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WHAT'S ON YOUR RADAR SCREEN?

Henry Barlow

As this issue of the Newsletter goes to press, we are in the final stages of the political campaigns for federal, state, and local offices. As members of Senior Lobby we should all be paying careful attention to the positions and policies of candidates. We should also be looking forward to the coming legislative sessions. All sessions, whether federal, state or local will address issues that impact the lives of older citizens as well as other age groups. The Senior Lobby, like many advocacy organizations, will only be able to impact the legislative process next year by reacting to proposals as they are introduced. Perhaps we may be able to work with some state legislators to introduce bills we support but the time frame is limited. If you know a legislator who shares our interests, please encourage him/her to meet with us soon after the election. As an advocacy organization, we need to be as proactive as possible. Legislators do not have a monopoly on ideas about issues which need to be addressed nor does the membership of the Senior Lobby. We do, however, need to share our best ideas and advance them as forcefully as we can.

Looking at my radar screen, I want to suggest that members of the Senior Lobby, other individuals and organizations that share our concerns, adopt a laser like focus on these topics:

1. Legislation that affects the pensions. This generation and future generations deserve a retirement system that does not leave them poor, deprived, or subject to the vagaries of an uncertain future. Social Security must be preserved as an earned benefit and not treated as an "entitlement" to be cut at will because we have a federal debt. Social Security has not contributed one cent to the federal debt. In fact, the Social Security Trust Fund has run a surplus for years and following federal law this surplus has been invested in treasury obligations that have yielded billions of dollars in interest each year.* Moreover, the

projected shortfall over the next 75 five year period will vanish if the payroll tax is permitted to rise to the historic norm for salary and wages rather than the lower rate at present. Even if nothing is done, the Trust Fund will still be able to meet 75 per cent of mandated obligations when the Fund is projected to be used up in 2033. Raising the age for retirement or reducing retiree income need not be a sacrifice handed to older citizens and their families.

2. Legislation affecting Medicare. Like Social Security, Medicare may be the object of a concerted attempt to change the system. Everyone should know a few facts about the system. When the prescription drug legislation was passed, we also had a change known as Medicare Advantage so that insurance companies could offer Medicare Plans. Now we have Original Medicare and the Medicare Advantage plans which have been reimbursed as much as 114 per cent of rate for Original Medicare. This rate, which many understand to be an overpayment, has placed added strain in the Trust Fund and led to political controversy over who is the real supporter of Medicare. The moral and financial question is how can one justify higher payments to insurance companies for Medicare Advantage Plans that draw down the Trust Fund more rapidly Original Medicare rather than the policy of a level playing field of equal reimbursements for both components. Another policy issue is that of using vouchers to pay for care. This proposal would give an older person a fixed sum to pay for health care and leave them at the mercy of the market place in dealing with insurance companies rather than being part of a large risk pool which shares a negotiating position. Unfortunately, the market place for health care is one of the foremost examples of market failure. Despite all the arguments about how markets limit cost and do other wonderful things for health care, the scientific evidence is another matter. For an excellent book on this topic, please read, John Cassidy, How Markets Fail.
3. Legislation affecting Medicaid. Medicaid is often thought of as the health care program for the nation's poorer citizens. It is also the program which pays for much of the cost of nursing home care after one's resources are exhausted. The proposal to watch is that of block grants to states as a replacement for the federal-state Medicaid program. Not only do the poor face a more uncertain future, the middle class also has a stake in the outcome of the policies being implemented. Unfortunately, many do not recognize the fact that

healthy workers add to the prospect for a more healthy economy and preventive care is a sound investment.

These are some of the issues which should be on our radar screen along with a number others that will be addressed in state legislation. Future issues of the Newsletter will deal with state issues and everyone is encouraged to submit papers for consideration.

**Please note this quote from page 2 of the 2012 Report of the Trustees for the Trust Fund: "Total expenditures in 2011 were 736 billion. Total income was 805 billion, which consisted of 691 billion in non-interest income and 114 billion in interest earnings. Assets held in special issue U. S. Treasury securities grew to $2.7 trillion.*

What are Health Insurance Exchanges and
What's Colorado Doing About Them?

Mary Kay Smith

This article discusses Health Insurance Exchanges; a critical feature of the Patient Protection and Affordable Care Act (ACA) passed by Congress and signed into law on March 23, 2010.

Those of us who fall into the category of "Senior" have the benefit of Medicare for our health care coverage. We will likely not ever need to go to a Health Insurance Exchange for our health care insurance but our younger family members, friends, neighbors may need them. This article will discuss how Colorado is planning for implementation of the Health Insurance Exchanges that become available to Colorado citizens in January 2014.

Health Insurance Exchanges have existed in many insurance markets for years. However, many suffered from adverse selection (a less healthy group of members) and high administrative costs, resulting in low value for consumers. The Statewide exchanges will pool people together in greater numbers than the small exchanges of the past. This will spread the costs of the higher users across a large pool of lower users of health care services, thus reducing the cost to administer the insurance programs. Perhaps the greatest feature is the requirement that all insurers participating in the Exchanges describe their benefits, services, costs in a fully transparent and comparable way. Consumers will finally have a neutral place to go to compare "apples to apples" in choosing a health care plan for themselves or their family. Exchanges create more

efficient and more competitive markets for both individuals and small employers. Efficiency and competition almost always result in lower cost to the consumer.

The Affordable Care Act included a provision for States to organize health care exchanges to help consumers and small businesses shop for coverage that permits easy comparison of different health care plans, based on price or benefits and services or quality or all of these features. The ACA requires all Americans to have health insurance as of 2014 or pay a penalty. This was the highly contested feature of the health care reform law that was upheld as constitutional by the Supreme Court. The penalty was deemed a tax and therefore within the authority of Congress to assess. States will likewise need to be ready to serve millions more Americans who now have no health insurance or are under-insured.

The ACA provides for two exchanges: one for individuals and one for small businesses. In January 2014, individuals and small employers will be able to shop for insurance from a range of health plans offered through the Exchanges. People today who cannot afford health insurance or are denied coverage due to poor health will be able to purchase insurance through the exchanges. Lower and middle income individuals may be eligible for premium subsidies. Small employers with lower-income workers that provide insurance may also be eligible for tax credits and premium subsidies.

Colorado's Response: In Colorado, about one in five lower income adults between ages 19 and 64 (over 153,000) do not have health insurance. This group will be seeking health insurance, many for the first time in their adult lives as the Affordable Care Act goes into effect. Our State is among the first in the nation to address the tsunami coming in 2014 of people needing health insurance, many of whom will qualify for subsidies to help them pay the premiums.

In June 2011, Governor Hickenlooper signed SB-11-200 into law, establishing the Colorado Health Benefit Exchange. Many states, hoping the Supreme Court would overturn the Affordable Care Act or at least the requirement that all citizens have health insurance, waited to establish their exchanges. Many will, as a result, have to begin 2014 with their citizens going to Federally operated exchanges rather than one tailored to their states. Our legislators and our Governor provided the statutory foundation for Colorado's home grown exchanges almost three years in advance.

Colorado's Exchange is a nonprofit, unincorporated public entity – a quasi governmental organization governed by a 12 member Board. Colorado's enabling legislation requires all Board members have skills and knowledge relative to the Board's areas of focus, such as, health benefits administration, information technology, or health care financing. The Board members may not be directly affiliated with the insurance industry nor may they be state employees.

The Colorado Health Benefit Exchange is a working organization. It is addressing the following issues and framework:

- Contracting with Health Care Plans operating in Colorado and preparing to serve as a clearinghouse for eligible citizens to purchase health insurance.
- Developing a Consumer Assistance and Outreach function, hiring and training Navigators to assist citizens in applying for health insurance through the Exchange and developing a Call Center.
- Working with an Advisory Group on Small Business to establish the Small Business Health Options Program (called SHOP) for businesses with 50 or fewer employees.
- Building new technology supports and links from the Exchange to the existing eligibility and enrollment systems for Medicaid and the Children's Health Insurance Program.
- Designing the "Essential Health Benefits" set of services that all Plans participating in the Exchange must provide.

In summary, we can be very proud of Colorado's legislators and Governor for their foresight in laying a solid foundation for the health insurance exchanges. The Colorado exchange is tailored to the needs of our citizens and well underway in development. Seniors can help by staying informed and making sure any family and friends who may need help to find and afford health insurance, know about Colorado's Health Exchange.

Mary Kay Smith is the former Denver Regional Administrator for the Centers for Medicare & Medicaid Services. She retired after 34 years of federal service in support of Medicare and Medicaid. She remains active in the aging community in Colorado. Additional articles on the health care reform law will be forthcoming in this newsletter.

More information:
State Exchange profiles: Colorado, Kaiser Family Foundation
http://healthreform.kff.org/en/state-exchange-profiles/colorado.aspx

Senate Bill 11-200
http://www.leg.state.co.us/clics/clics2011a/csl.nsf/fsbillcont/7233327000DC9A078725780100604CC4?Open&file=200_ren.pdf
Get Covered Colorado (Exchange website)
http://www.getcoveredco.org/
Colorado Health statistics
http://www.coloradohealthinstitute.org/uploads/downloads/EBNE_Adults_Fact_Sheet_FinalFinal_6_14.pdf

THE REAL COST OF MEDICARE
A CALL TO ACTION
Ed Shackelford

Recently my wife Beverly had a hip replacement. This, as it would be for anyone, was an important event in our lives. Before the operation we were socializing with several seniors who were all reasonably healthy and able to freely move around. When discussing the upcoming operation they considered it a minor event. One had 2 hip replacements and one knee. Another had two knees and one hip replaced. All had at least one joint replaced.

This was a revelation to me. It was not apparent that they had these operations. What if these seniors had not had these operations? Would they still be able to get around? Or would they be bed-ridden with in-home care or in a nursing home? What a great thing it is that replacement joints have been developed and that those who need them are able to have access to affordable surgery and recovery: if covered by insurance.

Beverly is recovering nicely and we anticipate a full recovery with her being able to walk normally without a walker or a crutch. Before the operation she was barely able to walk with the aid of a crutch. Although it looks like a routine procedure to others it was not routine to Beverly.

So this became an ***Ah Ha*** moment. The cost of the surgery was approximately $20,000. My cost $500. What if I could not afford the $20,000 and what if my senior friends could not afford the operations? What would their life be like? Would they be in a nursing home? Or an assisted living home? Or living at home with paid care? Or living at home with a significant burden on their family?

What if they could afford the $20,000 but then ran out of money sooner and relied on Medicaid a year sooner? What would that cost be? Immeasurably more than $20,000.

This is just an example of the old saying: “an ounce of prevention is worth a pound of cure”. This could not be more true. As expensive as the hip replacement was, it cost less than a third of a year in a nursing home. And I can continue working as a REALTOR® earning an income and paying taxes instead of staying home to care for Beverly.

As we have the debate on the cost of Medicare we have failed to take a holistic look at the situation. The cost to society would be many time the cost of the operation. And this does not dollarize the improved quality of life nor the freedom it gives family members.

The emphasis seems straight forward. We need to understand the cost drivers of our health care system and make the politically unpopular decisions to bring our health costs in line with other advanced countries, many of which have a healthier population than we do in the USA.

Medicare Monday Is Time To Make Decisions for 2013

Eileen Doherty, MS

Denver, Co. Amid campaign ads, television stories, and political speeches, Medicare has become a topic of conversation in this year's election. Even though the candidates are talking about changing how Medicare operates and proposing new ways to save Medicare, not much is likely to happen in the very near future. Although changes could come in the next Congress, most changes, if any would not happen in the very near future.

Medicare is here to stay at least for 2013! But Medicare beneficiaries will experience some changes for which they should prepare. Starting this fall, hospitals will not receive any reimbursement if an individual is re-admitted to the hospital for any reason within 30 days. Based on past experience, most hospitals in Colorado are already subject to penalties for their existing re-admission history. Under this new reimbursement methodology, hospitals are experimenting with many programs such as visiting nurses, home care, arranging for appointments, helping to arrange for equipment and medications and much more. If you are hospitalized, you should expect and receive more help from care navigators and others when you are discharged from the hospital.

Another focus for Medicare is continuing to look at ways to promote wellness and prevent disease. Although no new prevention services are being added this year, many beneficiaries are not taking advantages of available services.

For example, many diabetics are still paying for some of their supplies out of pocket because they are not using the right company from which to purchase the supplies and medications. Lancets, glucometers, and test strips are covered by Medicare Part B; while insulin and syringes are covered by Medicare Part D. Thus if a beneficiary buys lancets, glucometers and test strips at the local pharmacy which does not have a Medicare Part B billing number, the result is the beneficiary pays out of pocket for these supplies. The pharmacy, however, will usually have a billing number for Medicare Part D, so the glucose and syringes will be covered. Many times the beneficiary is unaware they have to use two companies to manage their diabetes.

As usual, the standard benefit for prescription drugs is changing. Many stand-alone prescription drug plans, as well as Medicare Advantage health plans will make changes to formularies, co pays and deductibles. Beneficiaries are encouraged to talk with a Medicare counselor to review the current drugs to determine if the current plan is still the most cost effective or if changes need to be made. These changes need to occur between October 15 and December 7, 2012 for the change to be effective January 1, 2013.

Individuals who are not new to Medicare who wish to enroll in a Medicare Advantage health plan must do so between October 15 and December 7, 2012 for coverage to begin January 1, 2012. Individuals wishing to enroll in or change Medicare Supplement plans may do so at any time during the year, however, they may be subject to underwriting criteria if they are not new to Medicare.

Research suggests that more than 70,000 Medicare beneficiaries may be eligible for the Medicare Savings Program in Colorado. Individuals whose monthly income is less than $951 ($1281 couples) and whose resources are less than $8440 for an individual ($ 13,410 for a couple), excluding the house, one car, term life insurance policies, and irrevocable burial policies may be eligible to have the Medicare Part B premium of $99.60 per month that is deducted paid by Medicaid, thus increasing their monthly spendable income by $1200 per year.

Studies also show that approximately as many as 18,000 Medicare beneficiaries may be eligible for Extra Help or Low Income Subsidy in Colorado. Those individuals whose monthly income is less than $1277 ($1722 for couples) and whose resources are less than $8440 for individuals ($13,410 for couples), excluding the house, one car, term life insurance policies, and irrevocable burial policies may be eligible for assistance for paying for the Medicare Part D of an average of $30 per month paid. In addition, the cost of their prescriptions is reduced to between $1.30 and $6.30.

These and other topics will be covered at **Medicare Monday** on October 15 from 9:30 am to 11:30 am at the following locations:

Community Recreation Center of Apex, 6842 Wadsworth Blvd, Arvada;
Holly Creek, 5500 E Peakview Av, Centennial;
Northglenn Senior Center, 11801 Community Center Dr, Northglenn;
RiverPointe of Littleton, 5225 S. Prince St, Littleton;
St. Andrew's Village, 13801 E Yale Av, Aurora;
Windsor Gardens (Auditorium), 595 S. Clinton St, Denver;
The Commons of Hilltop, 625 27 1/2 Rd, Grand Junction; and
The Inn at Garden Plaza, 2520 International Circle, Colorado Springs.

For those not able to attend, follow-up sessions are being held on October 29,

from 9:30-11:30 am at Villas at Sunny Acres, Ambassador Building, 2513 E 104th Av, Thornton;
from 9:30 am to 11:30 am at The Bridge at Alamosa, 3407 Carroll St, Alamosa;and
from 1:00 pm to 3:00 pm at the Greeley Senior Center, 1010 6th St, Greeley.

The last sessions are being held on November 5 from 9:30 am to 11:30 am, Heritage Club of Denver, 2020 S Monroe St, Denver; and from 9:30 am to 11:30 am at Third Street Center, 520 S 3rd St, Carbondale.

Medicare Monday is free and open to the public. Refreshments will be provided. Reservations are not required, but suggested at 719-630-1155 or www.senioranswers.org.

Eileen Doherty, MS, is the Executive Director of the Colorado Gerontological Society, 3006 East Colfax, Denver CO 80206. She has more than 35 years of experience in education and training, clinical practice, research, and public policy in gerontology. You may reach her at 303-333-3482 or Doherty001@att.net.

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