the doctors reverse the damage. I also have another life threatening illness that will never go away. I have doctors who have taken care of me for years and I have been able to live a long and productive life. Without Medicare, this would have been impossible. It is a life saving program that needs to remain as it is.”

*S.F. Medicare Beneficiary, Florida*

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“I want Social Security and Medicare to remain strong – or, better yet, become stronger still. And the “no rejection because of a pre-existing condition” should be made illegal for ALL insurance, not just Medicare.”

*J.C., Medicare Beneficiary, Pennsylvania*

“Privatized Medicare to seniors that are already on a fixed income would be a disaster for senior citizens who are already having to choose between food and medical care and prescriptions.”

*P.M., Medicare Beneficiary, Pennsylvania*

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“I will be on the streets at 66 yrs old without Medicare/Medicaid. Its as simple as that. My money has all gone raising 3 granddaughters after their mother died. There are millions of stories like mine everywhere. We must help the least of us that had bad luck or are sick etc.”

*J.D., Medicare Beneficiary, Michigan*

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“I am 71 years old and my only income in retirement is Social Security. Medicare is my healthcare insurance. Both Social Security and Medicare are working just fine for me as is. Privatizing either one of these would just reduce my benefits since the private providers would want to take profits.”

*F.W., Medicare Beneficiary, Wisconsin*

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“I am a disabled woman. I have brittle bones and need to use an electric wheelchair. Without Medicare I will die.”

*L.R.B., Medicare Beneficiary, Louisiana*

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“I am now age 81, and have many health issues, and must take multiple drugs each day, as prescribed by my doctors. Medicare is my only health coverage, and I depend upon it greatly. I would be very ill, and perhaps even at risk for death if it were not for my Medicare. My only income now is Social Security. We senior citizens, who have worked hard all of our careers depend upon these two programs, and I personally would be lost and bankrupt without these benefits provided by forward thinking people who enacted the benefits to provide health care for seniors.”

*A.C., Medicare Beneficiary, Washington State*

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“Without Medicare we would have probably spent our life’s savings, lost our house and become among the elderly poor needing public benefits for food and shelter. Medicare has made it possible for us to maintain our independence and our way of life into our retirement years. Thank you”

*S.G., Medicare Beneficiary, Oregon*

# 50 Insights for Medicare's 50<sup>th</sup> Anniversary (2015)

## 1. Medicare Was Key to Integrating Hospitals

Most people know Medicare as one of the most successful social programs in our country's history for its impact on the health of our older citizens and those with disabilities. But did you know that the Medicare program was key to integrating hospitals?



The Civil Rights Act of 1964, stated that “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

Medicare, in 1965, created an important financial and social change tool toward the integration of hospitals. As a Federal program affecting every hospital in the country, Medicare offered immense financial leverage. Any hospital that wished to be reimbursed by Medicare for the usually-uncompensated care for their oldest, and sickest patients was suddenly subject to the Civil Rights Act. According to Center for Medicare Advocacy Senior Policy Attorney Alfred Chiplin, the administration used this leverage particularly effectively in opening the door to hospital privileges for African-American physicians, in addition to it being a major tool in creating access to basic hospital and other health care services for African-American citizens throughout the nation, particularly in Southern states.

## 2. Medicare Reduced Poverty

Medicare has not only provided access to care for people who could not get private insurance, it has also significantly reduced poverty. As Nancy-Ann Min DeParle, former administrator of HCFA (Now CMS) stated in the preface to *A Profile of Medicare* in 1998:



*Few programs in the history of the United States have brought as much benefit to society as Medicare. Since its enactment in 1965, Medicare has provided access to quality health care for those Americans least likely to be attractive to private insurers – those over age 65, disabled, or with end stage renal disease. Medicare has also prevented many Americans from slipping into poverty. The elderly's poverty rate has declined dramatically since Medicare was enacted – from 29 percent in 1966 to 10.5 percent in 1995.*

*Medicare also provides security across generations: it has given American families assurance that they will not have to bear the full burden of health care costs of their elderly or disabled parents or relatives at the expense of their young families.*

As Medicare turns 50, the Center for Medicare Advocacy is taking some time to look back at our work over the last three decades. While much has changed, many challenges to Medicare, unfortunately, stay the same.

Fifteen years ago the Center, the National Senior Citizens Law Center, and the Consumer Coalition for Quality Care wrote “The public should be informed of the dramatic changes envisioned [for Medicare]... we must remember that the Medicare program is sound, and that it has served our nation’s elderly and disabled well.” This warning is even more critical today, as efforts to privatize Medicare continue, and expand.

We still must vigilantly protect a comprehensive, accessible, traditional Medicare program – the program that has improved the lives of our nation’s neediest populations and their families for 50 years.

### 3. Medicare Saves Lives

*By Connie Cherba, Iowa*



In early 2000, Edward, who was then 60 years old, applied for Social Security Disability. Despite having suffered from bipolar disorder for nearly 40 years, Edward had earned a PhD, but was not able to hold a job. While the Social Security Disability was economically important, becoming eligible for Medicare allowed him to access what would become life-saving, preventive medical benefits. Although Edward’s father died as a result of metastatic colon cancer, Edward had not been able to afford a colonoscopy. He was not eligible for any state medical assistance. When Edward first became eligible for Medicare, he had his first colonoscopy which revealed a large polyp. According to Edward’s gastroenterologist, “that polyp would have been cancerous within a year.” Medicare kept Edward cancer free and likely saved his life.

### 4. Medicare’s Future Was Strengthened by the Affordable Care Act (ACA)

*By Max Richtman, President and CEO of the National Committee to Preserve Social Security and Medicare*



Medicare – one of our nation's most popular and successful programs – celebrates its 50th anniversary this year, having been signed into law by President Lyndon Johnson on July 30, 1965. Before the enactment of Medicare, only 50 percent of seniors had health insurance and 35 percent lived in poverty. That was a time when even a minor illness or injury could bankrupt older Americans and their families.

Fast forward to 2015 when over 55.2 million Americans are expected to be receiving guaranteed health care benefits through the Medicare program regardless of their medical condition or income. This includes 46.1 million Americans age 65 and above and 9.1 million Americans receiving Social Security disability benefits. By the time the last of the baby boomers reaches age 65, it is expected that close to 80 million people will be covered through Medicare. Along with Social Security and Medicaid, Medicare's guaranteed health insurance coverage without regard to health status is vital to our economic and health security in retirement or if we become disabled.

Medicare's future has been strengthened by the Affordable Care Act (ACA), which improves care for Medicare beneficiaries by eliminating out-of-pocket costs for preventive screenings, annual wellness visits and personalized prevention plans; providing discounts on prescription drugs in the Part D coverage gap known as the "donut hole," which will be phased out by 2020; and providing incentives to improve the quality of care that is provided. The ACA strengthens Medicare's financing by reducing waste, fraud and abuse; slowing the rate of increase in payments to providers; and phasing out overpayments to private Medicare Advantage plans.

There's a lot to celebrate about Medicare's past, and thanks to the Affordable Care Act, a more hopeful outlook for the present and future.

## **5. Medicare is a Sacred Trust that Must Be Preserved**

*By Former U.S. Senator Christopher J. Dodd*

For half a century our nation, through Medicare, has made a sacred trust, a promise to our seniors. A promise which says that after a lifetime of hard work and paying into the system, they could enjoy the dignity of a secure retirement that includes quality, accessible health care. This is a promise that every succeeding generation has kept; a promise that I fought for throughout my thirty-six years in the United States Congress and one that we must keep for the 52 million Americans enrolled in Medicare today. I can think of no more successful or widely supported federal program within the last century, and the American people must continue to fulfill this promise by supporting and strengthening Medicare for another 50 years and beyond.



## 6. Medicare Helps People with Disabilities

*By Congressman Joe Courtney (2d Dis. CT)*



When Medicare was enacted in 1965, it covered only older people – those 65-years old or more. In 1972, Congress added coverage for people with long-term disabilities, recognizing that like older people, they were often unable to obtain health insurance. To limit the cost of covering this new cohort, Congress added a 24-month waiting period before coverage begins for people with disabilities. The waiting period was also intended to avoid overlapping with private insurance coverage and to ensure Medicare was available only for people with long-term disabilities. In practice, the 24-month waiting period has left millions of disabled people without health insurance, further jeopardizing their health and well-being.

Ms. Toth, a resident in Connecticut’s 2nd Congressional District, is an example of people caught in Medicare’s 24-month waiting period. She contacted my office in February, 2014. She received a fully favorable decision for Social Security Disability in May, 2012. Therefore, she was still waiting for Medicare to begin, in May, 2014. She did not qualify for Medicaid but did not have enough income to pay for the doctor visits and medicines she needed. It was very hard for her to get better when sick, or even maintain her health because she couldn’t afford necessary care. The best we could do at the time was help her navigate some social services – energy, SNAP, etc. until her Medicare kicked in.

Fast forward to a follow-up call in June, 2014. Ms. Toth called to report she is now covered by Medicare. Having Medicare has taken a huge burden off her. She is able to obtain nursing care at home, is seeing her doctors when needed and can get the medicines she needs to stay well. Unfortunately, she was diagnosed with leukemia since her original call to my office, so she is now more in need of, and grateful for, Medicare coverage than ever!

## 7. Medicare Beneficiaries Are Remarkable



We are continuously amazed at the courage and empathy of our clients. The plaintiffs in *Jimmo v. Sebelius*, a class action lawsuit, filed by the Center for Medicare Advocacy in 2011 and settled in 2013, are remarkable examples of this.

The Jimmo Settlement opens doors to Medicare coverage for people with long-term and chronic conditions throughout the country. Despite an extraordinary range of physical problems, Ms. Jimmo has remained very much involved in and interested in the issues raised in her case – and in seeing that others in similar circumstances have fair access to Medicare and necessary care. Ms. Jimmo finally prevailed. After numerous appeals and two lawsuits, she is getting the care she needs at home thanks to her attorneys at Vermont Legal Aid.

This is also true for another of the original Jimmo plaintiffs, Edith Masterman. Ms. Masterman, paralyzed by a farm accident, could not afford the home care she needed. Because she was unable to get the care, she could not appeal. This is a constant Catch-22 of the Medicare appeal system that needs to be changed. Nonetheless, Ms. Masterman fought on for herself and others.

Medicare beneficiaries are remarkable. Getting fair access to coverage is key for access to necessary care. If you don't have Medicare, you may not be able to get any care at all. With coverage, doors to care can open. Medicare matters!

## 8. Medicare is at the Heart of America's Character

*By Congresswoman Rosa DeLauro, CT-3*

"Along with Medicaid, Social Security and now the Affordable Care Act, Medicare is a bedrock part of the American social insurance system. Its enactment was a turning point in our history that has helped ensure the elderly do not have to go without basic health care. Before Medicare, only half of Americans over the age of 65 had health coverage; now virtually all do. Average life expectancy has risen by eight full years. I will continue to fight so that future generations can benefit from a strong Medicare system."



## 9. Medicare is Good. It Could Have Been Even Better.



Many people outside the Medicare and health care world don't know that in 1989 Medicare was briefly, dramatically altered. The "Medicare Catastrophic Coverage Act," (MCCA) was the most significant revision to Medicare since its inception. The law increased the amount of coverage available in all care settings, established limits to beneficiary cost-sharing, and added new benefits. Unfortunately, MCCA also added a new financing model; this proved to be the law's undoing.

From January 1, 1989 through December 31, 1989 – when it was repealed – MCCA eliminated the "Spell of illness" benefit period for hospital and SNF coverage, established a single annual inpatient hospital deductible, and removed co-pays and "lifetime reserve days" for hospital coverage. MCCA also expanded SNF coverage to 150 days per year, limited co-pays to the first 8 days of SNF care per year, and eliminated the prior 3-day inpatient hospital stay requirement. (This 3-day stay requirement causes more problems today than ever before, as so-called outpatient "Observation Status" comprises a greater share of hospital stays all the time, keeping beneficiaries from qualifying for SNF coverage.) In addition, MCCA removed the cap on the number of days of Hospice coverage.

MCCA was also supposed to add enormous value to Medicare Part B. In 1990 a \$1370 cap on out-of-pocket expenses was to become effective, as was coverage for “respite care” for individuals caring for chronically ill beneficiaries. And, perhaps most incredibly, a prescription drug benefit was to become a Part B benefit. Tragically, none of these additions were implemented.

What happened? MCCA looked only to those eligible for Medicare to pay for the new benefits. This annual payment, a set amount based on tax liability, was to apply to all Medicare enrollees, regardless of whether they participated or utilized the benefits. Opposition to this funding mechanism, which became known as the “Medicare Surtax,” resulted in such a groundswell that all the Medicare components of MCCA were repealed in December 1989.

The MCCA benefits seem like a dream now. Oh, what might have been.

## 10. Medicare Helps Older and Disabled People Stay Home



Medicare home health coverage can mean the difference between an individual staying home or becoming a nursing home resident. While the Medicare skilled nursing facility benefit is very limited, for beneficiaries who meet the coverage criteria, the home care benefit can be an ongoing Godsend.

For people who can't readily leave home without a major effort and/or assistance (defined as “homebound”), and who need nursing, physical, speech, or occupational therapy, Medicare home health coverage may be available. If so, Medicare covers these services as well as home health aides to assist with the activities of daily living – such as eating, dressing, bathing, and toileting. Social worker services and medical supplies are also coverable.

It is a common misunderstanding that Medicare home care coverage is “an acute care benefit only.” CMS and Medicare policy-makers often repeat this refrain. But it's not true. In fact, according to federal regulations and CMS policy, the home health benefit has no duration of time limitation. Indeed, in 1980 Congress actually rescinded the 100-visit limitation and removed a prior hospital requirement. Further, there is no co-insurance – although proposals appear annually to impose one.

## 11. Medicare Helps Low Income People

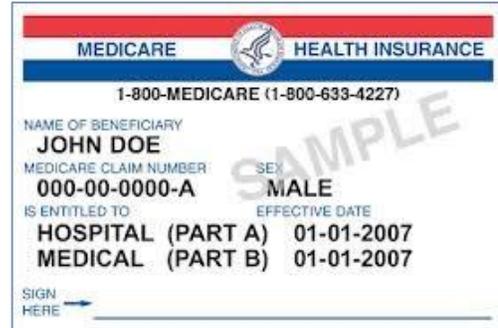
*By Kevin Prindiville, Executive Director, Justice in Aging*

Of the 54 million people with Medicare, a staggering 25% have annual incomes below \$14,400. For these people living in retirement, or coping with a disability in poverty, Medicare coverage offers a lifeline, a chance to get needed health care. That precious red white and blue

Medicare card means that a doctor will see you, a physical therapist will help you recover from a stroke and much more. But that lifeline disappears if you can't afford to pay your \$105 monthly Medicare Part B premium, or your \$1260 hospital deductible, or if you have 10 prescriptions that need filling, each with a co-pay of \$20 or \$30.

Fortunately, the Medicare lifeline does work for many people in poverty, but only because safety net programs work together with Medicare to plug coverage gaps and make the Medicare benefit affordable. The Medicaid program covers Medicare premiums, deductibles and co-payments. Enrollees in full-scope Medicaid receive Medicaid long-term services along with coverage of their Medicare costs; those who qualify only for Medicare Savings Programs – operated by state Medicaid agencies and generally offered to people with incomes slightly higher than full Medicaid cut-offs – get help with their Medicare costs but do not get other Medicaid services. Today fully twenty percent of Medicare beneficiaries rely on Medicaid-funded programs for Medicare premium or cost-sharing assistance. In addition, the Low Income Subsidy, known as “extra help,” provides relief to about 11 million beneficiaries who otherwise could not afford Medicare prescription drug program premiums, deductibles and co-pays. That subsidy also protects low income beneficiaries from falling into the infamous donut hole.

Dual eligibles, people who qualify for both Medicare and Medicaid, need these safety net programs to remain strong and to grow. When states seek instead to narrow Medicaid eligibility standards, they not only are cutting off people from needed Medicaid services, like long-term services and supports, but also are effectively making it impossible for dual eligibles to use their Medicare. Medicare is a benefit that many earned working their whole lives at low-paying difficult jobs. Like other workers, they saw their Medicare contributions deducted from each and every paycheck. We at Justice in Aging are committed to working with the Center for Medicare Advocacy and other advocates to ensure that all Medicare beneficiaries, especially those who most need what Medicare can provide, can afford to use the benefits to which they are entitled.



## 12. Medicare Is a Model for All Health Insurance

By Harry Ting, PhD, Health Economist

Medicare is the major driver of innovation in health insurance reimbursement. Early examples were establishing per case rates for hospitals in the form of DRG payments and requiring three-day hospital stays for coverage of skilled nursing home care. More recently, it adopted payment reductions for hospital acquired conditions and penalties for preventable hospital readmissions. Under the Affordable Care Act, Medicare is introducing medical homes, accountable care organizations, bundling and payment for care management. In all these areas, private insurers have followed the example of Medicare. Recognizing the influence of Medicare, it is crucial that its payment policies be carefully designed and scrutinized.



## 13. Medicare Increasingly Benefits Private Industry



At the Center for Medicare Advocacy's *National Voices of Medicare Summit* (March 20, 2015), three Medicare leaders presented their perspectives on Medicare's promise and challenges. All spoke to the value of Medicare for its intended beneficiaries: older and disabled people. They also noted the resources and funds Medicare spends on providers and private industries.

Current CMS Medicare Director Sean Cavanaugh noted that Medicare spends as much of its resources on the private Medicare Advantage program as on traditional Medicare, although over 70% of beneficiaries are in traditional Medicare. Mr. Cavanaugh's predecessor, Jonathan Blum told the gathering that Part D is projected to be the fastest growing component of Medicare and, in particular, that "specialty drugs" will drive costs. Since Medicare provides prescription drug coverage exclusively through private plans, and does not negotiate pharmaceutical prices, these payments are highly beneficial to both the insurance and the pharmaceutical industries.

Former HCFA (CMS) Administrator, Bruce Vladeck concluded that Medicare is responsible for approximately \$600 billion a year in income to providers. "They part with it with great reluctance," said Dr. Vladeck. "In other health systems [abroad], beneficiaries use more services, but providers don't collect as large checks," said Vladeck.

## 14. Medicare Opened Doors to Care – Let’s Not Really Celebrate Until They’re Opened for Everyone

*By Frank Miata, Medicare Beneficiary*

I wonder if "celebrating" is the appropriate stance to take towards 50 years of avoiding the obvious need for a single payer, national health care system. I am old enough to remember what life was like before Medicare and Medicaid. I remember people dying outside hospitals, denied care because they had no insurance.



You and your wonderful colleagues are fighting for decent treatment for the elderly. It is a fight, a struggle. I think you need to emphasize that the fight for the human right to health is what is to be applauded. The securing of that right is the willingness to fight to maintain and expand that system against predatory political and business interests.

I just think the celebratory tone should have a different emphasis.

## 15. Medicare Helps People at the End of Life

*By Terry Berthelot, JD, MSW*



Somewhere in our history, it became unacceptable to die. Elizabeth Kubler-Ross described in her seminal work, *On Death and Dying*, dying patients forced to endure fruitless procedures and then left in their dark hospital rooms, alone, to face the inevitable. Each death was treated as a failure. Then in the 1970's, the United States saw the birth of a new philosophy of care. This grassroots movement, known as hospice care, demanded quality of life for the dying and the

medical, psychosocial, and spiritual support necessary to die at home. Medical insurance, however, did not pay for this kind of care.

This changed in 1983, when Medicare started covering hospice care. Since then almost all other insurances followed suit. Today, most dying Americans have access to hospice care, and physicians and other healthcare providers are increasingly knowledgeable about the hospice philosophy of care. In fact, nearly half of the Medicare beneficiaries who died in 2013 received hospice services. Thanks to Medicare's leadership, dying in America is now viewed as part of the cycle of life, and patients and their families have access to appropriate care.

## 16. Medicare Was a Precursor to Current Debates about the Role of Government

By David Lipschutz, Center for Medicare Advocacy, Senior Policy Attorney

In the run-up to the passage of a major expansion of health insurance coverage, a prominent and rising political figure urged people to oppose such expansion, and contact their members of Congress to express their opposition:

"Write those letters now; call your friends and tell them to write them. If you don't, this program I promise you, will pass just as surely as the sun will come up tomorrow, and behind it will come other federal programs that will invade every area of freedom as we have known it in this country...And if you don't do this and if I don't do it, one of these days we are going to spend our sunset years telling our children and our children's children, what it once was like in America when men were free."



This was not a Tea Party activist denouncing the Affordable Care Act (ACA). It was Ronald Reagan in a 1961 recording sponsored by the American Medical Association meant to defeat passage of the proposed Medicare program.

While similar rhetoric abounds today regarding ACA, Medicare is now widely recognized as a grand success for older people, people with disabilities, and the American healthcare system. Very few would openly decry Medicare as a threat to democracy. Yet Medicare has been increasingly privatized, and it remains under threat from those who wish to further morph the program into a private system. Such threats range from policies that continue to favor Medicare Advantage plans over traditional Medicare, to annual budget proposals that would turn Medicare into a voucher (or premium support) program, to the recently passed "Doc Fix" law that weakens coverage of future Medigap plans and increases the cost of Medicare Part B, further encouraging people to enroll in private plans.

People who care about the soul of Medicare need to pay attention to these gradual but determined steps towards privatization and away from the original cost-effective, universal program. If we don't, we may have to tell our children what it once was like when Medicare was real.

## 17. Medicare Must Help People Communicate

*By Steve Gleason*

I was diagnosed with ALS four years ago. Now I am unable to move my body, except for my eyes. I communicate through technology called a Speech Generating Device (SGD). The SGD allows me to maintain contact with the world around me – to express my thoughts, feelings and needs. It allows me to communicate with my family and community, to retain independence, and to continue to be productive and purposeful.



If I had been diagnosed with ALS 50 years ago when Medicare began, I would have been unable to communicate, silenced by a lack of technology and expected to fade away quietly and die. Since Lou Gehrig's death there has been no effective medical therapy development for ALS patients. During the same time period technological advancements for ALS patients have been, like the technology industry, exponential. In a sense, while there is no medical cure, technology can act as a cure. Current technology has revolutionized the way society communicates. Texting, blogging, tweeting and using the internet is now the fabric of humanity's ability to communicate. We, citizens, must ensure that Medicare keeps pace with the technology advancements that give life and hope to those in need.

As technology has evolved, Medicare's willingness to expand coverage has, at times, lagged behind. In the past year, Medicare chose to only cover devices that produced audible speech. Last month, after receiving thousands of letters from the citizens of this country, Medicare proposed expanded coverage for devices (tablets, computers, and smart phones) and expanded coverage for communication (email, text, and phone messages) for those of us who meet the medical criteria. This coverage expansion will allow the proper type of technology and communication to be used in the most appropriate form – allowing people with disabilities to remain purposeful and productive members of society.

Medicare coverage must keep pace with the "cures" that technology provides that help people communicate and live productively. The quality of life for all our citizens depends upon it.

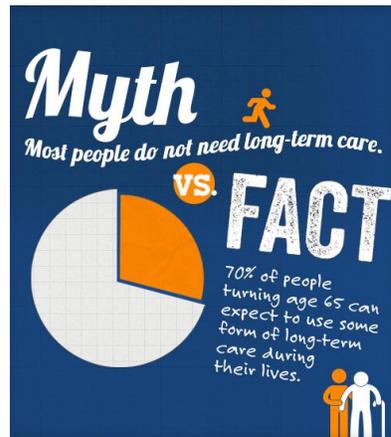
## 18. Medicare Doesn't Cover Long-Term Nursing Home Care

Medicare is a wonderful program. It provides important health insurance for millions of older and disabled people. But, contrary to common belief, Medicare does **not** cover long-term care in skilled nursing facilities (often referred to as nursing homes).

In fact, at best, Medicare only covers up to 100 days of skilled nursing facility care per benefit period. To be covered by Medicare, the patient must need and receive daily skilled nursing and/or therapy. It's not unusual for people to be told they don't meet this standard, even when they do. If the individual is receiving daily nursing, physical, speech, and/or occupational therapy, she should consider appealing for Medicare coverage.

In addition, Medicare only covers a nursing home stay if the stay was preceded by an **inpatient** hospital admission of at least three consecutive days. This prior hospital requirement is increasingly difficult to satisfy since so many hospital stays are now characterized as "outpatient" observation status, not inpatient admission. This policy is further, and unfairly, limiting the Medicare benefit for skilled nursing facility care.

If the patient can be cared for at home, Medicare home health coverage may be available for nursing, therapy and home health aides for as long as the individual meets coverage criteria. These include the general inability to leave home, or only occasionally or for certain specified reasons. Unlike the skilled nursing facility benefit, when the coverage criteria are met, Medicare home health coverage is not limited to a set number of days.



## 19. Medicare Has Options: Know What You Need... and What You Want

By Matt Shepard



My father worked his entire career for a private insurance company. When he retired before he was 65, he and my Mom were able to remain in the HMO that his company had used. The company was located in the next state over from my parents' home state, and so was the network. That wasn't a big deal for my folks, who lived right over the border, closer to those providers than most in their home state. They happily continued paying premiums and enjoying their doctors.

When Dad hit 65, his coverage options changed, but the company still offered a similar HMO for Medicare-eligible former employees. They lost their familiar old network, but remained in an HMO in their neighboring state. Mom had to find a new primary care provider. Dad got to keep seeing his cardiologist, but his primary provider also changed, as did their prescription coverage. New locations, new hours, a little hassle, but pretty similar.

A couple years later, the company stopped providing that plan, as well. The company contracted with "the country's largest private Medicare Marketplace" to find their Medicare-eligible retirees coverage, and offered a subsidy on any plan obtained through that exchange. Dad, always having been happy with his HMOs, waded in looking for a nice Medicare Advantage plan – and the site certainly focused on Medicare Advantage plans. They were the only option online. If you were interested in traditional Medicare and a Medigap plan, you needed to call to speak to someone. My Dad's search for a plan came up with just two companies, both operating only in his home state, neither offering coverage that would allow him access to the physicians, pharmacies, etc. that he and Mom had used for years. Although geographically closer than any in the offered networks, they were out-of-state, and therefore out of network. For the first time, my Dad felt the restrictions of an HMO.

Luckily, Dad found help when he called. When he explained his situation, she told him the very thing I had been telling him for two years – traditional Medicare, a Medigap plan, and a Part D plan would give him the flexibility he needed. I got an excited phone call after he'd finished the process. He explained that it was a lot of work to figure out what he and Mom had needed and get signed up, but now that it was all done, not only did he get to keep his cardiologist, they could also now get prescriptions at both a national grocery chain and a national pharmacy chain – no more having to get them at one of two locations in the neighboring state. Best of all, it looked like Mom could finally go back to her original primary care provider, thanks to traditional Medicare.

## 20. Medicare is There When People Need it Most

*By A Medicare Beneficiary*

Having Medicare saved my life, and I will be forever grateful. But I never thought of it before I was in the hospital, because I'd never really been sick. You have to fight for Medicare like your life depends on it. Because, like me, your life *may* depend on it.



## 21. Medicare is One of the Greatest Achievements of the 20th Century



*By Gill Deford, Director of Litigation, Center for Medicare Advocacy*

In 1965, I had a summer job as a go'fer for the administrative head of a unit at Johns Hopkins Hospital in Baltimore. Hopkins Hospital was and is one of the great teaching hospitals in the country, but I wasn't particularly interested in health care. It was just a job that I was lucky to get.

I don't recall having any discussions with doctors or nurses or anyone else about health care or health care coverage, even though that was the summer that Medicare was signed into law. But what I do recall was overhearing some doctors talking about the impending changes that would ensue because of Medicare. For the most part, they shook their heads ruefully and talked about "Socialized medicine," which, especially since this was during the Cold War, made me pay close attention. Many purported to believe that Medicare would bring about profound changes in the country – and they were not good ones. I can't remember if they actually used this old cliché, but the essence of what they were saying was that "This would be the end of life in America as we now know it."

Fewer than ten years later I was practicing law, with an emphasis on health care coverage for poor, elderly, and disabled Americans. My experience over the last forty years has demonstrated to me that this country doesn't have the greatest health care system in the world, but it's a damn good thing that it has Medicare, with all its faults. It opens doors every day to health care that older and disabled people would otherwise go without. The doctors were wrong. Medicare wasn't the end of life in America, etc. It was one of the finest achievements of the 20<sup>th</sup> century, and it keeps on giving.

## 22. Medicare Needs an Alert Watchdog

*By Douglas Gould, President, Douglas Gould and Company*

Medicare has done so much good over the last 50 years, but it needs a tough watchdog to keep it effective in the years to come. Case in point would be the so called “Improvement Standard,” in which care managers and other Medicare decision-makers determined that benefits should be cut off if a beneficiary’s condition was not “improving.” It wasn’t in the law, nor was it in the regulations, and yet it was being enforced. It limited the length and quality of life for hundreds of thousands of people.



I saw this policy misapplied firsthand, when physical therapy was withdrawn for my 88 year-old father after a hospitalization because he wasn’t going to improve. He was however, going to stay active, have better balance, and maybe stay alive a bit longer.

The Center for Medicare Advocacy’s successful “Jimmo” class action lawsuit had the policy removed from Medicare manuals, but the need still exists for a culture change within the Medicare system that incorrectly assumes that denials based on lack of improvement is ok. Without constant vigilance and pressure things will never fully change. The Center for Medicare Advocacy serves as the best watchdog Medicare can have, and it needs to be supported so it can have an even greater impact for the program’s next 50 years.

## 23. Medicare Should Fill Gaps in Coverage for Oral Health and Other Key Health Services

*By Judith Stein, Executive Director, Center for Medicare Advocacy*

When Medicare was enacted in 1965, over half of people over 65 had no health insurance. The fact that Medicare provided affordable, basic health insurance was a huge boon for older Americans and their families. (People with disabilities were added to the program in 1972.) However, certain coverage gaps were not filled.



Missing coverage components included routine dental, eye, and hearing care – including glasses and hearing aids – prescription drugs and preventive services. While major inroads have been made in providing coverage for medications and preventive services, eye care, hearing aids, and dental care – no matter how extreme the need – are still not covered by Medicare. These are all key to health and well-being, particularly for older people and people with disabilities, who are often more vulnerable to infection, malnutrition, and serious illness.

Unfortunately, Medicare contractors regularly deny coverage for pretty much any care that has to do with the jaw or mouth. This was not the intent of the law. The Center for Medicare Advocacy frequently hears from beneficiaries with urgent health issues who cannot obtain extraordinarily complex dental and oral health services due to inappropriately broad Medicare denials. Here is an example of a message recently received from a Medicare beneficiary:

*I'm in desperate need of dental treatment. I was just talking to an advocate for Sjogrens Disease in Washington State about what a shame it is that I can't get needed implants for my mouth. I ended up having to get all my teeth pulled and get dentures that have failed miserably. I haven't been able to eat a solid meal for months.*

To truly honor Medicare's 50<sup>th</sup> Anniversary, coverage should be provided for these critically needed health services.

## 24. Medicare and Prescription Drug Coverage

When Medicare began to provide coverage for prescription drugs almost 10 years ago, under Part D, millions of people who previously had no drug coverage were able to access needed medications. By any measure, the drug benefit has helped many people. While drug coverage was a key missing ingredient in Medicare coverage until then, the **way** drug coverage is provided in Medicare raises ongoing concerns, particularly as some would view it as a model for other Medicare coverage and delivery systems.



The Part D prescription drug benefit is only available through private, commercial plans – stand-alone prescription drug plans (PDPs) and Medicare Advantage plans that offer the Part D drug benefit (MA-PDs). Proponents of this market-based approach argue that competition has kept overall Part D costs well below initial cost estimates. Other analysts, however, note that costs are lower largely due to factors other than its market-based structure, including the widespread increase in use of generic drugs over brand-name drugs, a number of blockbuster drugs coming off patent (meaning that cheaper, generic equivalents usually became available) and fewer than expected people enrolled in Part D plans.

This private commercial structure requires Medicare beneficiaries to navigate among an average of 30 plan choices, most with 5 different tiers of cost-sharing, with varying formularies and utilization management rules (tools used to restrict or steer access to certain drugs). Along with a complicated private-only plan design that has led to significant beneficiary confusion and less than optimal selection by many enrollees, the federal legislation that created Part D also prohibited the Medicare program from negotiating prices with drug manufacturers, and moved individuals dually eligible for Medicare and Medicaid into the new drug benefit. Among other things, this means that drug manufacturers no longer have to provide rebates for the cost of drugs for these individuals as is required in the Medicaid program. With new “breakthrough” drugs entering the market (like last year’s effective but high-priced Hepatitis C drugs), will this piecemeal, market-based Part D program be able to adequately control costs in the future? Is there a more consumer-friendly, cost-friendly way to provide a drug benefit to Medicare beneficiaries, such as allowing the Medicare program itself, rather than a private plan, to offer the drug benefit?

A recent briefing in Washington hosted by the National Academy of Social Insurance asked the question, “Medicare Part D — A Beacon or a Warning Light for the Future?” The hazard lights on the Part D bus are flashing, it’s time to look under the hood.

## 25. Medicare Can Be a Source for LGBT Inclusive Medical Care

By LGBT Aging Advocacy (Connecticut) and CT TransAdvocacy Coalition



A substantial number of physicians serving Medicare participants do not know the sexual orientation or gender identification of the LGBT elders they care for, although this can be a critical factor for their patients' health and health care. This is particularly important to keep in mind as the current generation of older LGBT people were usually not able to express their true selves.

Indeed, the 2014 SAGE report *Out and Visible: The Experiences and Attitudes of Lesbian, Gay, Bisexual and Transgender (LGBT) Older Adults, Ages 45-75* reports that 40% of LGBT persons in their 60's and 70's say that their health care providers do not know their sexual orientations. (LGBT Aging Advocacy, Connecticut.)

Medicare coverage is based on health care needs. Sexual orientation should be irrelevant to coverage determinations. However, sexual orientation and activities **can** be relevant to one's health and health care needs. It's important for providers to reach out to their patients in appropriate and inclusive ways to discuss these important aspects of their lives and health. Training is available through the National Resource Center on LGBT Aging.

So too, transgender people should also be able to receive health care and Medicare coverage based on their medical needs, not on their gender identification. "Treat the body, not the gender" is how transactivists summarize the distinction. Medicare recently rescinded its coverage rule that denied coverage for gender identification-related surgery and services.

Medicare coverage is available for most reasonable and necessary health care, but obtaining access to coverage and quality health care depends on providers doing their part to create an environment in which LGBT persons are able to be fully themselves in an accepting environment.

## 26. Medicare Needs a Timely Way for Patients to Appeal Hospice Denials

By Howard Back, a Medicare Beneficiary from California

Medicare funding for hospice services is a wonderful thing.

But there is a missing element in the system: there is no timely way a hospice patient can appeal failure of a hospice to provide a drug, or piece of equipment or other service that the patient's physician prescribes.



Many hospices, both for-profit and not-for-profit, may make decisions that put their bottom line ahead of the patient's best interest. A hospice may take Medicare's per diem payment, but not provide the care and services necessary to ensure that dying patients do not suffer and that their families are adequately and appropriately supported.

I know, because I have "been there." My wife lay dying in February 2008, in agonizing pain from spinal stenosis, severe osteoporosis, diabetes, rheumatoid arthritis and other conditions. Increasingly large doses of morphine and fentanyl failed to provide pain relief. Her personal physician asked her hospice provider to start her on Actiq "lollipops," the only way he could suggest to alleviate the pain. Hospice refused.

I immediately bought the medication (it cost \$5,940). The "lollipops" helped – giving temporary relief from break-through pain. My wife died four weeks later. I requested payment for the medication. Hospice refused.

I have been trying since 2008 to recover the moneys spent for the "lollipops." Finally, I initiated a lawsuit.

Medicare told the court that if a Medicare beneficiary believes he or she has been inappropriately denied a necessary service by a hospice, the person can file a claim, on Form CMS-1490S. The Court of Appeals accepted that and dismissed the case as moot. See: *Back v. Sebelius*, 684 F.3d 929 (9th Cir. 2012). But this is not an appeal process that has any value or merit; more than two years after that court decision, I continue to get nothing but a series of run-arounds.

At the moment there is no legitimate process that lets a Medicare beneficiary appeal a hospice denial. **There should be one!**

What is needed is for a hospice patient to be able to get an expedited (within 24 hours) review of a hospice refusal to provide necessary care. Regulations should require that a patient receive a notice of his/her right to an expedited appeal when one enters hospice care. This would be an important protection for persons who are dying.

I continue to seek action by Medicare, not for the dollars involved, but out of principle. I worry about what could happen to other people like my wife.

My wife was fortunate; we were able to pay for the expensive medications that hospice denied; others may not be able to.

## 27. Medicare Covers Preventive Care

Medicare is not just an acute care benefit. It covers skilled maintenance nursing and therapy; in some cases it covers long-term home care. Also, importantly, Medicare covers many preventive services, which, when utilized, can help limit the need for more costly future care.



Most Medicare beneficiaries know about the "Welcome to Medicare" physical, but Medicare covers many other important preventive services. Some of the other services include annual mammograms for women age 40 and up, colorectal cancer screenings for people over 50 or at high risk, and prostate cancer screening tests for men over 50. Several other screenings and tests are covered, including diabetes self-management training and screening tests, HIV screening tests, cholesterol tests, and glaucoma screenings. Medicare covers medical nutrition therapy services for some patients. Flu, Pneumonia and Hepatitis B vaccines are covered. Importantly, in our changing health landscape, Medicare also covers smoking and tobacco use cessation counseling, and depression screenings. Thanks to the Affordable Care Act, the number of Medicare-covered preventive services has increased, and most do not require a co-pay.

Beneficiaries should take advantage of the preventive services covered by Medicare. An ounce of prevention is worth a pound of cure.

## 28. Medicare Makes Health Care Affordable

*By R.B, A Medicare Beneficiary from New Mexico*

"If it were not for Medicare I could not possibly afford the health care that I get."



## 29. Medicare Needs to Address Enrollment Confusion and Notify People When it's Time to Enroll



Our country has a patchwork of different types of health insurance coverage, including individual insurance policies, employer-based insurance coverage plans available through the new Affordable Care Act, Medicaid, and Medicare – the country's flagship insurance program. While some people go without health insurance altogether, others have different types of coverage over the course of their lives, some people may even have more than one type at a time.

The Medicare program has complicated rules about how other health insurance interacts with, or "coordinates" with Medicare coverage. This includes health insurance that someone has as a result of current, active employment. In certain circumstances, individuals can stay on their employer-based health coverage and forgo enrolling in Medicare Part B without penalty, until they retire. Unfortunately, people are often unaware of these complicated rules or get bad information about how they work. As a result, they may have to pay premium penalties and may face many months, or longer, without access to Part B coverage.

To add to this complexity, *when* someone chooses to collect Social Security retirement benefits can affect the timing of, and information they receive about, enrollment in Medicare. Eligibility for Medicare is based, in part, on an individual's work history (or that of a spouse) as recorded by the Social Security Administration (SSA). While most Americans are eligible for Medicare at age 65, full retirement under Social Security is increasing overtime to age 67. Further, while individuals can choose to take *early* Social Security retirement, at age 62, Medicare will still not begin until age 65. In addition, many people choose not to collect Social Security until they reach full Social Security retirement age, or beyond.

All this can create significant confusion about enrolling in Medicare. An error in timing can mean individuals will be subject to premium penalties, limited enrollment opportunities, and/or delays in coverage if they do not enroll in Parts A and B when they are first eligible. Yet, little or no notice about Medicare enrollment is provided to the ever-increasing number of individuals who don't collect Social Security retirement when they turn 65.

## 30. Medicare Provides Hope for Patients and Families

*By L.W., the Spouse of a Medicare Beneficiary from Florida*

Medicare has helped my husband to go to the hospital, Dr. Visits, Prescriptions. It has given my husband a fighting chance to LIVE. Thank God for Medicare.



## 31. Medicare Gives Freedom, Flexibility and Choice

*By Mary Ashkar, Senior Attorney, Center for Medicare Advocacy*



Prior to becoming eligible for Medicare, many Americans who have health insurance through employment are enrolled in some type of managed care plan. Health Maintenance Organizations (HMOs) are one of the most common types of managed care plans. Generally, individuals enrolled in HMOs are restricted to networks of providers, and must see certain health care providers to get coverage for their medical care. In addition, individuals in HMOs must obtain a referral from their primary care physician before obtaining treatment from a specialist such as an oncologist, a rheumatologist or a psychiatrist.

This lack of freedom and choice disappears when someone becomes eligible for Medicare and chooses the traditional Medicare program. Unlike Medicare Advantage, which offers Medicare's private plan options, traditional Medicare includes open access to most health care providers throughout the country. In Medicare Advantage, as in most HMOs, if you require non-emergency or non-urgent services while you are out-of-network, you will likely have to pay 100% for those services. Traditional Medicare, on the other hand, travels with you.

With traditional Medicare you can go to any doctor or hospital in the United States that accepts Medicare, so you have more choice and don't have to worry about being out-of-network. This is particularly important for "snowbirds," people who spend a large amount of time traveling away from their homes, and people who want to be cared for by particular providers or hospitals, or near relatives in different parts of the country. In addition, in traditional Medicare you don't need a referral to see a specialist so you avoid this potential roadblock if you need a specialist for necessary health care.

Older and disabled Americans in traditional Medicare do not have to worry about networks of providers, the costs associated with going out-of-network, or getting referrals for the specialized health care they need. Instead, they can take their accumulated wisdom and experience and focus on doing something awesome. So – for those of you who are eligible, welcome to Medicare! Whatever your purpose in life, you now have more freedom, flexibility and choice with traditional Medicare.

## 32. Medicare is a Success – And Americans Are Willing to Pay for It

*By Marilyn Moon, Institute Fellow, American Institutes for Research  
(and Center for Medicare Advocacy Luminary/Advisory Board)*

Medicare is a successful program that is extremely popular with its beneficiaries who rank it higher than others do their private insurance plans. And polls always show that people are willing to pay more for Medicare. So why do politicians persist in acting as though Medicare somehow must live within the current spending parameters?



When Medicare was enacted, analysts at the time envisioned that higher taxes would be needed periodically to address the growth in enrollment and higher costs that would be likely. It was thought to be irresponsible to set initial taxes too high since that would be a drag on the economy. But the payroll tax rate that goes to Part A has not increased since 1987, when the average cost of the Medicare benefit was much less than what it is today and the number of beneficiaries enrolled was just 60 percent of today's number.

Care is needed to make sure that the program is as efficient as possible and that we are getting a good deal for our money, but my insight is that when something works, when you value it highly, you need to be willing to pay for it. Medicare is covering a larger and larger share of the population—and an even higher proportion of those in our population who are most vulnerable to health problems. Americans are willing to pay; we just need to get the politicians away from the mantra that it is possible to get something for nothing.

### 33. Medicare is a Private–Public Partnership

Most people think Medicare is a government program. That’s only partly true. While Congress created Medicare, and continues to develop Medicare coverage and appeal rules, decisions to pay claims are actually made by private companies. The government does not make those decisions. This was one of the compromises made in order to pass Medicare in 1965 – and the public-private partnership continues to date.



Indeed, the entities granting or denying coverage, and those deciding whether or not to pay claims, are mostly private insurance companies. For example, Anthem is the parent company of “National Government Services,” one of the major Medicare claims administrators. Another Medicare administrative contractor, “MAXIMUS,” is a for-profit company that helps state, federal and foreign governments administer programs.

In addition, about 30% of Medicare beneficiaries are enrolled in private “Medicare Advantage” plans. These plans are also run by private companies, mostly within the insurance industry, and they make Medicare initial coverage decisions for their enrollees. We know that when Medicare is working right and covering necessary care, everyone is content. But, if coverage is denied unfairly... don’t blame the government. It’s probably not “Medicare” that made the decision; it’s most likely a private insurance company that’s paid by Medicare to make coverage decisions.

### 34. Medicare Helps People Help Others

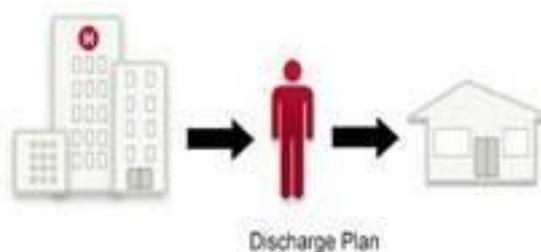


*By P. B., a Medicare Beneficiary from Colorado*

I would not have been able to have a career, care for others at work, care for my mother after my career or be able to NOT be a dependent at retirement time. All this is because of a prescription that is allowed because I have Medicare. I have paid into Medicare all my life! Thank goodness!

### 35. Medicare Helps Patients Transition from One Care-Setting to Another – But More is Needed

Many healthcare institutions are required to provide discharge planning for their Medicare patients as part of their “Conditions of Participation” in the Medicare program. Under the Medicare program, discharge planning services are required for hospital inpatients, long-term care hospital and rehabilitation inpatients, skilled nursing facility residents, patients in swing-beds, and hospice patients. Discharge planning services may include:



- Helping a beneficiary and his or her family and friends think through the beneficiary’s needs in the care setting to which he or she is transitioning;
- Determining whether the beneficiary will need help managing medications;
- Determining whether the beneficiary will need a visiting nurse or therapy services, such as physical therapy, occupational therapy, or speech therapy;
- Considering whether the beneficiary will need home health aides to assist with bathing, dressing, or preparing meals;
- Determining if the beneficiary will need assistance with obtaining and paying for necessary medications;
- Determining whether the beneficiary will need community services, such as transportation to various activities such as appointments with medical providers, getting to events such as religious services or recreational activities;
- Considering whether the beneficiary will need assistance in managing his or her financial and legal affairs;
- Considering if the beneficiary will need assistance in understanding their rights under the Medicare, Medicaid, and Older Americans Act programs.

Unfortunately, actually having the identified discharge services arranged and delivered remains a problem. The discharge planner is supposed to make sure the required services are reasonably available in the beneficiary’s community and that the beneficiary and family/friends are aware of the options. It is far less clear that the services have to actually be set up with quality providers before patients are discharged. All too often, beneficiaries end up in poor quality settings too far from their community, or needed home health services are not in place. Medicare beneficiaries should work with their primary care doctor, long term care ombudsman and community outreach programs, along with their discharge planners, to ensure quality transition care is arranged.

### 36. Medicare Provides Silent Support for Generations

*By an Anonymous Beneficiary from Iowa*

In the last year I lost both of my parents. They were 92 and 94 years old when they passed away. They had been married for 69 years and died within less than 10 months of each other. In the last decade of their lives, due to their slowly declining health, my parents had to sell the home that my father built, their car, Dad's beloved truck, and their boat. They first moved in to an assisted living facility where they received home health services. They continued to decline and eventually moved into a skilled nursing facility. Over the last months of their lives, they both required multiple ambulance trips to the hospital, lengthy hospital stays, several courses of physical, occupational and speech therapy, lab work, pain medications, and eventually hospice care.



I was an advocate for my Mom and Dad as well as their power of attorney. I was involved with helping to coordinate my parents' care and making sure they had the required medically necessary services in place. The last few years have been a rollercoaster of emotions as I watched my Mom and Dad decline and eventually pass away. Fortunately, not once did I have to worry about access to or coverage for the myriad health care services my parents needed. Medicare was there through the ups and downs of their lives as a silent supporter allowing me to focus all of my time and energy on loving my parents and making sure they were well cared for in the last years, months, days and eventually seconds of their lives.

As my parents went through their decline, I too became eligible for Medicare. I hope the Medicare program continues to be strong for me and a silent supporter for my children so they can focus on what truly matters most in life as my final days roll round and the end comes for me.

### 37. Medicare Should Be For Everyone

**LOVE IT!**  
**IMPROVE IT!**  
**MEDICARE**  
**FOR ALL!**

*By V.W., a Medicare Beneficiary from Colorado*

I am a 77 year old woman. I only used Medicare back in the earlier part of this decade, in 2002 and 2005, when I had accidents that required surgery to repair broken bones. The "out of pocket" costs for those surgeries were in the \$10,000+ range each. Thanks to Medicare, my co-pay was \$500 or less. I do not take any medications, or currently have any health issues, which is fortunate.

Most people my age whom I know take many prescription drugs and have health issues. I am grateful that I had, and continue to have Medicare, as I could not afford to pay for

private insurance coverage before I was eligible for Medicare. Back then I was simply “uninsured” as I was self-employed and could not afford the premiums.

Like me, many people who don't have insurance coverage at their jobs are uninsured. I would like to see Medicare extended to everyone as it is a much more affordable option than private insurance.

### **38. Medicare Makes Hard Things a Bit Easier**

*By Jenny Gore Dwyer, Washington State*

In 2005 my husband was diagnosed with ALS. ALS is also known as Lou Gehrig's disease...or "the Ice Bucket Challenge" disease...remember last August when everyone was dumping ice over their heads? That was for ALS.



ALS is a horrible disease where the nerve cells that tell the muscles to move, stop working, resulting in complete paralysis. When my husband was no longer able to work due to his paralyzing ALS, he applied for his Social Security Disability and Medicare.

I was very leery about "entering the system" and having Medicare provide for my husband's medical care needs. I'll be totally honest here...we were both pleasantly surprised! Yes, there were wait times, and yes some denials, but we were also given great guidance on how to work through issues. Nine times out of ten, what we needed was delivered as expected.

One choice people living with ALS must make is deciding to go on an invasive ventilator. A vent is needed when the diaphragm muscle becomes too paralyzed for someone to breathe on their own, and the ventilator breathes for them.

My husband chose against the invasive ventilator, and opted for Hospice care. Upon entering Hospice care, that's when we noticed the most benefit. We had care and medications coming to us. I didn't need to spend my energy dealing with ordering meds, equipment, or coordinating care. That was all provided for us, through our Medicare benefits.

With a disease like ALS, everything about it is hard. Nothing is easy. But, Medicare helped make a horrible disease a bit easier.

Happy 50th Anniversary and thank you Medicare for your help, guidance and caring people that you provided to us during my husband's time in Hospice, and at the end of his life.

### 39. Medicare Offers Benefits That People Can Count On

One of Medicare’s key strengths, compared with most other types of health insurance, is that its benefits are “defined.” The Medicare law, regulations and policies set out the minimum scope of benefits that the program must cover and outlines the out-of-pocket costs for which beneficiaries are responsible.



For example, as long as certain requirements are met, Medicare beneficiaries are eligible for hospital, skilled nursing facility, home health, and hospice benefits under Part A and a range of preventive benefits and services under Part B – including physician visits, lab tests, durable medical equipment and other items and services. In addition, beneficiaries can’t be charged more than certain designated deductibles, copays and coinsurance amounts.

One of the most prominent Medicare “reform” proposals, so-called “Premium Support,” would change Medicare from this kind of a defined benefit program, to a defined contribution program. This means, instead of a clear set of guaranteed benefits, Medicare beneficiaries would essentially be given a voucher for a certain dollar amount (the defined contribution) with which they could shop around on the private market to find Medicare coverage. While such proposals vary, and some purport to retain at least some guaranteed benefits, any voucher program would likely erode the scope of coverage – and protections related to out-of-pocket costs – that Medicare beneficiaries now have in both traditional Medicare and Medicare Advantage plans.

Private insurance does not have a history of working well for older and disabled people. That’s why Medicare was enacted. We should resist calls to return Medicare enrollees to the whims of the private market. Been there ... didn’t work.

Medicare’s guaranteed, defined benefits are a blessing for older people and people with disabilities. This key feature of Medicare must be protected.

## 40. Medicare Lets People with Disabilities Live Their Lives

*By C.G., California*

My younger sister who has now passed became very ill at the age of 12 years old with kidney disease. She eventually had both of her kidneys removed, and Medicare was there for the long haul. She also came down with a severe case of Rheumatoid Arthritis, and Lupus.



My sister still got an education, even though she was [often] too sick to get to school. She was determined, she was very intelligent... she became a nurse in the operating room, and when she could no longer do that because she needed to stay away from infectious diseases, she became a teacher of nursing. Unfortunately my sister lost the battle at 32 years old, but she was able to survive because of Medicare.

I will always be grateful we have Medicare to rely on in hard times.

## 41. Medicare's Appeals Process Is an Important Beneficiary Protection that Must Be Fixed



One of the most fundamental rights set out in the Constitution is the right to due process of law when government action harms an individual. "Due process" means both notice and an opportunity to be heard. In other words, individuals are entitled to be informed about a government action, as well as their right to challenge such action.

As a government administered program, Medicare provides due process to Medicare beneficiaries through an administrative appeals system – a five level process through which an individual can challenge certain denials or terminations of coverage. In addition to providing due process to beneficiaries, the Medicare appeals process serves as an important check on providers, contractors and program rules that might work to unnecessarily and inappropriately restrict coverage and care.

There are currently problems with the due process rights afforded to Medicare beneficiaries, both because of the structure of the appeals system and how the system works in practice. On the structural side, there are limits on one's ability to appeal coverage denials. For example, in many instances, in order to have an appeal right at all, an individual must first obtain the services or item in question and accept the related financial risk. In addition, in certain circumstances, such as issues relating to the hospice benefit, there is no meaningful avenue to challenge disagreements about coverage.

On the practice side, experience shows that the decision-making by Medicare Contractors at the first two levels of review most frequently “rubber stamp” denials. Beneficiaries do not have a fair shot at having their denial resolved until the third level of review, a hearing conducted by Administrative Law Judges (ALJs). Further, due largely to an increase in provider Medicare audits there is a tremendous backlog of appeals at the ALJ level, leading to Medicare beneficiaries experiencing undue delays in having their cases heard and fairly considered.

These issues must be resolved in order to provide Medicare beneficiaries access to the full and meaningful due process rights to which they are entitled.

## **42. Medicare Provides Economic Security**

*By L.S., a Medicare Beneficiary from New York*

Medicare has kept my family from being homeless. My husband had three different kinds of cancer, with surgery and radiation. He had three necessary replacements – hip and both knees and he had to have back surgery. Medicare took care of all the bills. There is absolutely no way that we could have gathered that kind of money and I am talking hundreds of thousands of dollars. We should have universal health coverage as they have in Canada – or Medicare for all people. Medicare absolutely extended my husband's life and I will be forever grateful for that. When I hear that people... want to privatize Medicare (and that really means to get rid of it), I become enraged.



## **43. Medicare Should Be Allowed to Work**

*By Lisa Hall, Appeals Administrator, Center for Medicare Advocacy*

After beginning to work for Medicare beneficiaries, I was amazed to realize that Medicare, which is a federal health care insurance that we are all entitled to and count on being there for us one day, spends so much time, money and energy trying to limit health care coverage – often with denials stating that care is not reasonable and necessary or that patients are chronic or stable or have longstanding conditions which are unlikely to improve. Though with advocacy, it's amazing how many Medicare denials are overturned in the appeals process.



Now that I am getting closer to retirement age myself, of course, these issues are becoming even more of a concern for me personally. We should all be dedicated not only to preserving Medicare for elders and those with disabilities, but also to advocating to be sure that it's the program President Johnson intended it to be when we all need it, too.

## 44. Medicare to the Rescue

*By D.C., California*



Last October I awoke early one morning with a severe pain radiating from my abdomen to my back. I had never had a pain quite like this before. I had recently moved, and my new primary care physician was not available. I had had a gastroenterology evaluation for acid reflux (negative) a few weeks before, so I went to that specialist for the pain and violent nausea. This physician/specialist immediately ordered me into Peninsula Hospital in Burlingame via the Emergency Room.

There I was diagnosed with a ruptured gall bladder, including infection in my pancreas and liver. I had no choice but to spend the next nine or ten days in Peninsula Hospital previous to abdominal surgery combatting the infections in the two vital organs, and post-operative. While there, I decided that I just could not worry about this major expense and prayed that Medicare and my private insurance would cover it. Medicare did come to the rescue and the private insurance did cover a lesser amount.

If Medicare had not been there, I would have been bankrupt in those 10 days of fine medical care. Many times since I have thanked God for Medicare, medical insurance and the many wonderful people who cared for me in this totally unexpected situation. My Medicare... saved my life, and saved me from financial ruin...

I would like to see Medicare for all US citizens, and an insurance program with single payer support. Yes, I would be more than willing to pay more taxes to do this for my fellow Americans.

Let's support Medicare, not bash and cut it!

## 45. Medicare May Be Helpful in the Event of a Disaster or Emergency

When a Medicare beneficiary lives in an area that has been declared an emergency or disaster by the President, a Governor, or the Secretary of Health and Human Services, the usual Medicare rules for coverage and related concerns may be changed in order to assist those in need. Below you will find specific information, if you have further questions, call 1-800-MEDICARE.



**Getting Care from Doctors or Other Providers:** You may be able to get Medicare coverage for health care at an airport from a military provider, or you may be able to see an out-of-network provider if you are in a Medicare Advantage plan, or you may not have to meet prior-authorization rules.

**Obtaining Prescription Drugs:** If you can't get to your usual pharmacy, you had to leave your home without your medications, or your medications have been lost or damaged, your Medicare drug plan can find another network pharmacy nearby. You can move your medications back to your regular pharmacy when the disaster or emergency ends.

**Paying Your Premium:** If you are in a Medicare Advantage Plan (Part C) or Medicare Prescription Drug Plan (Part D), you're still responsible for paying your premium on time, even when there is an emergency or disaster. If you don't pay, your plans may dis-enroll you. If you are dis-enrolled, you may be able to ask Medicare to reconsider the decision and get your coverage back.

**Getting Dialysis Treatments:** If you have Traditional Medicare, call your ESRD Network (or call 1-800-MEDICARE to get their contact information. If you have a Medicare Advantage Plan, contact your plan directly.

**Getting Chemotherapy or Other Cancer Treatments:** If you have Traditional Medicare, call the National Cancer Institute (NCI) (1-800-4CANCER) to help you find other cancer care providers. If you have a Medicare Advantage Plan, contact your plan.

**Replacing a Lost Medicare Card or Medicare Plan Membership Card or Temporarily Change your Address:** If you have Traditional Medicare, contact Social Security or call 1-800-772-1213. If you have a Medicare Advantage Plan, contact your plan directly.

**Replacing Lost or Damaged Durable Medical Equipment or Supplies:** If you have Original Medicare, Medicare will usually cover the cost to repair or replace your equipment or supplies. Generally, Medicare will cover the cost of rentals for items during the time your equipment is being repaired. Call 1-800-MEDICARE to find out about how to replace your equipment or supplies. If you have a Medicare Advantage Plan, contact your plan directly.

## 46. Medicare Must Continue to Evolve – Add Coverage for Hearing Aids

*By Max Richtman, President & CEO*

*National Committee to Preserve Social Security and Medicare*

As we celebrate Medicare's 50th anniversary, it's important to remember that one of Medicare's most important hallmarks is the program's long and successful history of adapting to the changing demographic and health security needs of America's seniors.



Ten thousand Americans turn 65 each day. A 65 year old senior today may live another twenty years, contrasted with a 65 year old senior in 1965 who was expected to live less than ten years. Unfortunately, living longer (for those who do see increased longevity) does not mean living healthier.

Hearing loss is the third most prevalent chronic health condition facing older adults. Yet an estimated 70% of Americans with hearing problems between age 65 and 84 are not using hearing aids. With an average cost of \$3,000 – \$7,000 and zero coverage from Medicare, it's little surprise that for a senior collecting an average monthly Social Security check of \$1,287, hearing aids are seen as a luxury they simply can't afford. In truth, hearing loss which goes untreated can lead to depression, cognitive impairment, life-altering falls, social isolation and a lack of independence. This not only threatens the well-being of seniors but also carries serious implications for the Medicare program overall. It's a threat our nation can no longer afford to ignore.

For millions of American seniors and the Medicare program they depend on it's clear that silence is definitely not golden. As our nation marks the 50th anniversary of Medicare, the time is now to expand the Medicare program starting with coverage of hearing aids to ensure our growing elderly population remains as healthy as possible.

## 47. Medicare Should Include Drug Coverage in the Traditional Program (and Negotiate Prices)

By T.P., PhD, a Medicare Beneficiary from Ohio

I would like to express my view that it would be cheaper and more efficient for all to have drug coverage as part of Medicare itself and not as a separate plan handled by private insurance companies. In addition, if the government can negotiate drug prices for veterans through the Veterans Administration, they should be able to negotiate prices for seniors and others covered by Medicare. Currently the drug companies are among the most profitable corporations in the world at the price of taking advantage of sick people who must choose between living expenses (food, housing, utilities, etc) and drugs.



## 48. Medicare Should Properly Cover Physical, Speech, and Occupational Therapies



While the Medicare Act covers physical, speech, and occupational therapies in various community-based and facility settings, coverage is often denied or inappropriately limited.

Most often, this is because the individual requires therapy to maintain her condition, or slow deterioration. When an individual is not going to improve, providers too often decline to provide therapy or discontinue services, believing Medicare will not cover “maintenance therapy.” While this has never been legally correct, Medicare claim administrators have reinforced the belief for years with incorrect coverage guidelines and frequent claim denials.

In January 2013, a national class action lawsuit that challenged Medicare denials for lack of improvement was settled in a federal court case, *Jimmo v. Sebelius*. The Jimmo Settlement makes it clear that Medicare is equally available for skilled therapy that is needed to maintain an individual’s condition, or slow deterioration, as it is for therapy that will improve the condition. This is particularly important for people with long-term conditions, illnesses, and injuries – such as Parkinson’s disease, Multiple Sclerosis, stroke, spinal cord injuries, brain injuries, and ALS.

Despite the Jimmo Settlement, which is the law of the land, people are still regularly denied Medicare and access to necessary therapy when they cease to improve, have an underlying condition from which they won’t improve, or do not improve within a particular period of time. Medicare Contractors need to address this inequity by properly covering claims for skilled maintenance therapies. CMS needs to monitor their Contractors’ behavior to ensure beneficiaries have fair access to Medicare and necessary care.

In addition to this ongoing problem, outpatient therapies are subject to a \$1,940 annual Medicare payment cap. While exceptions to this cap are available, providers often will not continue beyond the \$1,940 mark because of “the hassle” and for fear of being audited. This annual payment limit creates significant barriers to necessary therapy for people with ongoing conditions and injuries.

When we think about proper coverage for therapy and its value for people with devastating conditions, we should think about former Congresswoman Gabby Giffords, who was catastrophically injured in a shooting. Fortunately, because of years of therapy, she is now walking and talking. Everyone deserves the same opportunity if they are injured or ill.

Medicare law supports coverage for therapy to improve **and maintain** an individual’s condition. Medicare providers should provide the therapy, Medicare Contractors should cover the claims, and Congress should eliminate the arbitrary cap on outpatient physical, speech, and occupational therapies.

#### **49. Medicare Beneficiaries are Grateful (A Compilation of Beneficiary Testimonials)**

##### **From Beneficiaries throughout the Country**



*A.P., Medicare Beneficiary, Washington State*

“I have a pre-existing condition (Epilepsy) and if it wasn't for Medicare, I don't think I could afford the medications needed to control it”

\_\_\_\_\_

*L.F., Medicare Beneficiary, Colorado*

“Medicare has helped me in so many ways! It helped to pay for my pacemaker, plus doctor visits, medicine etc.”

Us older folks that are on disability need Medicare!!!”

\_\_\_\_\_

*E.R., Medicare Beneficiary, California*

“Medicare has enabled me to receive emergency services I could not have otherwise

*J.S., Medicare Beneficiary, California*

“I had NO medical insurance until I turned 65 and became eligible for Medicare. Since then I have had several expensive medical problems, plus chronic glaucoma. Without Medicare I don't know how I would have been able to get the care I needed.”

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*M.G., Medicare Beneficiary, Florida*

“I am diabetic and Medicare helps pay for my supplies, medications, and doctor visits. I could not manage without Medicare.”

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*P.L.D., Medicare Beneficiary, NY*

“Medicare covered all the medical bills when my husband fought pancreatic cancer. We could never have afforded the medicines and medical care he required. Thank God for Medicare.”

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*S.S., Medicare Beneficiary, Texas*

“I depend on Medicare to help me when I visit the doctor and for my medications. It is great for retired people. I am a senior citizen and I have worked all of my life, even after retirement age.”

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*P.J., Medicare Beneficiary, Tennessee*

“I get my primary medical care through Medicare, it has been great!”

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*D.G., Medicare Beneficiary, Pennsylvania*

“Before we were eligible for Medicare our finances were almost ruined by high health insurance premiums. Although we still have a fairly large cost to pay for supplemental insurance, Medicare has made a huge difference in our ability to remain adequately covered, particularly since the Bush Recession left our retirement funds badly diminished.”

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*K.M., Medicare Beneficiary, Minnesota*

“Even though I have to buy supplements, just having Medicare gives me a peace of mind that I have health insurance coverage. Medicare for all should be the healthcare policy of the United States. Medicare is far superior and much more cost effective than the market based health care insurance system we now have. For starters maybe we can have all persons fifty-five

older covered by Medicare and every five years reduce the age by ten years, so the next cohort with start at forty-five.”

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*P.M., Medicare Beneficiary, Texas*

“I’m a retired nurse who needed an organ transplant and was on a waiting list for almost 4 years, with Medicare as my insurance, I got that transplant and lived, but I had 2 siblings die 3 years apart in the 2000s simply because they didn’t have health insurance, though both worked, self-employed.”

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*J.P., Medicare Beneficiary, Minnesota*

“My husband was born with a birth defect in his heart that killed his mother. It was not detected until it was nearly too late! He was rushed to the Mayo Clinic in Rochester, Minnesota, where he had a 10-hour open-heart surgery. He was so fragile, he was in the ICU ten full days. We were dreading the bills, because we both took early retirement due to health issues and I get early retirement benefits from having taught for 25 years. Medicare saved our home! Without it, having lost our nest egg in the crash of 2008, we would have been unable to survive, financially.”

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*M.S., Medicare Beneficiary, Rhode Island*

“I was diagnosed with Multiple Sclerosis in 1986. Medicare has provided me with all the medications I needed and physical therapy. I don’t know what I would have done without it.”

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*D.S., Medicare Beneficiary, California*

“I would be dead without Medicare.”

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*C.S., Medicare Beneficiary, California*

“My 35 year old daughter gets Medicare because she is developmentally disabled and we, her parents, are retired seniors and get Medicare. Medicare means that we can pay rent AND buy groceries. And even go to a concert now and then.”

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*S.M., Medicare Beneficiary, Maryland*

“Medicare Is Such A Great System... It Works!!”

## 50. Medicare is 50! Help Keep It Strong for Future Generations

The 50th anniversary of Medicare has given us an opportunity to reflect on all it has accomplished to advance the health and well-being of families throughout the country. It also reminds us what could have been better – and what could still be improved.



We are thankful for the vision and fortitude of President Johnson and policy-makers in 1964 who insisted on a national program and refused its funding to segregated hospitals. We thank the 1972 Congress that added people with disabilities to those who receive Medicare coverage. We are grateful to those who expanded home health coverage in 1980 and added hospice coverage in 1982. We honor the years between 1965 and 1990 when Americans were willing to pay slightly more in payroll taxes to expand benefits. We recognize recent improvements to Medicare included in the Affordable Care Act – adding value to Part D drug coverage, new and no-cost preventive benefits to Part B, and years to the solvency of the Part A Trust Fund.

We remember the short-lived Medicare Catastrophic Coverage Act, which greatly added to coverage for nursing home care, added a respite benefit, and Part B drug coverage – and we regret its repeal. We are grateful for the 2006 addition of drug coverage, but regret it is only available through private plans. We appreciate all the support for Medicare and its anniversary, but regret the ever-increasing fragmenting and privatizing of the program. We are grateful for all Medicare has done to expand access to health care for older and disabled people, but fear it is becoming more oriented towards providers, insurance and pharmaceutical industries, and less focused on the needs and financial abilities of Medicare beneficiaries.

We celebrate Medicare with a renewed commitment to enhancing the well-being of older people, people with disabilities and their families. We call on those in power to honor Medicare by:

- Including a prescription drug benefit in Part B;
- Insisting on the best price for all Medicare-covered medications;
- Committing to parity between private Medicare Advantage and traditional Medicare payments;
- Adding dental, hearing aide, and vision coverage;
- Developing a long-term services and support benefit; and
- Ensuring access to a fair and accurate appeals system.

Medicare has been an incredible success. It's our turn to ensure it continues, in more than name only, and opens doors to health care and economic security for future generation.

# MEDICARE:

IMPROVING ACCESS TO HEALTH CARE SINCE

1965

## BEFORE MEDICARE

of those aged 65+

LESS THAN  
**50%**  
had insurance

**35%**  
lived in poverty

LIFE EXPECTANCY WAS ABOUT  
**8** years less for men  
**5** years less for women

## FUN FACTS

President Harry Truman was the first official Medicare enrollee



MEDICARE WAS OFFICIALLY SIGNED INTO LAW ON **July 30, 1965**

More than 19 million people enrolled in Medicare's first year

19M

Access to care increased by one-third

1/3

Poverty among older and disabled Americans decreased by nearly two-thirds

2/3

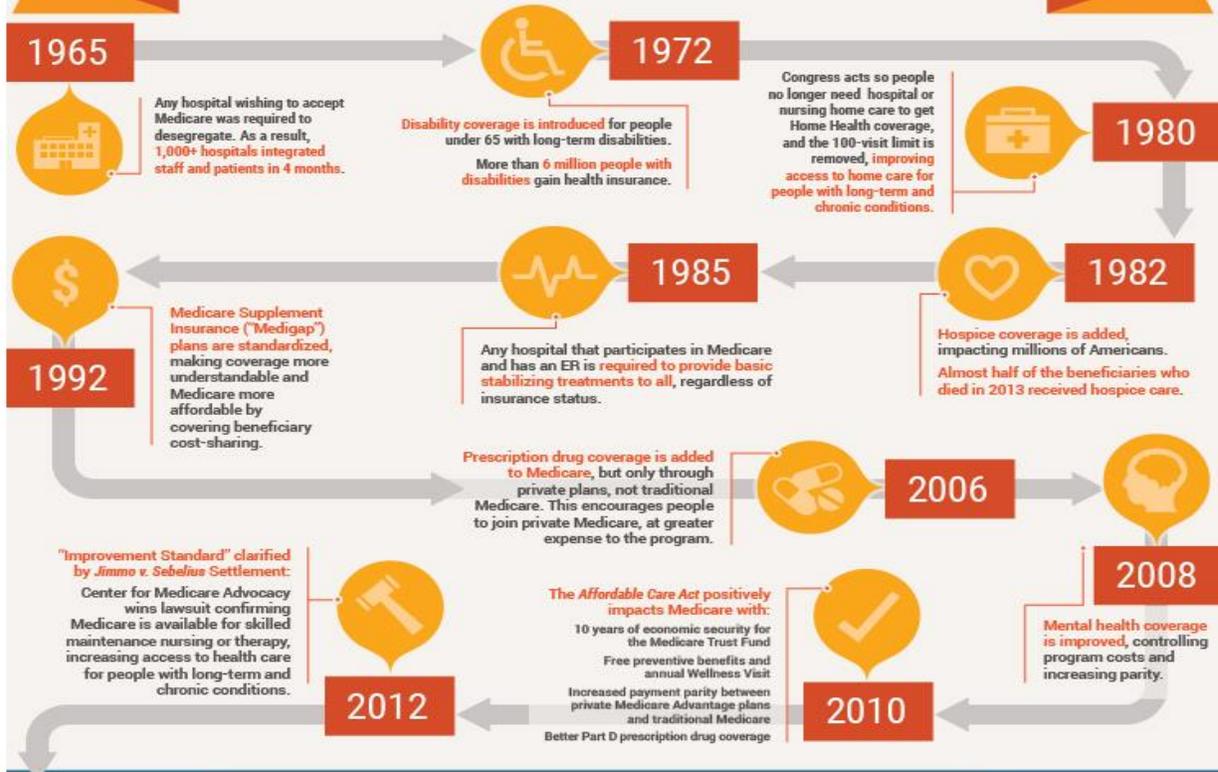
Personal economic security increased for older people and their families



\$3

The monthly Part B premium was only \$3.00

## MEDICARE HAS SERVED AMERICA WELL, AND INCREASED HEALTH EQUITY



Today there are more than **54M** people enrolled in Medicare.

## MEDICARE IS A SUCCESS. KEEP IT STRONG.

## TODAY

TO KEEP ITS PROMISE FOR CURRENT AND FUTURE GENERATIONS, WE NEED TO:

Pay private Medicare Advantage plans the same per-beneficiary rate as traditional Medicare, saving \$132 billion over 10 years.

Require Medicare to obtain the best prices for prescription drugs, including negotiating drug prices, saving \$141 billion over 10 years.

Add a prescription drug benefit to traditional Medicare.

Eliminate the unnecessary second level of the traditional Medicare Appeals process ("Reconsideration"), saving more than \$100 million per year in operating costs.

For other recommendations to strengthen Medicare, see [bit.ly/medicareolutions](http://bit.ly/medicareolutions). For more information visit [MedicareAdvocacy.org](http://MedicareAdvocacy.org) or follow us on Twitter @CMAorg and on Facebook at [facebook.com/MedicareAdvocacy.org](http://facebook.com/MedicareAdvocacy.org).

Image: Gaffert, Frank, President Truman, 1945. Wikimedia Commons. Web. 7 March 2015.

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Visit <http://www.MedicareAdvocacy.org/SaveMedicare>  
to donate securely online, or  
Mail your check, payable to the Center for Medicare Advocacy  
P.O. Box 350, Willimantic, CT 06226.

**Thank you!**

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## Center for Medicare Advocacy

The Center for Medicare Advocacy, Inc., established in 1986, is a national nonprofit, nonpartisan law organization that provides education, advocacy and legal assistance to help older people and people with disabilities obtain fair access to Medicare and quality health care. The Center is headquartered in Connecticut and Washington, DC with offices throughout the country.

The Center is staffed by attorneys, nurses, legal assistants, and information management specialists. The Center's work includes:

- Promoting access to rehabilitation, home health, and quality health care for people with long-term and chronic conditions.
- Advancing access to Medicare coverage and due process for individuals and all Medicare beneficiaries.
- Advocating in administrative, judicial, and legislative forums.
- Responding to thousands of telephone and email inquiries each year.
- Representing thousands of individuals in appeals of Medicare denials.
- Producing a wide array of seminars, webinars, electronic and print materials.
- Providing legal analysis, training and support nationwide.

The Center's staff act as consultants, presenters and trainers for groups that are interested in learning about health care rights, the Medicare program, Medicare coverage and appeals, nursing home resident rights, the Affordable Care Act, and related matters. Learn more at [MedicareAdvocacy.org](http://MedicareAdvocacy.org).

