Chapter 7
Health

Health Care Coverage (Cont'd.)

INTRODUCTION

AARP believes that there is a critical need to reform the nation's health care system in order to urgently address its problems. The US spends more on health care than any other industrialized nation and has less to show for it in terms of quality, access, efficiency, equity, and outcomes. Research indicates that there are serious and pervasive problems with the quality of care throughout the system. The ranks of the uninsured have grown to nearly 50 million, and millions more Americans are underinsured. Employer-provided health insurance is eroding. As health care costs continue to rise people's confidence that they will be able to get needed treatment without financial hardship decreases. Health costs are not only a leading cause of personal bankruptcy in the US, but also threaten the solvency of government programs, the ability of small businesses to offer coverage, and the global competitiveness of business.

Since the early 1990s, incremental proposals and piecemeal reforms have focused on different aspects of health care delivery, public-coverage programs, private markets, health care quality and accountability, and health care costs and financing. There have been limited successes in some areas. Policy initiatives such as the State Children's Health Insurance Program and Medicaid waivers have made important progress in extending coverage to more people. And the Medicare prescription drug benefit now provides older adults with much needed access to drugs and with protection against high drug costs. But many problems have worsened. Health costs continue to grow more rapidly than income and the economy. Health outcomes, disparities in access and treatment, quality, fraud and waste all continue to be problems. Along with these problems with health care, growing numbers lack coverage altogether or find themselves underinsured.

Reforming health care requires more than expanding coverage. It requires changing and improving the way care is delivered and managed throughout the entire system. Change in these areas is a long-range endeavor that involves ongoing research, education of providers and consumers, and changes in practices at all levels of the delivery system.

Recognizing this, AARP worked hard to make sure that changes to address these key issues were included in the 2010 Patient Protection and Affordable Care Act (ACA). It lays groundwork for progress. This law puts in place a framework for expanding coverage to nearly all Americans through expansion of public coverage for poor adults previously ineligible for Medicaid; changes in rules for private health insurance markets; subsidies for those without access to employer-sponsored coverage who may otherwise have trouble affording insurance. The law also puts in place policies that will close the doughnut hole in the Medicare prescription drug program in the coming decade and expands coverage of preventive services in Medicare while reducing their cost to beneficiaries. It improves the solvency of the Medicare Part A Trust Fund by reducing excess payments to Medicare Advantage plans as well as slowing future increases in payments to certain Medicare providers. The law includes important provisions in Medicare and Medicaid to reward health providers for better health outcomes and to explore different approaches to managing the costs of patients with chronic health problems. It creates a new voluntary insurance program to help people pay for long term care services and support, and provides resources and incentives to states to expand efforts to keep people with long term care needs in their homes. Measures to help address disparities in health care, to focus on prevention and wellness, and begin to address healthcare workforce shortages are also part of the law. These and other aspects of the law are discussed in the relevant sections of the chapter.

AARP is committed to working to realize the promise of ACA through its implementation even in the face of the national and state fiscal challenges that pressure existing publicly funded health programs and priorities, and even as opponents of health reform pursue legal challenges to ACA. Continuing to work to improve the quality and safety of health care and to raise consumers' understanding of these issues is essential, even as we redouble our efforts to achieve the goal of affordable health care for all. Unless the country can make progress on these key fronts, the problems with our health care system will only become more urgent.

AARP PRINCIPLES

AARP's health care principles are designed to guide the association in its efforts to reform the health care system and participate in the public debate over health care reform and its implementation at the national and state levels. The principles do not address every health care issue but establish criteria for evaluating and comparing reform proposals and for developing specific positions on comprehensive reform.

All individuals have a right to health care services when they need them. The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures access to needed physical and mental health care services for all individuals. Particular consideration should be given to eliminating disparities in care and ensuring access for minorities, people with disabilities, and medically underserved communities.

All individuals have a right to affordable health care coverage that provides adequate financial protection against health care costs. The public, through the federal and state governments, has the ultimate responsibility to develop a system that provides access to affordable health care coverage for all individuals, including those with physical or mental health problems or disabilities. The health care system should include public and private health coverage. Governments should establish a minimum, adequate, defined package of benefits to which all individuals are entitled (see below for additional principles on adequacy and affordability of coverage).

All individuals have a right to high-quality health care. Information about the performance of the health care system (e.g., data on individual practitioners, institutions, and health plans) should be collected, analyzed, and made publicly available. This information should address the six domains of quality: safety, effectiveness, patient-centered responsiveness, timeliness, equity, and efficiency. Quality assurance programs, such as peer review and professional licensing, should be strengthened and coordinated. Quality improvement should be an integral component of the quality assurance process.

All individuals should have a reasonable choice of health care providers. Access to providers who are knowledgeable about and sensitive to the culture and values of individual patients, as well as access to practitioners with appropriate expertise, should be ensured in all circumstances, including in health plans with networks that limit choice of providers in order to contain costs or improve quality. Consumers should be provided with sufficient information about health care providers and treatment options to make informed health care decisions.

Health care system financing should be equitable and broad-based, and health care should be affordable for all. Government, employers, and individuals share the responsibility of participating in health care financing. However, our present method of financing health care should be made fairer and more progressive. Burdensome cost-sharing requirements (e.g., high deductibles, coinsurance, and copayments) should be avoided because they disproportionately affect the poor, minorities, and those with chronic and severe health problems. The public, through the federal and state governments, should subsidize the cost of health care coverage for individuals with lower incomes and should fully finance health care coverage for the poor. The method of administering subsidies should preserve the dignity of the individual, regardless of income level.

Containing unproductive health care spending and cost growth should be a shared responsibility. Providers, purchasers, government, and consumers all have a role to play. Design of the delivery system, health benefits, and provider reimbursement can potentially contribute to improving health care quality and efficiency while eliminating waste and inappropriate care. Changes in these areas should be grounded in strong scientific evidence in order to inform both consumers' and providers' decisions about appropriate care. To achieve cost containment over the long term, government and the private sector will need to invest in an infrastructure to support quality improvement and cost containment through solid evidence, tools to broadly assess performance, adoption of effective health information technology, and aligning payment incentives with quality and reduced costs.

Methods of provider reimbursement should promote high-quality medical care and efficient service delivery and compensate providers fairly. All payers should compensate providers through equitable, timely, and fair reimbursement arrangements. Provider reimbursement should not vary dramatically in a given geographic area and should align incentives with desired health outcomes.

Health care spending should be more rational and support the goals of more efficient planning, budgeting, and resource coordination. Cost containment should be an explicit part of decisions relating to the distribution and allocation of health care resources, capital, technology, and personnel; and should encourage innovation, efficiency, and cost-effectiveness while promoting reasonable access to services. Federal and state governments should play a major role in planning and coordinating the allocation of health care resources.

Efforts to promote health and prevent disease should be strengthened. The public health system should be strengthened to ensure the public's health, safety, and well-being. Public health efforts should increase citizen understanding and awareness of health, environmental, and safety issues and improve access to primary and preventive care services. Public health efforts should encompass research on health, environmental, and safety issues, as well as the coordination, collection, and dissemination of public health information. The public health system should protect the public's health through surveillance of health problems and enforcement of health, environmental, and safety standards.

Individuals share a responsibility for safeguarding their health by educating themselves and taking appropriate preventive measures to protect their health, safety, and well-being. The government, health care providers, employers, and consumer organizations should educate the public about health and health care. Individuals have a responsibility to adopt healthy behaviors. Incentives to promote healthy behavior should be encouraged as long as they do not deny access to health care or unfairly discriminate.

Acute, chronic, and long-term care services should be coordinated and integrated to ensure a continuum of care throughout an individual's lifetime. Providers and patients should work together to coordinate the delivery of all health care services and support in order to address effectively an individual's multiple and/or changing health care needs and to avoid disruption. Providers, individuals, and caregivers should work together to meet all patient-care needs. Payers, including governments, should create incentives for care coordination, appropriately compensate all service providers, and assist with resource integration.

Adequacy and Affordability Principles. The following principles are meant to guide the development and evaluation of efforts to define what constitutes both an adequate benefit package and an appropriate affordability standard in the context of health care reform.

An **adequate benefit package** would have the following components:

- a continuum of care, including but not limited to prevention and wellness; primary care; chronic care coordination; emergency care; hospitalization benefits; prescription drugs; mental health care; vision, dental and hearing care; rehabilitation services; end-of-life care; home care; and long term-care.
- a benefit structure that promotes: wellness, preventive care, and healthy behaviors; and an upper limit on out-of-pocket costs with reasonable standards for what those costs should include—The limit on out-of-pocket costs should be consistent with the limit on total health care costs defined in the affordability standard.

An **affordability standard** would have the following components:

- a limitation on total individual or family health care costs, including premium and out-of-pocket costs—The maximum anyone should be expected to pay for the costs associated with an adequate health insurance package should be limited to between 5 percent and 10 percent of income, depending on the specifics of the proposal and the circumstances in the jurisdiction. As a practical matter, premiums can be defined as a percentage of income and out-of-pocket costs limited to a specific dollar amount. The affordability standard should be structured progressively, with lower-income individuals and families expected to contribute a smaller share of income than higher-income individuals and with very low-income individuals and families expected to contribute nothing;
- a limit on premiums to ensure affordability for those not eligible for subsidies—These limits should address the allowable variation in premiums based on age, medical history, gender, and geography;
- a progressively structured subsidy schedule for premiums, so that lower-income people and those facing extraordinary premium costs can attain adequate coverage as defined above;
- parameters that account for variations in costs based on geography and family status;
- provisions to adjust the parameters of the affordability/subsidy schedule annually to reflect changes in health status;

- gradation of subsidies to minimize benefit "cliffs" (in which a small difference in income creates a large difference in subsidies);
- a method for delivering subsidies that is progressive and available to those with low incomes (for example, if a tax mechanism is used to provide subsidies for premiums or out-of-pocket costs, it should be a refundable credit); and
- an on-going mechanism to secure adequate funding so the government can support subsidies and other reforms.

Other Principles Related to Adequacy and Affordability. Adequacy of the benefit package, affordability for the individual, and affordability for the government cannot be achieved without additional reforms including but not limited to automation of individual health and systems information, quality improvements, and cost containment measures. Insurance market reforms are necessary to any health care reform proposal involving private markets. In addition, to promote and allow state-based reform, federal assistance is needed. For example, federal reinsurance could offer relief to insurers from the cost of covering individuals who incur catastrophic medical expenses, enabling insurers to lower premiums. In addition, states should be given more flexibility in administering Medicaid, and at the same time required to ensure an open and accountable process for public input as this flexibility is exercised.

An adequate and affordable health reform plan must also be affordable for government. For a state, that means that it can be funded in accordance with state law, and for the federal government, that it can be funded in accordance with AARP's budget principles in Chapter 2, Budget and the Economy. States must be able to establish reasonable standards consistent with efficiency, quality, and effectiveness.

HEALTH CARE: SLOWING THE GROWTH IN HEALTH CARE SPENDING

In 2008, the US spent $2.3 trillion on health care. Health care spending affects our society as a whole. The high cost of health care affects individuals, business, and society. Health care premiums and cost sharing are rising every year for people with insurance, and the share of the population who spends more than 10 percent of their income on health care spending also is rising. Individuals' medical debt is on the increase as well. The costs of providing health coverage for employees is leading some employers (particularly smaller ones) to drop coverage; all employers are looking to lower spending by reducing coverage and shifting more of the premium to their employees. As this happens, employees are more likely to forgo coverage and become uninsured.

Medicare and Medicaid programs are seeing costs rise; these programs are not the source of the problem but experience the same cost pressures in the broader system. However because these programs are part of federal and state budgets, cost increases are especially visible.

Even while health care costs are growing, the evidence is clear that we do not always receive higher quality care for the money spent. Higher spending does not yield higher quality, and some studies show that spending and high quality are inversely related. The major factor driving spending growth is the introduction and rapid dissemination of new—often unproven—medical technologies, including prescription drugs, tests, and procedures. The rise in the prevalence of chronic disease has also contributed to spending increases. Provider payment systems and other features of our health care system have incentives that fuel the cost growth. Researchers have shown considerable waste and inefficiency in the health care system from overuse of services and services that offer little or no value to patients; duplication of services due to poor communication and lack of coordination among providers; and medical errors, preventable hospitalizations, and lack of preventive care that can forestall other care that could have been avoided. In addition, there are administrative inefficiencies as well. It should be noted that compared to private insurance, Medicare spends less on administrative expenses. Quality and safety issues are discussed in more depth in the section of this chapter on quality.

The effects of the health reform legislation passed in 2010 will be felt in different ways across different parts of the health care spectrum. The effect on health insurance premiums will vary by type of market and group or nongroup coverage. The Congressional Budget Office estimated that the federal government's health care spending would increase over the next ten years, but would likely decrease in years beyond that. Both federal and state governments will spend more on Medicaid as the program expands to cover all low-income children and adults. Significant cost savings are projected for the Medicare program—almost $400 billion in savings over the next 10 years. These savings are expected even with no reduction in guaranteed benefits. However, the Chief Actuary of the Centers for Medicare & Medicaid Services (CMS) has expressed concern that the savings envisioned in the legislation cannot be realized without significant losses to providers and without risking access problems for some beneficiaries.

Despite the changes included in health reform, there continues to be a need to address cost containment. Health care spending is a significant driver of the long-term budget deficit, and reducing the deficit is not feasible without addressing health care costs. Cost containment approaches should address the root causes of unproductive cost growth and should not simply cut necessary benefits or shift the costs from one party to another.

Key transformations in the organization and delivery of health care hold great promise not only for quality improvement and greater efficiency but for cost containment as well. However, to realize the savings potential of these strategies, some investment is needed to build evidence for comparative effectiveness and tools for using it.

The application of scientific evidence would inform clinical and patient decisionmaking and would inform the development of evidence-based guidelines and, in general, clinical practice and the delivery of services. Basing clinical decisions on evidence would eliminate services that offer no or very limited value. Comparative effectiveness research would provide an objective basis for selecting appropriate procedures, preventive services, and interventions (e.g., prescription drugs and other new technologies).

More widespread use of health information technology would: provide decision support for clinicians (thereby helping to ensure their adherence to evidence-based guidelines); eliminate duplication of services; reduce errors (e.g., from poor

handwriting); facilitate information sharing among clinicians (thus promoting coordination); remind clinicians and patients to use preventive services; enhance patient self-management and engagement by affording consumers easy access to their personal health information; and streamline administrative processes through electronic appointments and prompt retrieval of test results.

Greater accountability through transparency coupled with informed decisionmaking, quality, resource use, and price information would allow consumers and purchasers to make better informed decisions through the use of public reports on a range of standardized measures assessing physicians, hospitals, health plans, nursing homes, and other institutions and health care providers. Programs need to be developed to support patients' use of such information. Savings would follow if patients are drawn (e.g., through physician referrals) to the practitioners and providers with the most efficient and effective practice style.

Better alignment of payment with desired outcomes would encourage higher quality, more effective and efficient care (e.g., "pay-for-performance").

Improved coordination of care, particularly for individuals with chronic conditions, would improve quality and potentially save resources from avoided duplication of tests and hospital and emergency room visits that result from poor outpatient care. Care coordination programs should improve coordination among clinicians and the quality of care as patients transition among clinicians and care settings.

Research is needed to inform optimal methods of service delivery. It would be beneficial to consider how operations research could inform clinical practice.

Shorter term strategies to control health care costs include tiered cost-sharing (e.g., to encourage the use of generic drugs) and changes to provider-payment approaches that create incentives for providers to find more efficient and effective ways of furnishing services and that reward good outcomes. New methods of payment that create these incentives should be accompanied by robust risk adjustment so that providers do not benefit from avoiding high-cost patients and measures that assess performance. Examples of new payment methods worth considering include payments for bundles of services, episodes of care, lower or no payments for preventable readmissions to hospitals, no payments for services that result from care that should never be provided, e.g., operation on the wrong site (called "never events"), and shared risk strategies like that explored in Medicare's physician group practice demonstration. In this demonstration, multispecialty group practices are paid using fee-for-service methods, but can share savings with the government if they are able to reduce overall spending for their patients while attaining high quality scores.

HEALTH CARE: SLOWING THE GROWTH IN HEALTH CARE SPENDING: Policy		
Quality of care	FEDERAL STATE	Federal and state governments should initiate cost-containment measures that effectively constrain growth in price, volume, and intensity of health care services without compromising quality of care or inappropriately denying access to care. Cost-containment efforts should not create incentives to shift costs inappropriately to patients or other payers.
Payment reform	FEDERAL STATE	Federal and state governments should initiate, test, and evaluate payment approaches that create incentives for providers to be more efficient and effective and that reward good outcomes. Payment approaches should have robust risk adjustment (so that providers do not benefit from avoiding high-cost patients) and be designed to hold providers accountable. In addition they should be fully transparent, fair, and feasible to implement and administer. Good performance measures will be needed to determine where to set payment levels.

REFORMING THE DELIVERY OF HEALTH CARE SERVICES

For most Americans, health care is uncoordinated, quality is uneven, and the cost of care is increasingly unaffordable. The prevailing method for paying physicians (i.e., fee-for-service) encourages fragmentation and offers little incentive for clinicians or health plans to improve, coordinate, or integrate care. Cost is an issue for employers as well. Individuals and families with employer-based insurance often experience discontinuity due to coverage changes their employers make in search of lower premiums. Such churning makes it difficult for people to receive continuous care, develop meaningful clinician/patient communication, or establish trusting relationships with their clinicians.

The 2010 Patient Protection and Affordable Care Act (ACA) included several provisions to address the combination of affordability and quality concerns. A new Center for Medicare and Medicaid Innovation (CMMI) will be established to test payment and service delivery models that reduce spending while enhancing the quality of care in Medicare and Medicaid. The center will give preference to programs that improve coordination, quality, and efficiency of patient-centered health care, and promote broad payment and practice reform. Other provisions authorize pilot testing new models of care, such as medical homes and accountable care organizations (ACOs), and strengthening primary care. The broad range of strategies in the legislation relating to delivery reform, payment, quality improvement, and the primary care workforce signals Congress' belief that improving care delivery and affordability requires a multidimensional approach. Consumers stand to benefit if innovative approaches and other reforms are found to improve the quality and affordability of care.

Primary care is the entry point to the health care system for most people. New problems and other patient needs are triaged and addressed in the primary care setting, which is also the focal point for management and coordination with other parts of the system. Primary care offers patients easy access to first-contact care and an opportunity to develop a sustained, personal relationship with a clinician in the context of a continuous care relationship. Primary care can also focus on wellness and prevention, population management (e.g., via registries), and the ability to monitor and address proactively the health care of subpopulations. Research suggests that health care systems with a strong primary care foundation have better quality, lower costs, better population health, and less inequality.

Growing shortages in the primary care workforce and the widening gap between payment for primary care and specialist services is receiving attention. Approximately 65 million Americans live in officially designated primary care shortage areas. Experts observe that the disparity in incomes between primary care and specialist physicians discourages medical graduates from choosing primary care careers. The ACA mandated a 10 percent Medicare bonus payment for primary care services for the period January 1, 2011 through December 31, 2015 (see this chapter's sections on Medicare payment). In today's health care system, primary care has suffered additionally from a narrowing of focus, a tendency to mirror the "physician-centricity" of the rest of the health care system, and a failure to make adequate use of health information technology. A recent study reported that only 42 percent of visits for treatment of a newly occurring health problem are made to an individual's personal physician. (The rest are made to emergency departments, specialists, or outpatient departments.) New delivery models specifically address these issues as do provisions in the American Recovery and Reinvestment Act (ARRA) that provide financial incentives for physicians to adopt and use health information technology.

Team-based care—The multiplicity of demands and the range of skills and expectations of primary care suggest that it is best provided through a care team, with each professional member allowed to practice to the full extent of his or her license with a clear definition and understanding of roles and responsibilities.

All patients benefit from care that is well-coordinated and appropriately managed by a team of professionals with skills targeted to the needs of the individuals served. In a patient-centered system, an individual's needs are the primary focus, and managed by a team whose members consult, communicate, and coordinate with one another as well as the patient or caregiver. In particular, people with multiple chronic conditions benefit from the skills of a range of health professionals representing a variety of disciplines. The composition of the team may vary, depending on the patient's needs, but, in addition to the patient and family caregiver, it is customary to find physicians, advanced practice registered nurses, social workers, pharmacists, nutritionists, and others as members of an interdisciplinary team.

Although examples of teamwork can be found throughout health care (e.g., operating rooms, intensive care units), teamwork in geriatric care is fundamental and long-established as a standard way of delivering care. Community health centers and integrated health systems are examples of settings that often are organized by teams to serve their patient populations. New models of care can borrow from the experience of these successful examples.

It is widely recognized that disparities in care occur by race, ethnicity, gender, age, and sexual orientation. Experts agree that it is essential for health care delivery, regardless of model, to take into account the specific needs of the populations that are being served. In particular, it is important for systems and providers to be able to measure disparities so that gaps in care can be identified and specifically addressed. Therefore, collecting and reporting information on performance that is stratified to determine the existence of disparities is essential. In addition, care delivery must be culturally competent and honor individuals' preferences, values and circumstances. Specific techniques such as use of community health workers, interpreter services, and recruitment, training, and retention practices to ensure a culturally competent workforce are effective approaches. In addition, culturally competent health promotion and education can help members of minority communities understand the value of emerging service delivery models.

Chronic Care Coordination, Medical Homes, and Accountable Care Organizations

Improving Chronic Care

The number of older people with chronic diseases is large and growing. In 2005, more than 70 million Americans ages 50 and older—four out of five older adults—suffered from at least one chronic condition. More than half of older adults have two or more chronic conditions and 11 million live with five or more chronic conditions.

A chronic condition or illness is defined as a health care condition that is likely to last more than one year, requires ongoing medical attention, and can limit a person's daily activities. Some of the most prevalent chronic illnesses/conditions in the older population include arthritis, emphysema, cancer, cardiovascular disease, depression, diabetes, and obesity.

A 2003 study found that, on average, US adults received only 56 percent of recommended services for chronic conditions. While progress has been made, there are large gaps in the quality and delivery of health care for people with chronic illness. Chronic conditions are costly for patients and payers. Moreover, people with chronic conditions account for 83 percent of all health care spending. There is an urgent and compelling need for change to address the poor care and high costs of those with chronic conditions.

Coordinating care for people with chronic conditions can contain or reduce health care costs by ensuring that these patients: receive recommended services when they need them, avoid unnecessary care such as duplication of services; have providers who monitor medications; receive information to manage their conditions; and avoid exacerbation of their conditions. A key objective in chronic care management is to coordinate care; for some patients this would include a full range of medical and social support services.

All consumers, including those with chronic conditions, can safeguard their health by practicing healthy behaviors (such as engaging in physical activity, not smoking, and eating nutritionally balanced meals) and learning to manage their conditions by taking recommended preventive measures to avoid the onset or exacerbation of illness; achieve resiliency (the ability to recover from setbacks); and attain an ability to manage their health effectively. Under the 2010 Patient Protection and Affordable Care Act (ACA) Medicare coverage will include an annual wellness visit, a personalized prevention plan, and preventive services with a US Preventive Services Task Force grade A or B; these services will have no cost sharing. Patients will need the tools and confidence to pursue healthy behaviors and lifestyles. Medical homes are expected to provide these supports.

In traditional Medicare, numerous barriers hamper widespread, sustained improvements in care for people with chronic conditions including:

- failure to value team-based primary care;
- fragmentation of care delivery and poor transitions across health care settings;
- misaligned payment incentives of the fee-for-service system that do not value integration of services;
- lack of interoperable electronic health information systems which makes it difficult for providers to monitor patient progress, share information, and track patients over time; and
- inadequate medication management that might increase preventable drug-related problems and compromises adherence to evidence-based regimens.

Addressing these barriers requires multi-pronged strategies aimed at providers, patients and family caregivers. To have impact, the delivery of chronic care services needs to improve quality and outcomesand be widely adopted throughout the health care system. Recent studies of chronic care coordination models have focused on three interventions: coordinated care; self-care management; and transitional care. Although additional study is needed, evidence-based research supports the use of these interventions and has demonstrated improved care and cost savings (from fewer hospital readmissions and emergency department visits). These models are not necessarily mutually exclusive.

Coordinated care interventions include patient self-management, ongoing monitoring of a person's health and long term care needs, and systems to ensure smooth transitions of care between care settings and providers. These programs typically involve patient support, medication management, improved communication, and coordination among multiple providers. Interventions that support patients (and their caregivers) with information and strategies for managing and coordinating their care can improve quality of life, functional autonomy, and efficiency in the use of health services and can help control the cost of care.

Transitional care interventions are designed to reduce problems that may occur when patients move from one care setting to another. Those with chronic conditions are particularly vulnerable to adverse medical incidents where health care facilities and clinicians fail to plan for these transitions and to provide follow-up services. Patients at high risk for a poor transition across health care settings, such as from hospital to home or nursing facility, include those with five or more chronic conditions, numerous office visits, poor health status, limitations on daily activities, and a low level of engagement in their care. Transitional care models assign a transitional care manager, such as a nurse or other trained health professional, to coordinate and monitor care and provide patient and caregiver education and support.

The Centers for Medicare & Medicaid Services (CMS) has sponsored many demonstrations of chronic care improvement with differing features and target populations to explore ways of improving the quality of care and care coordination without increasing Medicare costs. These projects have targeted a variety of conditions, such as congestive heart failure, diabetes, and emphysema, and used different approaches to improve care, including care management, disease management, and the "medical home." (See below.) Interest remains high in expanding the evidence base to determine the most effective ways to treat people with multiplechronic conditions. Recently enacted health reform legislation expands the number and type of Medicare projects to demonstrate ways to coordinate care and smooth transitions for beneficiaries, including those with chronic conditions, in Medicare Advantage plans and traditional Medicare. These new programs include the following:

- The Medicare Community-Based Care Transitions Program;
- The Medicare Independence at Home demonstration;
- Community Health Teams to support Medical Homes, regardless of payer type; and
- Incentives to reduce Medicare hospital readmissions.

In addition, several states are implementing a variety of approaches to improving chronic care coordination.

Emerging Models of Service Delivery

Delivery reform accomplished through adoption and implementation of new models of care, such as medical homes and accountable care organizations (ACOs), will present a major departure from the way most primary care practices now provide services (where care continues to be fragmented and siloed). Practice redesign is disruptive, expensive, and time-consuming. There is evidence that organizing effective teams, improving coordination, and implementing health information technology will require reorganizing and retraining as well as new incentives.

"Medical homes" implement the recommendations of the Institute of Medicine's "Future of Family Medicine" study and are designed to lead to higher-quality, more cost-effective care through better coordination of services and support for patients that is culturally appropriate, interactive, and respectful. Although there is not a single definition, medical homes are inherently patient-centric and embody a "whole-person" approach to improving care through enhanced access, coordination, and support for patient self-management. In practice, a medical home involves a clinician or clinical practice (physician- or nurse-led) that assumes responsibility for coordinating, integrating, and enhancing access to needed services, including self-management and self-efficacy for all patients. Medical homes have been implemented in several different settings. The health reform legislation authorizes the Department of Health and Human Services to pilot test medical homes for high risk Medicare and Medicaid beneficiaries with chronic conditions. Proponents hope that these early initiatives will confirm the expectations for improved care and reduced costs.

However, additional evidence is needed to determine whether medical homes consistently produce improved outcomes and which features drive these changes.

ACOs are a new model of care in which a group of providers who will be held responsible for the cost and quality of care a population of individuals receives. The ACA outlines how ACOs in the traditional Medicare program will be formed, organized, and paid. ACOs will also be developed in the private sector. Several pilot programs are underway to test various ways to organize ACOs. These will provide valuable insights into best practices. But this is an emerging concept that has not been fully tested and many questions remain about the most appropriate ways to ensure such entities can in fact produce favorable quality at reduced cost. A range of models will be appropriate, at least during the early years.

While there is general agreement on the goals for ACOs of improving health care quality while reducing costs by means of shared accountability, some analysts have expressed concerns that formation of ACOs may exacerbate a growing trend toward consolidation among provider groups in the health care market and the attendant potential for adverse impact on premium rates. Higher premiums could negate savings resulting from ACOs' greater efficiency and better quality. Possible approaches to address these concerns include more aggressive anti-trust regulation and enforcement, implementation of all-payer rate systems, as well as effective monitoring of quality metrics and proper oversight.

For ACOs to deliver on their promise of improving quality and lowering costs, and thus increasing the value that patients and payers realize from premium dollars spent, is an exciting and encouraging opportunity. For consumers, in particular, it will be necessary for them to be assured access to the total continuum of care with an emphasis on a strong and stable source of primary care and opportunities to benefit from quality improvements as well as savings that are generated by more effective, efficient care. ACOs will also require monitoring to ensure that they provide stable, ongoing care.

To be successful, it will be essential for ACOs to demonstrate their commitment to high quality, excellent patient experience, and reduced costs. This raises the issue of how patients will be identified with a particular ACO and whether they should be informed of their physician's decision to join an ACO. Some argue individuals should be "assigned" prospectively based on their past receipt of services with a particular physician using historical claims data. In a voluntary scenario, an enrollee could then make a decision to remain with the provider/ACO or, in the alternative, select another physician outside of the ACO. Others propose that patients should be attributed to ACOs retrospectively as determined by their use of services during a specified period of time. However, in this case, enrollees would not be fully informed about the nature of the delivery system in which they were receiving care.

CHRONIC CARE COORDINATION, MEDICAL HOMES, AND ACCOUNTABLE CARE ORGANIZATIONS: Policy		
Quality of care for Medicaid and Medicare beneficiaries	FEDERAL STATE	AARP supports systems and strategies that help people of all ages maximize function, independence, and well-being and adapt to changes as medical conditions and needs change. To this end, AARP supports policies that will lead to improvement of the quality of care for people with chronic conditions. Congress and the states should finance and support evidence-based models and demonstration and pilot projects of chronic care delivery models to identify the most effective. Congress should authorize, and the Centers for Medicare & Medicaid Services (CMS) should implement, payment incentives, public reporting of provider and institutional performance, and other approaches that encourage: • intervention to prevent or mitigate the progression of disease, • coordination of care to ensure effective transitions across care settings, and • greater patient and caregiver activation through appropriate education and self-management programs and improved patient-provider communication.

Quality care for chronic illness	FEDERAL STATE	AARP supports Medicare and Medicaid policies that result in the efficient delivery of optimal care for beneficiaries with chronic illness and disabling conditions including approaches that encourage: • appropriate use of evidence-based interventions; • interdisciplinary care teams composed of physicians, nurses, social workers, dietitians, therapists, pharmacists and others (see Health Care Workforce and Education: Policy which calls for adequate training of health professionals); • appropriate use and timely monitoring of medications; • greater affordability of medications; • accelerated adoption of health information technology that contributes to improved care; • rapid dissemination of information and adoption of effective, evidence-based chronic care interventions; • support to family caregivers to help them become effective partners with professionals; • greater emphasis on chronic care in clinical education and continuing education of health care professionals; and • effective use of the health care workforce (see this chapter's section on Health Care Workforce and Education).
Integrating health and long-term care	FEDERAL STATE	AARP supports developing comprehensive, coordinated approaches to financing and delivering a wide range of needed care to beneficiaries with chronic conditions. Medicare and Medicaid should facilitate joint funding streams and integration of health and long-term care services for beneficiaries who are dually eligible for both programs.
Lifting budget-neutrality requirements	FEDERAL STATE	Budget-neutrality requirements should be eliminated for current and future Medicare and Medicaid demonstrations regarding care coordination and medical homes for beneficiaries with chronic conditions; a long-term, multiyear time frame should be applied when determining the budget impact of these demonstrations.
Beneficiary protections	FEDERAL STATE	Chronic care coordination programs and medical homes should include the following beneficiary protections: • Beneficiary and provider participation should be voluntary; without additional cost to beneficiaries; and not affect access to other Medicare benefits. • Patients should receive complete information about the program's objectives, roles and responsibilities for patients and clinicians, how and where to receive services, which services are beyond the scope of the program, and how to obtain such services. • Physicians, other practitioners, and providers currently providing care should be made aware of beneficiary participation in these programs to facilitate care coordination. • Medicare and Medicaid beneficiaries must be permitted to opt out of participation if they are automatically enrolled in chronic care programs or medical homes. • Beneficiary access to other providers should not be restricted. • Beneficiary privacy must be protected. • Protections for patients with disabilities, particularly cognitive impairments, should be explicitly addressed.

Incentives	FEDERAL STATE	Chronic care programs should be permitted to include the following incentives: • Medicare and Medicaid beneficiaries should be encouraged to participate in rigorous trials and evaluations of demonstrations and pilots that focus on coordinated care services. • Conditions for beneficiary participation should permit care managers to offer various levels of incentives, including nominal financial and other incentives, to encourage enrollment and participation. Incentives should be permitted to vary for different target populations.
Medical homes	FEDERAL STATE	A medical home should include voluntary patient selection of a primary provider or medical practice and maintain an individual's ability to change primary providers or medical homes. Medical homes should have the following attributes: • ease of patient access and communication, including during nonbusiness hours; • periodic assessment of a patient's clinical needs grounded in evidence-based protocols when available, and assessment of social and support needs and resources of both patient and family caregivers as needed; • care management, preferably employing an interdisciplinary team approach, especially for patients with multiple chronic conditions; • education and training for patients and their family caregivers in support of patient self-management; and • capacity to use data to identify patients with specified conditions and risk factors, compile patient registries, track referrals and test results, and follow-up with other providers, including community resources. Preferred approaches rely on health information technology, such as interoperable electronic medical records and electronic prescribing. In advance of receiving care from a medical home, patients should receive information about their rights and responsibilities as medical home patients.
Accountable care organizations	FEDERAL STATE	AARP supports pilot testing multiple forms of accountable care organizations to determine which models achieve improved quality and reduced costs. AARP believes delivery reform will not succeed without beneficiary acceptance of new care models and active patient engagement in their care. • AARP strongly favors attribution of patients prior to the period for which ACOs will be held accountable—the "performance period." • Beneficiaries need clear and consistent information before they decide to receive care from a clinician or institution participating in an ACO. Full disclosure about the providers' participation in the ACO and the impact of such participation on patients is necessary to ensure a patient understands and can actively engage in her care. • Transparency and patient engagement are essential elements for patients to accept new models of delivery, such as ACOs.

Accountable care organizations (cont'd.)	FEDERAL STATE	Participation in an ACO by beneficiaries in Medicaid and traditional Medicare should be voluntary and should not affect access to other Medicare providers, physicians, or practitioners. ACOs should be required to meet qualifying criteria identified and enforced by a regulatory body. If the regulatory body wishes to deem the accreditation standards of a private accrediting body, the standards must be at least as rigorous as those established by a state or federal regulator. An ACO must have: • a formal legal structure to allow the organization to receive and distribute payments, a mechanism for governance, and a governing body that includes consumers; • the capacity to manage risk and resources to ensure accountability; • an adequate provider network, including a strong foundation in primary care that can function as medical homes (see policy on medical homes); • ability to coordinate services across the continuum of care and care settings; • ability to meet the requirements of at least stage 1 of federal "meaningful use" regulations to demonstrate that use of health information technology improves care (see this chapter's section on health information technology) and use technology to support clinical operations and patient-centered functions (e.g., email, tele-health) (In accordance with the provisions of HITECH, to be eligible for financial assistance to purchase electronic medical records eligible physicians and hospitals must demonstrate "meaningful use" of technology to achieve significant improvements in care); • capability to measure and report performance on quality and cost (resource use); and • demonstrated ability to improve quality, including establishment of performance goals and targets and collection of data to support improved care. ACOs must collect and report performance data on clinical effectiveness and patient experience. Aggregate cost sharing charges in an ACO should not exceed those in the traditional Medicare program.

QUALITY AND SAFETY

Quality Improvement

The Institute of Medicine (IOM) has defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." There is substantial evidence that serious quality problems exist throughout the US health care system. The IOM has characterized these as underuse, in which individuals fail to receive services that save lives or prevent disability; misuse, in which individuals are injured when avoidable complications of health care are not prevented; and overuse, in which individuals are exposed to the risks of health services from which they cannot benefit. Quality problems are found throughout the health care system and in all types of delivery systems and result in wasted resources and, for individuals, lost lives, reduced function, or injury. The IOM found that the current environment in which health care is delivered inhibits the changes needed to achieve quality improvement. It recommended refocusing and realigning the system

so that it is safe, efficient, patient-centered, timely, efficient, and equitable.

Collecting and publishing standardized information on quality and resource use would help providers and others meet the IOM's criteria. Finally, clinicians and institutions need technical assistance to improve quality.

Performance Measurement, Quality Improvement, and Safety

Measuring performance is key to identifying problems in the health care system and thus to improving quality. Ideally, measures would serve the dual purposes of quality improvement and public reporting. In addition, to realize value from the measurement process, performance measures should be developed from evidence-based guidelines. The development of priorities, goals, and standards, to guide measure development should be national (to ensure standardization) with local implementation (to permit innovation and focus on community needs). The 2010 Patient Protection and Affordable Care Act (ACA) recently called for the Department of Health and Human Services (HHS) to develop a national health care quality strategy and plan that establishes principles and priorities to help improve the quality of care nationwide.

Measuring disparities in health care must be integral to the process of performance assessment. The "National Healthcare Disparities Report" documents the disparities related to race, ethnicity, and socioeconomic status that pervade the US health care system. Without a consistent and uniform method of collecting information on an individual's race, ethnicity, gender, age, primary language, and sexual orientation and gender identity we cannot assess where and why disparities exist and we miss a fundamental tool for developing programs that address gaps in care for minority populations. A first step toward eliminating these disparities is a systematic approach to collecting data on race, ethnicity, socioeconomic status, and language. These data would facilitate monitoring health care processes and outcomes for different population groups and help target quality improvement initiatives focused on eliminating identified gaps in care. In addition, it is important to recognize the unique preferences of all individuals and to meet their needs through care delivery. Congress significantly advanced the use of standardized performance measures when it provided a stable source of adequate funding to the National Quality Forum (NQF).

For the LGBT community, for example, access to knowledgeable and sensitive providers and recognizing and eliminating barriers to treatment that arise from social stigma are important approaches to ensuring equity for this population group.

Safety is a critical component of quality and is a core attribute of a high performing health care system. In the current system, preventable errors needlessly endanger patients. In its landmark 1999 study, "To Err Is Human: Building a Safer Health System," the IOM estimated that many thousands of Americans die each year in hospitals due to medical errors. The IOM estimated that the annual costs associated with error-based injuries range from $17 billion and $29 billion. Findings from a study released by the Society of Actuaries estimate that measurable medical errors cost the US economy $19.5 billion in 2008.

The Patient Safety and Quality Improvement Act of 2005 authorized a system for hospitals, doctors, and other health professionals to voluntarily report information to patient safety organizations (PSOs) on a privileged and confidential basis. The data are intended to be used to analyze events that compromise patient safety. The underlying philosophy of this legislation rests on recognition that the causes of risks and hazards in patient care may be best identified through the aggregation of numbers of individual events. Research conducted by the Agency for Healthcare Research and Quality (AHRQ) also finds that the organization of the health care delivery system and system-level failures are major contributors to medical errors and safety threats to patients.

Public Reports

The lack of adequate information to assess the performance of doctors and hospitals impedes efforts to improve the quality of health care delivery. Performance results need to be transparent to all health care stakeholders, including patients, providers, and purchasers. Ideally, data in the form of usable, actionable information would be universally available for multiple uses and users. The IOM has recommended a "full performance measurement system that is purposeful, comprehensive, efficient, and transparent." The measures used in public reports must reflect good science based on evidence-based guidelines and be clinically important, useful, and meaningful to end users—consumers, purchasers, regulators, and providers.

It is a truism that "what gets measured gets done." Consequently, publicly available performance information would drive resources to high performers and to the areas being measured. Initially, measures should focus on high-priority areas that have been identified and agreed upon by all stakeholders.

The assessment of resource use and efficiency in conjunction with a corresponding quality assessment of doctors, hospitals, and other providers would offer patients and purchasers useful information about the cost and quality of care and shed light on the value of care provided.

Public Reports on Serious, Preventable Events—"Never Events"

NQF has published a list of 28 unambiguous, serious, preventable adverse events, sometimes referred to as "never events." They include surgery performed on the wrong body part, patient death or serious disability associated with an electric shock while in a hospital, and care provided by someone impersonating a physician. The list, from the report entitled "Serious Reportable Events in Health Care," is intended to form the basis of a national reporting system that could substantially improve patient safety. The expectation is that each event would be investigated to determine its cause or contributing factors and that such findings would help deter or prevent future occurrences. In issuing the list of never events, the NQF expected that such events would be publicly disclosed.

The ACA included several provisions that address health care quality and delivery system reform. The legislation:

- created the infrastructure for a national strategy to improve the delivery and quality of health care services that identifies priorities and goals that align the efforts of public and private payers;
- required the Department of Health and Human Services (HHS) to identify gaps in quality measures and to fund the development of measures to fill these gaps, giving priority to measures that assess health outcomes, care coordination, shared decisionmaking, efficiency, and health disparities;
- charged HHS with overseeing a process for collecting and aggregating performance data and developing a framework for the public reporting of performance information;
- charged AHRQ to conduct and support research into best practices for quality improvement and to disseminate research findings; and
- established a mechanism for multistakeholder input to HHS on the selection of national priorities and quality measures.

In addition, the ACA addressed the performance of plans participating in the insurance exchanges by requiring them to be accredited and assessed on clinical and patient experience, consumer access, appeals, and other factors. The plans will be required to implement a quality improvement strategy and provide information to consumers on quality measures. HHS is also required to develop a system to rate qualified health plans on the basis of plans' relative quality and price. The plans will be reimbursed by means of a payment system that uses market-based incentives to encourage better health outcomes through implementation of activities such as quality reporting; effective case management; care coordination; chronic disease management; medication and care compliance initiatives; activities to prevent hospital readmissions, promote patient safety and reduce medical errors; and implementation of wellness and health promotion programs.

QUALITY IMPROVEMENT: Policy		
Funding measurement and quality improvement	FEDERAL STATE	The states and the federal government should sufficiently fund the development of quality measures, quality oversight, and technical assistance to help clinicians and institutions develop the capacity to collect, aggregate, report, and use data to improve the care they deliver. Congress should advance the use of standardized performance measures by ensuring a stable source of adequate funding for this purpose.
Public education	FEDERAL STATE	Education programs should promote the public's understanding of the health care system, the need to improve health care quality, the role individual consumers can play in maintaining their health and improving their care, and how they can make the best and most efficient use of health care services. To help consumers make informed decisions, information that pairs quality and cost should be publicly available whenever appropriate and feasible.

Consumer representaton	FEDERAL STATE	Consumers should be adequately represented at the governance and policymaking levels on all multistakeholder entities, such as those charged with advising the Department of Health and Human Services on health care priorities and goals, measure selection and other issues for quality improvement and public reporting.
Safety	FEDERAL STATE	AARP supports efforts to eliminate preventable medical injuries and accidents due to procedural errors or inadequacy. As steps toward this goal, AARP supports: • the multifaceted work of the Agency for Healthcare Research and Quality (AHRQ) to improve quality and safety; and • nationwide mandatory reporting to enable states to collect standardized data on adverse events that result in serious injury or death. Congress should provide funds and technical expertise to help states establish or adapt their current reporting systems to collect and analyze the data and follow up as needed with health care practitioners and providers. The AHRQ should: • ensure that information and expertise on best practices for implementation is disseminated; assess the impact of state programs, and analyze aggregate reports from the states to identify persistent safety issues that require more intensive and/or more broad-based responses; • encourage voluntary reporting efforts, which should include reports of hazards that have the potential to cause patient injury, as well as cases in which injuries have actually occurred; • develop performance standards for health care organizations that focus on patient safety—The standards should require regulators and accrediters to implement meaningful patient safety programs. Public and private health care purchasers should provide incentives to organizations to demonstrate ongoing improvement in patient safety; • facilitate action by health care organizations and affiliated professionals to make patient safety a declared and serious aim—Organizations should make quality improvement and safety a defined responsibility at the governance level and should institute measures including developing and implementing nonpunitive systems for reporting errors and proven medication safety practices; • inform the development of methods to facilitate the collection of data on medical errors, consistent with patients' legal rights; and • encourage states to develop effective systems to protect the public by removing from practice those health care professionals incapable of providing consistently safe and effective care.
Assessing performance and improving quality	FEDERAL STATE	Measures should focus on high-priority areas identified by the consensus of a multistakeholder group that includes adequate consumer representation. A core set of quality and performance measures in the Institute of Medicine's six domains of quality should be developed, at least in part with public funds, and collected from all providers and practitioners across all care settings. States and the federal government should identify a consistent and uniform method of collecting information on an individual's race,

Assessing performance and improving quality (cont'd.)	FEDERAL STATE	ethnicity, gender, age, socioeconomic status, and primary language and require health plans, public and private insurers, and other appropriate entities to collect and use the data to reduce or eliminate inappropriate disparities. States and the federal government should identify gaps in access to care and care quality for vulnerable populations, including people with multiple chronic physical and mental illnesses. States and the federal government assess resource use and efficiency in conjunction with quality so that doctors, hospitals, and other providers are fairly evaluated and patients and purchasers have useful information about the value of care they receive.
Public reports	FEDERAL STATE	All public reports should present information that is grounded in evidence, clinically important, and useful and meaningful to the end users: consumers, providers, purchasers, and regulators. The federal government and states should ensure that valid, accurate, objective, and standardized information is available to consumers to help inform their health care decisions. Information for consumer decision making should include but not be limited to data on treatment options; plan benefits and procedures; plan, provider, and practitioner performance; consumer experience; and cost. To the extent possible, such reports should permit consumers to compare the performance of competing types and models of plans, such as health maintenance organizations, preferred provider organizations, conventional fee-for-service plans, and those with integrated delivery systems, among others. Comparative data on medical groups, physicians, and institutions, including hospitals, also should be provided. To the extent possible, quality information should be paired with information about the cost of care to help consumers and others make determinations about efficiency and resource use. Information should be presented in formats that promote understanding and correct interpretation of data. Processes known to reduce the cognitive difficulty of using information should be employed, and users' literacy levels should be taken into account when information is developed and reported. Consumer information should be evaluated to assess its usefulness and relevance.
Reporting preventable events	FEDERAL STATE	The federal and state governments should require individual providers and health care facilities (including hospitals, nursing homes, rehabilitation centers, medical centers or offices, outpatient dialysis centers, and ambulatory surgical centers) to report the occurrence of any of the serious, preventable, adverse events identified by the National Quality Forum. Policymakers should require that facility-specific reports be publicly disseminated. The federal and state governments should prohibit facilities responsible for serious, preventable, reportable adverse events from passing the cost of treating related complications either to the federal government, states, other payers, or patients.

Ensuring an Evidence Base for Decisionmaking

Although there is some disagreement on the precise figure, most experts agree that not more than half of medical interventions have a strong evidence base. This means that much of the care patients receive is not based on firm, scientific evidence and is instead determined by the level and quality of a clinician's training and his/her individual expertise, and judgment. To ensure high quality of care and most efficient resource use, it is essential that the best possible evidence is available to clinicians and patients. Evidence can be developed by conducting research that compares various treatment interventions and devices (i.e., "comparative effectiveness research") to determine which works best and for which patients. This type of research is costly and requires public financial support. In addition, it is critically important for consumers and other stakeholders to participate in the identification of research priorities and goals to optimize resources spent on comparative effectiveness research and to ensure that research reflects areas of importance and salience to consumers.

In 2009, the American Recovery and Reimbursement Act provided $1.1 billion for HHS, through the Agency for Healthcare Research and Quality and the National Institute of Health, to conduct comparative effectiveness research. The Affordable Care Act also contained provisions to advance the use of evidence in health care settings by directing the establishment of a Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policymakers to make informed decisions based on evidence. The Institute will identify research priorities, establish a research agenda, conduct research, and disseminate research findings.

ENSURING AN EVIDENCE BASE FOR DECISIONMAKING: Policy		
Evidence and decisionmaking	FEDERAL	Congress should continue to ensure adequate funding for research on the comparative effectiveness of treatment interventions, including prescription drugs, medical devices, and procedures. Research should be applicable to all health care settings and populations, including vulnerable groups. Funding should also support research to determine the most effective delivery of care approaches, including those intended to address the needs of people with multiple chronic conditions.

Health Information Technology

Health information technology (HIT) is a critical tool that can enhance quality improvement efforts. HIT can promote and facilitate data collection, storage, and retrieval; reduce errors; foster coordination; support clinical and patient decisions; and reduce unnecessary duplication. Ultimately, it is hoped, HIT will yield savings. However, many barriers inhibit widespread adoption of HIT. These include concerns about privacy and confidentiality; the lack of standards for interoperability; the cost of automation, including acquisition, implementation, and maintenance expenses; and the need to develop a workforce to create and maintain the database.

The goals for a national health information infrastructure are to:

- inform clinical practice through the use of electronic medical records;
- connect clinicians through regional collaborations;
- personalize care through the use of personal health records and tele-health systems; and
- improve the health of the general population through better monitoring of quality, improved dissemination of evidence, and more unified public health surveillance efforts.

Electronic prescribing systems, or "e-prescribing," use digital devices to enter, modify, review, and communicate drug prescriptions. Well-designed systems can improve quality by reducing medication errors at the point of prescribing through decision support, can increase formulary adherence, and can promote greater efficiency through the electronic connection between prescribing clinician and dispensing pharmacy.

The Health Information Technology Act of 2009 (HITECH), part of the American Recovery and Reinvestment Act of 2009 (ARRA), substantially advanced opportunities to accelerate the acquisition and implementation of HIT and promoted information exchange. In addition to setting the expectation that individuals should be able to get electronic copies of pertinent information about themselves, the HITECH codified and funded the Office of the National Coordination for Health Information Technology and authorized the

development of standards and certification processes to guide HIT investments. Two important committees were established: the HIT Policy Committee, to advise the Department of Health and Human Services on policy matters concerning the development of a nationwide technology infrastructure, including electronic exchange of information in a manner that ensures protection of the confidentiality of the data; and an HIT Standards Committee to recommend standards, implementation specifications, and certification criteria.

A key HITECH provision was the requirement that to be eligible for financial assistance under this legislation, providers, (including physicians, hospitals, and long-term care facilities) had to be able to demonstrate that they were putting the technology to "meaningful use" (MU), a term that has been broadly defined in regulations promulgated by CMS. The goals of MU of HIT are to improve health care quality, efficiency, and patient safety, care coordination, medication management, etc., and not mere adoption of the technology as an end state. A companion regulation detailed the requirements for certified electronic medical records, including the standards, implementation specifications, and certification criteria to enhance the interoperability, functionality, utility, and security of HIT.

HEALTH INFORMATION TECHNOLOGY: Policy		
Promoting health information technology (HIT)	FEDERAL STATE	The Department of Health and Human Services should ensure steady progress to full implementation of the meaningful use requirements so that federal HIT investments advance health and improve quality and efficiency in the health care system. To the extent that states encourage the use of HIT through adoption of interoperable electronic medical records and information exchange, they should develop infrastructures to support appropriate standards and privacy protections that are at least consistent with national standards.

Privacy and Confidentiality of Health Information

Fully computerized data systems will facilitate access to personal health information. While the public generally recognizes the value that health information technology (HIT) brings to health care, it strongly favors a comprehensive approach to privacy and information-access practices to go along with HIT applications.

However, the public's concerns are heightened by the increasing number of breaches reported in the media. The widespread use of Social Security numbers as a primary form of identification in Medicare and other programs further exposes individuals to the threat of identity theft and security breaches. Many states have enacted statutes providing some protection against inappropriate disclosures of personally identifiable medical information, although the patchwork of state laws leaves many gaps in privacy protections. A comprehensive framework of privacy and security protections, including transparency regarding uses and disclosures of personal health data is necessary to ensure public trust in HIT and health information exchange.

The Genetic Information Nondiscrimination Act (GINA), enacted in 2008, bars insurers and employers from using genetic-testing information for purposes related to insurance or employment decisions, including setting eligibility requirements or premiums. It should be noted that the increased marketing of genetic test kits to consumers poses potentially unnecessary risks, due to misinterpretation and possible unreliability of results. Therefore, counseling for patients on the proper use and interpretation of such tests is appropriate. GINA does not apply to life, disability, or long-term care insurance.

Regulations issued under the 1996 Health Insurance Portability and Accountability Act (HIPAA) established important privacy protections for health care consumers, such as requirements for covered entities to provide notice to consumers of their rights and protections and to provide consumers access to or copies of their personal health information if requested. HIPAA rules generally apply to health plans, health care clearinghouses, and health care providers that conduct certain financial and administrative transactions, like billing and fund transfers, electronically. The privacy protections in the HITECH portion of the ARRA significantly strengthened privacy protections and moved closer to achieving the necessary privacy and data security framework. HITECH also extends accountability to entities doing business (known as "business associates") with HIPAA-covered entities.

Notification to an individual of a provider's privacy policies is necessary but insufficient protection. In addition, requiring consent any time records are shared may appear to be a reasonable protection but could have unintended consequences, such as promoting the use of blanket consent forms that give consumers a false sense of security. Moreover, many consumers do not read privacy notices. Ideally, privacy protections should be integral to clinical operations. Entities complying with federal regulations should ensure that implementation of these requirements minimizes interference with the routine delivery of health care services or measurement of service quality. Sound network design encourages information-sharing and protects the confidentiality of personal health information, as does effective oversight and accountability, including enforcement.

Appropriate federal and state agencies should monitor and enforce compliance with privacy regulations and educate and guide covered entities about whether their policies and procedures are reasonable and appropriate.

PRIVACY AND CONFIDENTIALITY OF HEALTH INFORMATION: Policy		
Right to privacy	FEDERAL STATE	Federal and state governments should ensure individuals' right to privacy and data security with respect to their personal health information. State and federal policies should grant individuals the right to examine and copy the contents of their health care records, be notified who has examined these records, and identify who may have access to their personally identifiable health information and for what purpose. The Department of Health and Human Services(HHS) should ensure that business associates of HIPAA-covered entities restrict their uses and disclosure of an individual's personal health information only to what is necessary for the business associate to carry out the activities it has agreed to perform for the covered entity.
Design attributes for health information technology (HIT) systems to protect personal health information	FEDERAL STATE	Essential design attributes of HIT systems must address the following: • control and access—Individuals must have the ability to control who has access to their personal health information and the ability to review who has reviewed their files; • disclosure and accountability—Individuals should receive information that fully explains policies affecting the transfer of their personal health information and how that information may be used; • functionality—Individuals must be able to move their information securely and reliably from one health care entity to another; and • governance—Consumers must be represented on an equal footing with other parties in the governance and advisory structure of all regional and national bodies, including standard-setting and operational entities. AARP supports the policy principles identified by Connecting for Health (a multistakeholder organization supported by the Markle Foundation). Federal and state agencies should enact privacy protections to ensure that: • policies and practices addressing personal health information are developed in an open and transparent manner; • the purposes and intended uses for which personal data are collected are specified at the time of collection and subsequent uses are limited to the initially specified purpose unless otherwise disclosed;

Design attributes for health information technology (HIT) systems to protect personal health information (cont'd.)	FEDERAL STATE	• personal health information is not made available or used for any purposes other than those specified; • individuals can control access to their personal health information and have the right to obtain data relating to them communicated in a reasonable timeframe, at an affordable charge (if any), and in a form that is readily understandable; • if an individual's request for personal health data is denied by the entity controlling access to the data, the individual should be able to challenge such denial and have such data corrected, completed, or amended; • all personal data collected are relevant to the purposes for which they are to be used and are accurate, complete, and current; • personal data are protected by reasonable security safeguards against risks such as loss, unauthorized access, destruction, use, modification, or disclosure; • entities controlling personal health data are held accountable for implementing effective practices to ensure adherence to these principles; and • legal and financial remedies exist to address security breaches or privacy violations.
Disclosures	FEDERAL STATE	AARP opposes the use or disclosure of an individual's health information without prior consent except for: • public health reporting, as required by law—A court order must be required of law enforcement agencies seeking access to personal health information; • ensuring the financial integrity of publicly funded health programs (provided that personal identifiers have been removed whenever possible); • research and quality assessment and improvement (provided that personal identifiers have been removed whenever possible); and • health care interventions, including disease management programs and chronic care coordination. AARP supports policies that: • prohibit the use of patients' clinical information for marketing purposes without the individuals' express written consent or opt-in authorization; • require the types of communication constituting "marketing" to be clearly delineated—Criteria to define this term include whether information is directly related to ongoing treatment regimens, whether it concerns new products, and whether a covered entity is receiving any remuneration for giving information to consumers; and • assure consumers the right to have their names removed from marketing lists.
Genetic testing	FEDERAL	Genetic testing should not be performed on individuals unless they have provided informed consent. AARP supports the role of licensed health professionals in advising consumers about the need for, and interpretation of, all genetic testing. AARP supports the value of family health history being discussed with family members and clinicians, with appropriate referral to genetic counselors as necessary.

Social Security numbers	FEDERAL STATE	Medicare and other insurers should transition by a certain date from the use of Social Security numbers as the primary form of identification to some other appropriate form of identification to better ensure individual privacy and security while maintaining convenience and access to services (for background and further policies on protecting the privacy of Social Security numbers, see Chapter 11, Financial Services and Consumer Products: Information Privacy).

Medical Malpractice

Preventable medical injuries caused by medical errors are widespread and costly. They result from flaws in the complex interactions among health care professionals, sophisticated technologies, products, and organizational systems. They also can arise from individual negligence, impairment, and incompetence. Preventable medical injuries may be subject to redress under an area of tort liability called medical professional liability or medical malpractice. Other areas of tort liability that may pertain to users of health and long-term care services—but are distinct from medical malpractice—are product liability (e.g., for defective drugs or devices) and liability for negligent injury resulting from neglect or abuse, such as in a nursing home or other long-term care setting.

The 1999 Institute of Medicine (IOM) report, "To Err Is Human: Building a Safer Health System," consistent with other studies, attributes most preventable medical injuries to systems failures, not individual negligence or incompetence. A systems approach to preventing medical injury focuses on learning how and why errors occur and developing and implementing systems that will avoid them.

To date, most discussions concerning preventable medical error and injury have focused on the medical malpractice system instead of the error or injury itself. Tort liability continues to be attacked as an important source of problems in America's health care system. Although in the aggregate medical malpractice premiums make up less than 1 percent of total health care expenditures, the overall cost of the medical liability system, including defensive medicine, has been estimated at 2.4 percent of total health care spending.

Although the estimated number of medical injuries nationally may be as high as one million per year, only about 85,000 malpractice suits are filed annually. Since the early 1990s, the number of settlements and judgments of malpractice claims reported to the National Practitioner Data Bank (NPDB) has hovered under 15,000 per year. Eight times as many patients are injured as ever file a claim and 16 times as many suffer injuries as ever receive compensation. Physician advocacy groups say that 60 percent of liability claims against physicians are dropped, withdrawn, or dismissed without payment. Most malpractice claims that are settled (73 percent) involve medical error. Only about three percent of claims are not associated with injuries. According to the NPDB, just 5 percent of physicians account for 54 percent of malpractice payouts.

From a patient perspective the most important purposes of the medical malpractice system are to compensate negligently injured patients and deter unsafe health care practices that lead to injury. A variety of solutions to the current problems in the medical malpractice system have been proposed and in some cases implemented. Perhaps the most controversial is a limit or cap on damage awards. Because nonpecuniary damages are likely to constitute a larger share of an award for older, retired, or poor people, such caps would exclude a larger portion of legitimate potential claims and therefore would disadvantage these groups the most. Caps on damages of varying levels have been imposed in more than half the states. Several of these caps have been struck down as unconstitutional or been repealed.

To be effective in the long run, approaches to address problems in the current medical malpractice system must both significantly reduce the number of preventable medical injuries and offer appropriate compensation for people who are injured despite improved safety efforts. One attempt to do this is the patient-centered, safety-focused, nonjudicial injury compensation system described by the IOM in "Fostering Rapid Advances in Health Care: Learning from System Demonstrations," released in late 2002. Under this system, recommended for immediate state-level demonstration, patients would be compensated for avoidable injuries based on a preset schedule of awards. Providers would be required to report and analyze medical errors, implement programs to reduce medical injury, and involve patients in safety improvement efforts.

Another approach to malpractice reform has been to encourage providers to openly acknowledge their errors, apologize to patients and quickly offer compensation. This approach, often referred to as "sorry works," helps patients find answers they are looking for about what went wrong in their care and how the problem has been addressed. In one example of this approach, the University of Michigan Health System adopted new policies on medical errors in 2002. In the years since adopting these policies, the health system has cut the amount it spends on litigation in half and the number of new claims has dropped dramatically as has the time required to resolve claims. The "sorry works" approach has been aided in several states which have adopted laws that prevent a doctor's apology or expression of remorse from being used against him or her in court.

The 2010 Patient Protection and Affordable Care Act authorized grants to states to establish demonstration programs to evaluate alternatives to the current approach to medical malpractice based on tort litigation. The Department of Health and Human Services has allocated $25 million for three-year grants that will allow states to test models that emphasize patient safety, disclosure of medical errors, and alternative dispute resolution approaches. Patients will be allowed to opt-out of these alternatives at any time.

MEDICAL MALPRACTICE: Policy		
Malpractice reform	FEDERAL STATE	All medical providers and hospitals should be required either to carry adequate levels of medical malpractice insurance or demonstrate an ability to pay potential malpractice claims. If malpractice exclusions or waivers are established for providers, states should not single out Medicaid beneficiaries or recipients of uncompensated care for reduced protection. While voluntary arbitration should be an option, pre-dispute mandatory arbitration should be unenforceable (see Chapter 8, Long-Term Care Services and Supports: Quality and Consumers' Rights Across Settings and Chapter 12, Personal and Legal Rights: Individual Enforcement of Legal Rights, for related policy). States should initiate demonstration projects to explore and evaluate promising methods of patient compensation, such as accelerated compensation events systems and mediation. In so doing states should be careful to avoid restricting patient access to fair and just compensation. Statutes of limitation should be no shorter than two years and should not begin until the injury is discovered or should have been reasonably discovered. Insurance mechanisms that make liability insurance coverage available should be supported, and states should require that malpractice insurance premium increases be approved by state regulators, ensuring that proposed rates are justified by claims-loss ratios. States should also require that insurance companies report filed claims to the state insurance commissioner on an annual basis. Insurance regulators should identify and collect additional, mutually beneficial data necessary to further the understanding of conditions in current and future medical malpractice markets. AARP believes that any efforts to address medical malpractice concerns should begin with a patient-centered focus on reducing errors and promoting fair compensation. AARP does not support malpractice reform proposals that do not reduce errors or that would impair the right of injured patients to full and just compensation for injuries resulting from inappropriate medical care.

Malpractice reform (cont'd.)	FEDERAL STATE	AARP endorses the Institute of Medicine's recommendations for exploring alternatives to the tort system, and specifically supports: • reforms that would promote access to the courts for all legitimate claims, including smaller malpractice claims, and accelerate the resolution of cases; • further exploration of alternative dispute resolution systems for medical malpractice cases that could serve injured patients better than the current system does, such as "sorry works" approaches; • the development and evaluation of demonstration projects for other promising systems of compensation for preventable medical injuries, such as the comprehensive patient-centered, safety-focused, nonjudicial injury compensation system proposed by the institute—Such projects should be conducted under government auspices, with strong oversight, adequate funding and staffing, and rigorous evaluation, and should apply schedules of damages that do not result in disproportionately low or otherwise unfair awards to older, nonworking patients; and • malpractice insurance rates that fairly and accurately reflect claims experience.

HEALTH CARE COVERAGE

Private Health Plans

Individual- and Employment-Based Group Plans

Most Americans rely on health insurance coverage to pay for some portion of the health care services and supplies they need. Most people under age 65 obtain coverage through the private insurance market, which makes access to private coverage crucial. Ensuring that everyone has access to private coverage has been at the heart of past and the latest efforts to reform practices of health insurers and private health care plans, including self-insured employer plans. The 2010 Patient Protection and Affordable Care Act (ACA) made a number of changes to address practices in the private markets that have been barriers to coverage or posed other concerns for consumers.

Regulation of private health insurance has traditionally been a state responsibility. However, regulation of employers' self-insured benefit plans, which are covered by the Employee Retirement Income Security Act (ERISA), is a federal responsibility; and state requirements are often preempted by ERISA rules. Consumers thus have different protections depending on the state in which they live and whether they are covered by an insured or self-insured health plan. This division of responsibility for regulating private plans and private markets between federal authorities and the states may hurt consumers and destabilize markets. It has also frustrated some states' efforts to reform health care and consumer protections. At the same time federal efforts to create uniformity in health coverage create unique challenges at the state and local levels.

The federal government and many states have sought to regulate practices in the private health market that hamper access to private coverage. In 1996 Congress limited the use of preexisting-condition exclusions for people changing group coverage and prohibited discrimination in group coverage against those with health conditions. These protections apply to both ERISA plans and fully insured plans. The law also guarantees access to coverage in the individual market for those losing group coverage and for the renewal of coverage in the individual market. However, people buying coverage as individuals had fewer protections than those covered through a group. The new health reform law now extends the same protections to the individual market.

Restrictions on insurers' ability to use health status in setting premiums are common in the group market, but rare in the nongroup market. Regulation of rate-setting practices affects how narrowly or broadly costs or risk are spread among the insured. A few states require "pure community rating" or "adjusted community rating" to narrow the premium differences among covered individuals. Under pure

community rating, everyone covered under the same plan is charged the same premium regardless of individual characteristics. Under adjusted community rating, changes in the pure community rate can reflect specified demographic factors, such as age, number of dependents, and geography, but not health status or experience.

The ACA limits the factors that can be used to vary premiums. Starting in 2014, insurers will only be able to vary premiums for small groups and individuals based on family size, geographic rating area, age (3:1), and tobacco use (1.5:1). While health status will no longer be used to set premiums, the ACA permits premium discounts or rebates or adjustment in cost-sharing related to health promotion and disease prevention programs.

Many states use high-risk pools to guarantee access to coverage to those the private market considers uninsurable. To help reduce the cost of high premiums for coverage in the risk pool, states and some federal grants have provided subsidies. Even so, premiums may be too high for people with modest incomes.

The ACA creates a temporary federally funded high-risk pool program to provide health insurance coverage for US citizens and lawfully present immigrants who have a preexisting medical condition and have been uninsured for at least six months. An appropriation of $5 billion has been made to subsidize the cost of claims in the program.

Other approaches to spreading the risk of insuring high-cost individuals include risk adjustment and reinsurance pools. These methods help insurers cover those with poorer health by paying some of the higher costs involved. The new law includes these approaches to spread risk as part of the transition to new market rules.

To address the higher costs and lack of choice that individuals and small-group purchasers face, additional proposed and implemented reforms have created other types of pooling mechanisms. One example considered at the federal level was an association health plan that would allow pooling through entities not subject to state insurance regulation.

States have authorized public or private mechanisms to pool purchasers, structure plan choices, and in some instances, negotiate premiums. Evidence from reforms in the 1990s shows that these mechanisms may expand the number of insurance options available to small purchasers in the short term. But they have not done much to expand coverage among employers that previously did not offer health coverage, nor have they led to significant reductions in premiums. Experience also indicates that it can be difficult to sustain coverage pools. More recently Massachusetts' Connector was created as a way for small employers and individuals without access to employer-sponsored plans to receive coverage.

The ACA creates the American Health Benefit exchanges to provide a new path for individuals and small groups to access insurance. Starting in 2014, individuals and small businesses will be able to purchase qualified health plans through a pooling mechanism, and eligible individuals buying coverage through an exchange will be able to apply for premium and cost-sharing credits to help with the cost of coverage.

The ACA includes provisions to improve insurers' accountability and transparency through rate review and the requirement to provide rebates if plans do not achieve medical loss ratio standards.

As health care costs and premiums rise, pressure grows to develop more affordable options. One being promoted in the market is the high-deductible health plan (HDHP), which shifts more out-of-pocket costs to the insured in exchange for lower premiums. Proponents contend that HDHPs will limit growth in costs by making consumers more cost conscious.

Congress gave certain HDHPs a boost by authorizing tax breaks for health savings accounts (HSAs). Account holders may use the account to pay out-of-pocket expenses under the HDHP. Contributions to HSAs are tax deductible up to a statutory limit, and account gains and withdrawals for health expenses are tax free. Contributions are not permitted, however, after age 65. Some employers have established HSAs to help employees pay for costs under their HDHP.

In the nongroup market, where the consumer generally pays the full premium, a HDHP may be the only affordable option for some. In the small-group market, employers facing steep annual premium increases may also turn to HSA-qualified HDHPs instead of more comprehensive health plans.

A number of public policy concerns are associated with the spread of HDHPs and HSAs in the private market. The first is risk segmentation. Enrollment in these products draws people away from more comprehensive products, which could become too expensive to sustain if those who remain are the less healthy. A second concern is that consumers without the resources or savings to pay for care below the deductible will be underinsured and may be unable to access needed care. Low-income individuals and those with expensive chronic conditions are particularly vulnerable.

INDIVIDUAL- AND EMPLOYMENT-BASED GROUP PLANS: Policy		
General	FEDERAL STATE	AARP supports health care reform that achieves universal access to health care coverage and provides adequate protection against health care costs. AARP may support reforms that will expand access to private health coverage for individuals seeking to obtain or retain coverage in the private market, either on their own or through a group. To ensure a level playing field, reforms should apply uniformly to all insurers and self-insured plans in a particular market, covering all individual, small-group, and large-group purchasers. Associations and similar nontraditional pools should be subject to the same rules as the rest of the market. Federal policies on private insurance markets should set a floor for states but should not preempt higher state standards. Policymakers regulating the private insurance market should provide and enforce: • guarantees that all individuals and groups wishing to purchase or renew health insurance can do so; • prohibitions on selective premium increases for individuals based on their health status or claims experience; • limits on coverage exclusions or waiting periods for preexisting health conditions and credit policyholders' prior coverage toward satisfying limits on preexisting conditions and the prohibitions on preexisting condition exclusions or other discriminatory practices for individuals under age 19 prior to 2014 and for all ages as of 2014; and • ACA rating rules when they take effect. Policymakers should examine changes to ACA rating requirements to further phase down age variation from 3:1 to pure community rating. Policymakers should carefully monitor premium increases and trends as well as medical-loss ratios in order to make sure that rates are reasonable and fair (see Chapter 11, Financial Services and Consumer Products—Insurance Industry Oversight, on the authority to approve rates prior to their implementation). Insurers and private sponsors of health coverage should be required to provide prospective and current subscribers with accurate, readily understandable information using standard descriptions on: • benefits, limitations, exclusions, expenses that will and will not count toward satisfying deductibles, how deductibles for family policies work, and whether network discounts apply to services received before the deductible is met; • ownership of, carry-over provisions in, and retention rights to health account funds; contribution and spending rules for the accounts, including their tax treatment; and fees, charges, and limitations associated with accounts; and • provider performance, to the extent it is available.
The 2010 Patient Protection and Affordable Care Act (ACA)	STATE	States should take full advantage of federal funding for: • planning and developing health benefit exchanges; • developing, expanding, and supporting health insurance consumer assistance or ombudsman programs; and • supporting the review of premium increases.

Pooling mechanisms and high-risk pools	FEDERAL STATE	AARP may support reinsurance, risk adjustment, or similar mechanisms to spread the insurance risk more broadly. Any pooling mechanisms created to enhance access to health coverage and plan choice, such as purchasing cooperatives, association health plans, connectors, or the like, should not restrict participation on the basis of demographic characteristics (e.g., age or gender), health status, or type of employment; should provide consumer access to fair grievance and appeals procedures; should give consumers a voice on governing bodies; and should not undermine existing federal and state protections. Policymakers should create exchanges that: • give consumers a voice on the governing body; • give the exchange the authority to contract selectively with plans offered through the exchange, negotiate with insurers for packages of benefits and coverage that meet minimum coverage requirements, and negotiate plan premiums; • set standards for benefit offerings that are based on consumer wants and a consumer desire for choices that they can easily understand and compare; and • develop an application and enrollment system and infrastructure that: provides consumers with a single point of access to coverage choices that helps them navigate their options; offers a simple application and enrollment process; and that is not stigmatized. Exchanges must be publicly accountable and must oversee the activities of plans offered. Policymakers should provide a funding base for high-risk pools adequate to ensure that enrollment does not close; that subsidies are available and sufficient to make coverage affordable for those with modest incomes; and that existing state pools have resources to operate until 2014. Policymakers should use cost-containment features, such as chronic disease management and incentives, for administrative effectiveness.
Health Insurance Portability and Accountability Act (HIPAA)	FEDERAL STATE	Federal and state governments should enforce the access, portability, and renewability protections in Title I of HIPAA for group and individual coverage.
High-deductible health plans	FEDERAL STATE	AARP does not view high-deductible insurance products paired with health accounts as an optimal approach to providing adequate, affordable coverage to consumers who now lack access to health insurance. AARP urges policymakers to conduct research on and monitor these products in terms of how they compare with traditional products with respect to: • characteristics of enrollees, • health service utilization and health outcomes among enrollees, and • affordability of coverage and health spending, especially with regard to vulnerable populations for whom high deductibles and cost-sharing may pose financial barriers to care, exhaust savings, or result in unaffordable medical bills. Policies governing high-deductible health coverage should require that plans cover preventive care and health-maintenance drug treatments as benefits not subject to the deductible requirement.

High-deductible health plans (cont'd.)	FEDERAL STATE	Policies also should require these plans to clearly communicate their design to potential and actual policyholders to ensure they are aware of their potential out-of-pocket costs. When incorporated as a part of health reform proposals, high-deductible health plans should meet AARP's affordability principles.
Employee Retirement Income Security Act (ERISA) and state-regulated health plans	FEDERAL STATE	Federal insurance reforms should apply equally to ERISA plans and state-regulated health plans. AARP supports changes in ERISA that would provide a means for states to apply their health care initiatives to both ERISA-covered health benefit plans and state-regulated insurance plans. Such reforms might include: • consumer protections and grievance procedures; • broad-based financing strategies to contain costs or provide funding to improve access and coverage; • health insurance market reforms; • financial solvency guarantees; • uniform claims procedures; and • uniform utilization and cost data.

Private Health Plans

The vast majority of workers with health insurance are enrolled in some type of managed care plan; only about 1 percent are in conventional insurance plans. Managed care combines health insurance with delivery of care and provides an alternative to traditional indemnity insurance. Most models of managed care generally share three characteristics: limitations on the use of providers, negotiated provider reimbursement, and some form of utilization review.

Managed care insurance products, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), reflect a blend of features of several models. Some HMOs require enrollees to obtain prior approval from a primary care provider for most care, while others offer "open access" to specialists without prior approval. A point-of-service (POS) plan allows HMO enrollees to seek care outside the HMO, typically with significantly higher deductibles and/or copays and sometimes higher premiums.

Preferred provider organizations (PPOs) are more loosely structured. Physicians are generally paid on a discounted fee-for-service basis, and consumers have incentives, usually in the form of reduced cost-sharing, to obtain care from participating providers.

Enrollment in a managed care plan is available in the public and private sectors but is far more prevalent in the latter. In 2010, 58 percent of covered workers were in PPOs; 19 percent in HMOs, 8 percent in POS plans; 13 percent in HDHP/SOs (High Deductible Health Plans with Savings Option) and 1 percent in conventional plans.

By contrast only 11 million Medicare beneficiaries were enrolled in private health plans (about 24 percent), as were 33.4 million or 70 percent of Medicaid beneficiaries.

Regulation and oversight of managed care plans are inconsistent across the states, with a patchwork of varying rules.

Many states have responded to the growth of managed care in the commercial sector and within state Medicaid programs by enhancing licensing and oversight activities. In some cases states have adopted a broad set of regulations that address the bulk of managed care activities for all models of managed care plans. In other cases states have chosen to regulate only one type of managed care plan (e.g., HMOs but not PPOs) or have enacted laws that regulate only a particular aspect of a managed care system, such as utilization review, length of hospital stays, or physician-patient communications.

Private accrediting bodies and government agencies are paying greater attention to developing measures that can be used to hold PPOs accountable as well.

Some states require accreditation for licensing; others, as a way to avoid costly duplication of effort, give deemed status to a plan that has satisfied all or some of the state's requirements. Many states allow private accrediting organizations to deem that a health plan satisfies some or all requirements in such areas as quality assurance, utilization management, access to care, and credentialing.

National uniform standards would provide all consumers, regardless of where they live or how they obtain coverage, with a consistent level of protection.

The 2010 Patient Protection and Affordable Care Act (ACA) contained several consumer protections that address access to primary care physicians, coverage of emergency services, and external appeals. Published reports of performance on standardized measures, including patient experience and the clinical effectiveness of care, would help to advance health plan accountability and inform consumer decision making. Plans that publicly report in the Healthcare Effectiveness Data and Information Set (HEDIS) have better performance scores than those that do not.

In general, Medicare has been a leader in identifying and codifying standards for the conduct of managed care plans in the Medicare Advantage (MA) program.

One obstacle to consistent and uniform regulation is the federal Employee Retirement Income Security Act (ERISA). Some courts have ruled that the law prevents employees in self-insured plans from suing their plans in state court for damages that result from denied or delayed care. ERISA does permit participants in self-insured plans to sue in federal court, but plaintiffs are allowed to recover only the actual cost of the benefit denied or delayed, not punitive or compensatory damages. The US Supreme Court has ruled that ERISA completely preempts state laws that conflict with the federal law's civil enforcement remedies.

Managed care plans often use financial incentives to induce participating providers to provide high quality, cost-effective care. These incentives include capitation payments, withholds, and bonuses for meeting budgetary or other performance targets, as well as financial incentives for improving quality. The ACA contains provisions to reward MA plans that demonstrate high quality (see Private Health Plans in Medicare: Medicare Advantage). Depending on how these arrangements are implemented, they can have an adverse or positive impact on patient care. For example, in fee-for-service medicine, the fact that providers are paid a fee for each service they offer could result in overuse of services and unnecessary care. Special protections are needed to ensure that financial incentives to induce providers to be cost-conscious do not become disincentives to provide appropriate care. It is also critical that incentives not constrain providers from discussing with patients the full range of treatment options or any other issue that might affect patient health.

A growing practice among large purchasers and employer coalitions is to offer health plans financial incentives to improve their clinical and service performance. Such "pay-for-performance" can take many forms but all initiatives are intended to reward enhanced quality of care, greater efficiency, or a demonstrated commitment to quality and public reporting of performance. Incentive programs typically assess performance in clinical care, member access to services, and patient-reported experience, and ideally are grounded in evidence-based measures.

PRIVATE HEALTH PLANS: Policy		
Choice of options	FEDERAL STATE	AARP does not favor any particular health care coverage option. Public (e.g., Medicaid) and private sponsors should offer more than one health insurance option to those eligible for coverage, and plan selection should be voluntary and at the consumer's discretion.
Research	FEDERAL STATE	Ongoing research should determine whether managed care organizations achieve savings and deliver high-quality care, analyzing the impact of managed care by health plan and patient characteristics and provider organization. In addition research should analyze the effect of managed care delivery systems on population subgroups such as older people, racial and ethnic minorities, those with chronic conditions, and people with disabilities or low incomes, with particular attention to cost, quality, and access to care.
National standards	FEDERAL STATE	Uniform national standards should be applied by states and the federal government to all forms of private health plans, including provider-sponsored organizations and preferred provider organizations. To the extent possible these standards should be the same for all plans, and across all payers, including Medicare, Medicaid, self-insured plans regulated by the Employee Retirement

National standards (cont'd.)	FEDERAL STATE	Income Security Act (ERISA), and state-regulated plans offered to employer groups and individuals. Medicare's comprehensive system of consumer protections for coordinated care plans, such as health maintenance organizations, should be maintained. AARP supports comprehensive standards for all other public and private coverage plans, including ERISA plans and plans offered through state Medicaid agencies. AARP does not support federal preemption of state managed care laws until a federal law is established that affords consumers greater protections than they have under state law.
State standards	STATE	In the absence of national standards, states should enact a comprehensive set of rigorous standards comparable to those that AARP supports in Medicare. To the extent possible these standards should apply to all types of public and private managed care plans, including preferred provider organizations, regardless of their profit status or organizational structure.
Finances	STATE	All health plans must be financially sound. Financial standards should address solvency requirements, including requirements for capital reserves that take into account the plan's level of risk and service-delivery capabilities and should be set at levels adequate to protect enrollees in the event of a plan's insolvency.
Accessibility	STATE	Women should have direct access to obstetricians and gynecologists and be allowed to designate these physicians as their primary care provider. Health plans should be required to provide referrals to specialists affiliated with the plan or recognized specialty-care centers affiliated with the plan pursuant to treatment plans. Referrals should include provisions for standing referrals, as determined by the referring practitioner. Health plans should be required to provide out-of-network referrals at no additional cost to the enrollee if the health plan does not have a network physician with appropriate training and experience or affiliation with a recognized specialty-care center to meet the enrollee's covered medical needs. Patients with mental disorders should receive appropriate referrals to mental health specialists.
Continuity of care	STATE	To facilitate continuity of care, health plans must notify affected enrollees at least 90 days before the termination of a provider, when such termination is not for cause. Enrollees who are undergoing an active course of treatment for a life-threatening disease or condition, or a degenerative and disabling disease or condition, or who have entered the second trimester of pregnancy at the effective date of enrollment, should be able to receive covered medically necessary care from their physician specialists for up to 90 days (or through postpartum). This should apply to new enrollees who belong to a group that did not provide them the option of continuing with their previous physician specialist and to existing enrollees if their previous physician specialist is terminated by the health plan for reasons other than cause.
Managed care liability	STATE	All managed care plans should be held accountable for their actions. In cases where a health plan has been involved in a decision to delay or deny needed services, and the decision has had medical

Managed care liability (cont'd.)	STATE	consequences, the plan should be liable for any injuries or harm to the enrollee. The right to seek meaningful judicial redress for decisions that lead to injury or death should be available to all managed care enrollees regardless of the source of their health care coverage. State laws on the corporate practice of medicine that prevent holding managed care organizations accountable for harm caused by an inappropriate treatment decision should be revised to afford the injured enrollee access to state court.
Confidentiality	FEDERAL STATE	Managed care plans must prevent improper use or release of personally identifiable medical information and must adopt protections appropriate to the use of electronic information and nationally based payer and provider systems.
Data collection and reporting	STATE	All health plans must comply with data and reporting requirements that address the frequency, content, and format of reports. States should require commercially licensed and publicly sponsored health plans (e.g., Medicaid) to report their performance as assessed by standardized, evidence-based measures, including on clinical effectiveness and enrollee experience, in a format that consumers will readily understand. Data collected by health plans must be independently audited by an authorized entity. States also should require data on: • medical costs or expenditures on a per capita basis by type of expenditure (physician, inpatient, outpatient, home health, skilled-nursing facility, etc.); • plan administration costs; • complaints and grievances and their resolution; • physician satisfaction; • health care quality (assessed through standardized measures), including performance of participating physicians, hospitals, skilled-nursing facilities, home health agencies, and pharmacies; • credentialing; • utilization management or appeals regarding use of out-of-plan services; • accessibility, including wait times for appointments and numbers of practitioners accepting new patients; • rates of physician turnover; and • enrollment and disenrollment.
Ombudsman programs	STATE	Consumers should have access to an independent, nonprofit ombudsman program. These programs should receive federal and/or state funding as needed. Such programs should assist consumers in understanding plans' marketing materials and coverage provisions, help assess information on quality, educate enrollees about their rights within health plans, help identify and investigate enrollee complaints, assist enrollees in filing formal grievances and appeals, operate and staff a telephone hotline, and report to and advocate before appropriate regulatory bodies on issues of concern to consumers. Health plans should be required to cooperate with such programs.

Oversight	STATE	To ensure strong and effective oversight, states should allocate sufficient resources and personnel to the regulation of managed care organizations. States should ensure that the personnel assigned to regulate managed care plans are adequately trained to enforce applicable laws and regulations effectively. States should engage in ongoing oversight by reviewing data submitted by managed care plans and taking such actions as may be necessary, such as setting performance targets or issuing compliance notices. In addition periodic site visits should be conducted biannually, or more frequently as appropriate. In states where more than one agency has authority to regulate managed care organizations, the agencies should coordinate their activities to facilitate effective oversight. Consumers should be represented on health plan decisionmaking and advisory bodies. State task forces that study managed care should include enrollees, prospective enrollees, and other consumer representatives. States must ensure that all standards are met by plans operating in sparsely populated areas, including but not limited to standards on the adequacy of the provider network, taking into account the prevailing patterns of service delivery in those areas. (For policy on private health plans in Medicare, see this chapter's section Private Health Plans in Medicare.)

Medicare Supplement (Medigap) Insurance

Many Medicare beneficiaries supplement their Medicare benefits with private insurance, typically under either an employer's health benefit plan or a Medicare Supplement policy, commonly called Medigap.

Congress standardized the Medigap policies insurance companies may offer in 1990. In addition Congress created a variety of important consumer protections, such as a uniform outline of coverage, guaranteed issuance of coverage at age 65 or older regardless of health status for the first six months of Medicare Part B enrollment, a six-month limit on coverage restrictions for preexisting conditions, guaranteed renewal, and a prohibition on the sale of duplicative policies. In 1997 Congress expanded guaranteed access to Medigap under certain circumstances and improved portability protections by requiring that prior, continuous insurance coverage be credited against the allowed six-month restriction on benefits related to preexisting conditions.

The Medicare Modernization Act of 2003 (MMA) provided that once its Medicare drug benefit was implemented, Medigap drug benefits could no longer be sold. It also created two new standard Medigap plans and called for the review and updating of the 1990 standard plans. Insurers can sell only the updated Medigap plans, but can renew the 1990 standardized plans.

Only one change in federal law governing Medicare Supplement insurance was part of the 2010 Patient Protection and Affordable Care Act (ACA). It changes to Medigap plans C and F (the most popular plans) in 2015. The change requires the addition of nominal cost-sharing for physician services to encourage use of appropriate physician services.

While a number of consumer protections are in place, there are Medigap access problems. For example, federal law does not guarantee issue of Medigap to disabled Medicare beneficiaries under age 65. This also affects beneficiaries who are eligible for Medicare because of end-stage renal disease, whose out-of-pocket liabilities under Medicare are large. Among this group of beneficiaries, a small share have any form of individually purchased private insurance, compared with older beneficiaries. Also, Medicare Supplement insurance rules do not protect beneficiary access to coverage outside designated enrollment periods. As a result, under current law, when beneficiaries disenroll from a Medicare Advantage plan and change to Medicare fee-for-service, they may not be able to buy Medigap coverage.

Rate increases on the basis of age can contribute to the expense of Medigap coverage over time, as can administrative costs and rising premiums—all may push Medicare Supplement insurance beyond the reach of many people on fixed incomes. Medicare beneficiaries without supplemental coverage of some sort, whether Medigap, retiree health benefits, Medicaid, or Medicare Advantage, risk incurring substantial out-of-pocket costs if they have a serious health problem.

MEDICARE SUPPLEMENT (MEDIGAP) INSURANCE: Policy		
Affordability and availability	FEDERAL STATE	Congress and state legislatures should keep Medicare Supplement health insurance (Medigap) affordable and available to those who need it by: • requiring pure community rating and prohibiting insurers from varying premium levels and premium rate increases for different individuals on the basis of age; • applying similar regulatory rules on medical underwriting to all Medigap insurers; • requiring Medicare Supplement insurers to provide disabled Medicare beneficiaries under age 65 who are not in Medicare's end-stage renal disease (ESRD) program with the same guaranteed access to supplemental coverage given to beneficiaries age 65 and over; and • protecting ESRD beneficiaries against high out-of-pocket costs—Potential solutions include creating a managed care option; developing a federally supported Medicare Supplement policy, Medigap risk-pool program, or reinsurance program for guaranteed access to private supplement coverage; or some variation or combination of these options.
Reviewing standards and trends	FEDERAL STATE	Federal and state policymakers, together with the National Association of Insurance Commissioners, should review Medicare Supplement standards to ensure that plans continue to offer meaningful benefits and affordable choices for beneficiaries to supplement their coverage in fee-for-service Medicare and protect them from high out-of-pocket costs. Congress should ensure that people with pre-existing conditions have access to Medigap coverage and should make the Medigap medical loss ratios standards similar to the standards for other private insurance plans including Medicare Advantage plans.
Open enrollment	FEDERAL	Congress should put Medicare fee-for-service and Medicare Advantage on a level playing field by creating a uniform annual open-enrollment period that makes all Medigap products available without regard to health status to Medicare beneficiaries who are switching from Medicare Advantage into Medicare fee-for-service.
Monitoring premiums	STATE	When reviewing and approving Medigap premiums, states should be particularly attentive to ensuring that rates appropriately reflect claims exposure and that premium increases are justified and reasonable.

Retiree Health Coverage

Several aspects of health reform have implications for retirees. The 2010 Patient Protection and Affordable Care Act (ACA) created a retiree reinsurance program to help share retiree health benefit program costs for high cost claims for retirees age 55 to 64 who are not eligible for Medicare. These resources will be available until 2014. For early retirees without access to retiree health benefits who have been uninsured for 6 months, the temporary high risk pool program may provide a new coverage option. After 2014, early retirees without retiree health benefits will be guaranteed access to coverage regardless of any health problems, and those qualifying for premium and cost sharing assistance will have help with the cost of their coverage.

The availability of health benefits is a key factor in retirement decisions for most workers, especially those who are not yet eligible for Medicare. Since 1993 the percentage of large employers offering retiree health benefits has dropped significantly for retirees under age 65 and for Medicare-eligible retirees. Given the importance of health insurance for maintaining financial security in retirement, the continuing erosion of retiree health insurance coverage, which shifts costs to retirees and government, is a matter of serious concern to AARP.

Large employers that continue to provide retiree coverage are increasingly shifting a portion of those costs to retirees. Retirees with employer-sponsored health benefits are paying higher premiums and cost-sharing amounts and are also likely to face reductions in coverage, as employers seek to limit their future financial liability for benefits. For example, more retirees may face caps on employer contributions or be required to pay a fixed share of growing health costs. If the price of retiree health benefits grows beyond the reach of retirees, they may be forced to drop coverage, exposing themselves to the risk of major out-of-pocket costs should they become seriously ill.

Health care cost inflation, the increasing number of years people spend in retirement, a declining ratio of active workers to retired workers, and changes in private- and public-sector accounting standards requiring that projected retiree health obligations be reflected in financial reports all have led employers to change or stop offering retiree health benefits. As a general practice, employers have not prefunded retiree health benefits. There are no federal tax incentives similar to those for pensions that could encourage employers to prefund. Retiree health benefits, promised to retirees in their working years, are compensation that has been deferred in lieu of wages.

Recognizing that fewer employers are offering retiree health benefits, Congress included special subsidies in the Medicare Modernization Act of 2003 as an incentive for employers to retain non-Medicare retiree drug benefits. More than 6 million retirees were benefiting from these subsidies in January 2008. However, while evidence to date is lacking, there is some concern that employers might use the subsidy to offset plan contributions for covered drug spending while continuing to shift costs to retirees. Employers have been able to deduct Part D subsidies as a business expense; health reform ends this deduction as of 2013.

In 2009 the Equal Employment Opportunity Commission has implemented final regulations concerning the application of the Age Discrimination in Employment Act to retiree health benefits. The rule, which allows employers to treat older retirees differently from younger retirees based on their Medicare eligibility, is intended to reduce employers' costs and prevent or slow the further erosion of coverage for retirees not yet eligible for Medicare.

RETIREE HEALTH COVERAGE: Policy		
Maintaining benefits	FEDERAL STATE	In the absence of universal health coverage, the federal government should provide employers with incentives to maintain and safeguard retirement health benefits. AARP opposes policies that will increase the number of uninsured early retirees or Medicare-eligible retirees without adequate coverage. Policies affecting retirement health benefits should incorporate features that prevent deterioration of health benefits. Retiree health benefits should be accompanied by vesting, prefunding, and other standards to ensure that employers provide promised benefits.

Federal retiree subsidies	FEDERAL	Congress and the Centers for Medicare & Medicaid Services should monitor the implementation of retiree drug subsidies under the Medicare Modernization Act of 2003 and the early retiree reinsurance program under the ACA to make sure that funds are being used to encourage the retention of retiree drug benefits and reduce sponsor and/or retiree plan costs for early retiree benefits.
Age Discrimination in Employment Act (ADEA)	FEDERAL	The Equal Employment Opportunity Commission should rescind its exemption that allows employers to escape liability under the ADEA when they reduce or terminate retiree health benefits for individuals who become eligible for Medicare or a comparable state-sponsored program.
Government employees	STATE	States should provide retired state and local employees and spouses with opportunities and options for adequate health insurance coverage at group rates. States should provide Medicare-eligible retirees benefits that supplement Medicare.

Medicare

Medicare was enacted in 1965 as a social insurance program to help the elderly obtain and pay for necessary medical care. Before Medicare only about half of older Americans had any health insurance. Employer-provided retiree health coverage was the exception, not the rule, and those seeking to purchase coverage privately were frequently denied it on the basis of age or preexisting conditions, or they found it unaffordable. Today Medicare is a popular federal health insurance program that serves more than 45 million beneficiaries, including most Americans age 65 and over, and younger people who have been receiving federal disability benefits for at least two years. All beneficiaries are entitled to the same level of benefits, regardless of age, income, or health status, reflecting the fundamental principles of social obligation and interdependence among generations that are the hallmarks of social insurance. The program benefits not only elderly and disabled people but also their families by providing a financial safety net.

Medicare has several parts. Part A (Hospital Insurance) covers inpatient hospital care, including inpatient drugs, home health services linked to a prior hospitalization, limited skilled-nursing home care, and hospice care. Part B (Supplemental Medical Insurance) covers physician services, some home health services that are not linked to a prior hospitalization, and outpatient services. Part C covers private health plans that contract with Medicare, and Part D is an optional benefit that covers outpatient prescription drugs.

Medicare does not cover long-term nursing home care, or most vision, hearing, or dental services. Good oral health is inseparable from overall health and well-being. Older adults are particularly likely to have oral disease and tooth loss, which contributes to poor nutrition and may lead to other health problems.

Beneficiaries pay a monthly premium for doctor services and significant coinsurance and deductibles for covered services. Medicare currently covers about half of beneficiaries' total health care costs; supplemental coverage generally makes up another quarter, leaving beneficiaries exposed to about a quarter of spending themselves.

Participation in Medicare Part A is mandatory and financed primarily by payroll taxes—employers and employees each pay 1.45 percent of wages to the Part A trust fund. The 2010 Patient Protection and Affordable Care Act (ACA) raised the Medicare Part A tax by 0.9 percentage points on high wage workers. Most individuals become automatically entitled to Medicare Part A when they turn 65. Participation is voluntary for Medicare Part B, which is financed by a combination of beneficiary premiums and general federal revenue. Beneficiary premiums are intended to cover about 25 percent of Part B program costs, while general federal revenue finances the remainder through the Part B trust fund. Beginning in 2007, high-income beneficiaries are required to pay higher Part B premiums. Approximately 95 percent of beneficiaries who participate in Part A also enroll in Part B. Low-income Medicare beneficiaries may also be eligible for Medicaid.

Subject to plan availability, Medicare beneficiaries have the option of receiving Medicare benefits through Medicare Part C private plans, referred to as Medicare Advantage plans. Medicare Advantage plans must provide all the benefits covered by Medicare Parts A and B; many plans also offer additional benefits and lower cost-sharing. Beneficiaries who choose a Medicare Advantage plan are still responsible for paying the Part B premium, in addition to any premiums and cost-sharing that the plan may charge.

Beneficiaries can elect to receive outpatient prescription drug coverage under Medicare Part D either by enrolling in a Medicare Advantage plan or a stand-alone drug plan. About two-thirds of beneficiaries choose the latter option.

Some have advocated placing Medicare Advantage plans, which are currently subsidized by Medicare, in direct competition with fee-for-service Medicare. In effect, this would set up competition between a defined benefit program (traditional Medicare) and a defined contribution program (Medicare Advantage). There is serious concern that doing so would leave the traditional program at a disadvantage due to statutory limits on benefits and the possibility that Medicare Advantage plans might attract younger and healthier beneficiaries, forcing the traditional program to raise premiums sharply in order to meet higher costs. The Medicare Modernization Act of 2003 called for a future demonstration program of limited scope and duration with protections against excessive premium increases and strict standards of accountability to test the effect of competition between defined benefit and defined contribution programs.

Fiscal pressures on Medicare have raised questions about its future viability and engendered numerous proposals for reform. In addition to calls to privatize the program, there have been proposals to, among other changes, raise the eligibility age, convert from a defined benefit to a defined contribution system, require means-testing, and alter the program's financing structure.

Widely recognized problems relating to quality of care beset America's health care system, including Medicare. These problems include overuse (providing more services than medically necessary) and underuse (inappropriate or unnecessary services). Efforts to improve quality are essential for reforms to succeed (see Quality and Safety—Quality Improvement for related policy).

The ACA included significant changes to the Medicare program. Starting in 2011, Medicare will cover an annual wellness visit, a personalized prevention plan, and preventive services with a US Preventive Services Task Force (an independent panel of health care experts that evaluates the latest scientific evidence on clinical preventive services and grades their effectiveness) grade of A or B will be free from cost sharing. Over time, this legislation will strengthen Medicare by testing a number of demonstration and pilot programs, such as value-based purchasing that ties provider performance to quality measures, physician reporting measures and pay-for-performance to enhance quality, bundled payment and shared savings programs to enhance efficiency, and incentives to reduce avoidable hospital readmissions and improve quality of care, particularly for beneficiaries with chronic conditions. Medicare will take steps to slow the growth of spending through such initiatives as reducing subsidies to Medicare Advantage plans, reducing the rate of increase in payments to providers, improving clinical decisionmaking by increasing availability of research on what works and what does not; strengthening oversight and enforcement activities to reduce waste, fraud, and abuse; and establishing an Independent Payment Advisory Board to recommend further steps to slow Medicare spending growth.

Americans of all ages link the availability of Medicare to financial security and independence in retirement. While continued increases in medical costs, rapid changes in medical technology, and the aging of the baby-boom population will require consideration of Medicare reforms in future years, there is a need to ensure that Medicare remains a strong, broadly supported social insurance program so that it can continue to protect current and future generations.

MEDICARE: Policy		
General	FEDERAL	Medicare should remain a social insurance program and should not be converted from a defined benefit to a defined contribution system. The federal government should maintain and strengthen Medicare so it will continue to provide high-quality and affordable health care coverage for current and future beneficiaries.

General (cont'd.)	FEDERAL	Over the longer term, Medicare must address demographic shifts and delivery-system changes in the rest of the health care marketplace. Any Medicare reforms should be made deliberately, with extensive input from current and future beneficiaries. Original Medicare should be strengthened so that it remains a viable option for all beneficiaries. AARP supports changes that improve operating efficiencies and enhance Medicare's ability to function as a large purchaser of health care. Specific proposals to expand Medicare's contracting and procurement authority must preserve access to and ensure the delivery of high-quality care for beneficiaries in the original fee-for-service program.
Beneficiary protections	FEDERAL	Changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket costs. Medicare reforms should neither reduce access to health care nor shift burdensome financial risks to Medicare beneficiaries. Medicare beneficiaries should continue to have access to a choice of providers and health plan options, including a strong and viable original Medicare program. To enhance these choices all beneficiaries should have access to coverage that supplements original Medicare. All health options offered to Medicare beneficiaries must meet rigorous standards for consumer protection and quality of care. All competing options should do so on a level playing field.
Financing quality improvement and fraud and abuse	FEDERAL	Criteria for evaluating Medicare's financing sources should include the extent to which they are broad-based, stable, progressive, consistent with furthering public health objectives, and grow with enrollment. Medicare should improve the quality of care for beneficiaries and maximize the value of the program's expenditures by implementing ways to prevent the overuse, underuse, and misuse of health care services. Medicare must rigorously attack waste, fraud, and abuse in order to ensure value for the program and for beneficiaries.
Major reform	FEDERAL	Major changes in the Medicare program should first be evaluated in demonstration projects that assess the effects of proposed changes on Medicare costs, access to health care services, continuity of care, quality of care, beneficiary satisfaction, stability of the Medicare risk pools, and beneficiaries' out-of-pocket costs. Ultimately comprehensive health care reform offers the best opportunity to ensure that all Americans, including Medicare beneficiaries, have access to needed high-quality health services and to control health care costs effectively. By virtue of the number of people covered and the amount of money spent, Medicare should also be both a leader in health care reform and a cooperative partner with other stakeholders (e.g., Medicaid, states, employers, etc.) in achieving an affordable, effective, and efficient health care system serving all Americans.
Eligibility	FEDERAL	Medicare should guarantee coverage for all older Americans and people with disabilities, regardless of income or health status. AARP opposes raising the age of eligibility for Medicare or basing eligibility on income or assets.

Eligibility (cont'd.)	FEDERAL	Policymakers should eliminate the existing 24-month Medicare waiting period for Social Security Disability Insurance recipients.
Benefit design and cost-sharing	FEDERAL	Medicare should guarantee specified benefits defined in law that meet beneficiaries' health care needs. The government's share of the costs of Medicare benefits must keep pace with the growth in those costs and not be tied to artificial budgetary targets. Program deductibles and coinsurance should not vary by income or assets except to the extent that low-income beneficiaries may receive subsidies for premiums and cost-sharing as they do under Part D. Medicare's benefit package should provide access to the most effective medical treatments for all beneficiaries, without regard to income, geographic location, health status, or choice of Medicare plan. Medicare should cover vision care and eyeglasses, dental care, hearing exams, and hearing aids. Coverage of dental services is an essential benefit that should be available to all Medicare beneficiaries. Congress should expand Medicare to offer coverage for long-term care.

Beneficiary Out-of-Pocket Costs

The basic Medicare benefit exposes beneficiaries to significant out-of-pocket expenses. Medicare beneficiaries are financially responsible for coinsurance, deductibles, and Part B and Part D premiums (Figure 7-1), as well as for the costs of services and products Medicare does not cover. It is estimated that in 2006 older beneficiaries living in the community spent an average of $4,586 out-of-pocket on health care costs, or almost half of their income. Beneficiaries under age 65 spent $3,379 on average, or 46 percent of their income. These costs include Medicare cost-sharing payments, Medicare Part B and private-insurance premiums, and payments for goods and services Medicare did not cover. (While Medicare Part D was launched in 2006, many enrollees' first full year of enrollment was 2007; therefore Part D costs were not fully captured in 2006.)

In 2006 about nine out of ten beneficiaries age 65 and older received help to pay for Medicare's cost-sharing requirements through supplemental insurance such as private insurance (i.e., employer-sponsored insurance or individually purchased Medigap), a private Medicare plan, or Medicaid. However having such coverage does not guarantee low out-of-pocket expenses. Those with private insurance may face high premiums and/or diminishing coverage. Beneficiaries with only original Medicare are fully responsible for all their Medicare cost-sharing responsibilities, unless they are able to obtain some type of assistance through a charitable organization or other public program.

Being eligible for full Medicaid benefits does protect some of the poorest beneficiaries from the high costs of health care. Yet experts estimate that only about half of beneficiaries age 65 and older with incomes below the poverty level actually receive Medicaid assistance. Poor beneficiaries may not receive Medicaid because they do not meet the federal categorical requirements or the state income and asset requirements; others who meet those eligibility requirements may not realize they are eligible for benefits or decline to participate.

Those with partial protection from Medicaid through the Qualified Medicare Beneficiary program or the Specified Low-Income Medicare Beneficiary program can face substantial expenses as well.

Figure 7-1

Medicare Part A, Part B, and Part D Deductibles, Coinsurance, and Premium Amounts, 2011

Part A (Hospital Insurance)	Part B (Medical Insurance)	Part D (Outpatient Prescription Drug Benefit)
Deductible $1,132 per benefit period **Coinsurance** $283 per day for the 61st to 90th day of each benefit period $566 per day for the 91st to 150th day of each benefit period **Skilled-nursing facility** $141.50 per day for the 21st to 100th day of each benefit period	**Deductible** $162 per year **Coinsurance** 20 percent of Medicare allowable charges **Part B monthly premium** $115.40 for individuals with incomes under $85,000 and married couples with incomes under $170,000. Beneficiaries with higher incomes pay between $161.50 and $369.10.	**Deductible** $310 per year **Initial coverage limit (i.e., spending needed to reach doughnut hole)** $2,840 total drug spending ($943 out-of-pocket) **Out-of-Pocket threshold (i.e., spending needed to reach catastrophic coverage)** $4,550 out-of-pocket ($6,448 total drug spending) **Coverage gap** $3,608 **Average monthly premium:** $32.34

Source: The Centers for Medicare & Medicaid Services, Medicare Premiums, Deductibles for 2011, November 5, 2010; Release of the 2010 Part D National Average Monthly Bid Amount, the Medicare Part D Base Beneficiary Premium, the Part D Regional Low-Income Premium Subsidy Amounts, and the Medicare Advantage Regional PPO Benchmarks, August 13, 2009; and *Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies,* April 6, 2009.
Prepared by AARP Public Policy Institute.

Medicare Part D's prescription drug coverage tends to reduce out-of-pocket spending for many enrollees, particularly those who receive the low-income subsidy (LIS). The benefit will undergo several changes as part of the 2010 Patient Protection and Affordable Care Act (ACA). For example, non-LIS Medicare Part D enrollees have traditionally been responsible for 100 percent of their prescription drug costs while they are in the Part D coverage gap, or doughnut hole. Starting in 2011, the doughnut hole will begin to close through a combination of Part D enrollee contributions, Medicare contributions, and brand name drug manufacturer contributions. By 2020, non-LIS Part D enrollees will be responsible for just 25 percent of their prescription drug costs from the time they meet their deductible to the time they enter catastrophic coverage, effectively eliminating the coverage gap. In addition, the growth rate for the Part D benefit's catastrophic spending threshold, which is the amount a beneficiary must spend out-of-pocket before lower coinsurance applies, will be artificially slowed from 2014 through 2019. In 2020 the growth rate will return to growing with enrollees' per capita drug spending.

Another ACA provision will require higher-income enrollees to begin paying higher Part D premiums in 2011 using the same income thresholds used for Part B premiums.

Part D premiums are increasing for all enrollees who are required to pay them. When weighted by enrollment, the average monthly Part D premium for stand-alone prescription drug plans (PDPs) has increased by roughly 50 percent since the benefit was first offered in 2006, and is now almost $38.

Cost-sharing under Part D is also growing: median copayments for many prescription drugs have grown by 40 percent or more since 2006. Furthermore, the share of PDPs using coinsurance instead of copayments has increased over recent years. When combined with rapidly escalating prescription drug prices, this trend will result in enrollees' paying substantially more for their drugs at the pharmacy counter.

Other parts of the Medicare program have no limits on out-of-pocket spending. While filling those gaps would increase program costs substantially, it would

significantly improve the quality of care for beneficiaries and allow original Medicare to compete more effectively with managed care plans, many of which offer enhanced benefits.

Because Part B premiums and coinsurance payments are determined by Part B spending, increases in spending translate into increases in out-of-pocket costs for beneficiaries. Beneficiaries have faced steep increases in recent years. The Part B premium is $110.50 in 2010, with higher-income beneficiaries paying more. The Part B deductible also increases annually by the growth in Part B costs, and stands at $155 in 2010.

BENEFICIARY OUT-OF-POCKET COSTS: Policy		
Making Medicare more affordable	FEDERAL	Congress should: • close gaps in Medicare coverage that lead to burdensome out-of-pocket costs; • limit increases in out-of-pocket costs, including increases in Medicare's overall cost-sharing requirements and premiums for current benefits; and • ensure that low-income beneficiaries are protected against high out-of-pocket expenses. When considering program changes (e.g., cost-sharing or provider-reimbursement reforms), Congress should explicitly analyze and report on the direct and indirect effects on beneficiaries' out-of-pocket spending. The Centers for Medicare & Medicaid Services should monitor the effect of increases in Part B and Part D premiums on both high- and low-income beneficiaries, particularly those without Medicaid, and determine whether premium cost is a barrier to Part B services and outpatient prescription drugs. Medicare reforms should explicitly recognize the special health care and economic needs of low-income beneficiaries, the vast majority of whom are women, and protect them from bearing undue out-of-pocket health costs.
Prescription drugs	FEDERAL	Pharmacies, prescription drug plans, and Medicare Advantage plans should be allowed to forgive copayments in cases where they would hinder a low-income beneficiary's ability to obtain medically necessary prescription drugs.

Beneficiary Coinsurance for Hospital Outpatient Services

A loophole in Medicare law relating to payment for hospital outpatient services, such as one-day surgery, diagnostic tests, and radiology, resulted in beneficiaries paying almost 50 percent of total Medicare payments for outpatient services, instead of the standard 20 percent of total payments. This is because the coinsurance was based on 20 percent of whatever amount the hospital charged, rather than on the amount Medicare approved. Compounding the problem, the lack of payment rules for hospital outpatient care creates incentives for hospitals to categorize patients as outpatients, even when treatment lasts for several days in the hospital.

Since 2000, beneficiary coinsurance has been declining each year as a share of total payments for hospital outpatient services through the "buy-down" provision. It is intended to reduce beneficiary coinsurance payments to 20 percent of total payments for outpatient services. In 2008, beneficiaries' coinsurance payments accounted for 25 percent of total payments.

Recently, the Medicare Payment Advisory Commission and the Centers for Medicare & Medicaid Services have noted that frequency and duration of observation stays has been increasing. Patients in observation status are classified as hospital outpatients, not as hospital inpatients. However, in many hospitals, actual medical services provided in the inpatient and observation settings are virtually

identical. Unfortunately, the financial impact for Medicare beneficiaries who spend time under observation can be burdensome. Due to the loophole in Medicare law relating to payment for hospital outpatient services (described above), Medicare beneficiaries under observation may be responsible for out-of-pocket costs that substantially exceed the 20 percent coinsurance imposed for other Medicare Part B service. In addition, since Part B does not cover the cost of self-administered drugs provided in the outpatient setting, these beneficiaries are typically responsible for the full hospital charges for these drugs. These out-of-pocket costs can quickly add up, especially for beneficiaries on fixed incomes. In addition, time spent under observation does not count toward the three-day prior inpatient stay required for Medicare coverage of skilled nursing facility services, so some beneficiaries who need this care may fail to qualify for coverage, even though they have spent more than three days in the hospital under observation (see Medicare: Provider Payment: Postacute and Subacute Care for related policy).

BENEFICIARY COINSURANCE FOR HOSPITAL OUTPATIENT SERVICES: Policy		
Outpatient coinsurance	FEDERAL	The Centers for Medicare & Medicaid Services (CMS) should ensure that the phase-down of beneficiary coinsurance for outpatient hospital care continues as rapidly as possible. Federal policymakers should accelerate the buy-down of beneficiary coinsurance for all outpatient services to the appropriate level of 20 percent of Medicare's approved amount as quickly as feasible. Congress should limit the maximum dollar amount of beneficiary copayments for each outpatient service to one-half of the hospital inpatient deductible. Congress and/or CMS should prohibit hospitals from billing beneficiaries who stay in the emergency room or under observation longer than 24 hours as outpatients, whether or not they are subsequently admitted as inpatients. Congress should allow any days spent in observation status to be counted toward the current three-day hospital stay requirement for skilled nursing facility coverage.

Physician Balance Billing and Private Contracting

Balance billing—"Balance billing" occurs when physicians bill patients for charges exceeding the Medicare approved payment. Physicians and other practitioners who agree to participate in the Medicare program ("participating physicians") are required to accept the Medicare fee schedule amount as payment in full and submit claims directly to Medicare, also referred to as accepting assignment. In 2008, Medicare paid over 99 percent of allowed charges based on assignment. Physicians who do not accept assignment for Medicare claims are allowed to balance bill patients, not only for coinsurance of 20 percent of Medicare's approved rate but also for excess charges that exceed the approved rate. Balance billing by nonparticipating physicians is limited by law to 15 percent of Medicare's allowed charge. Thus, nonparticipating physicians are permitted to charge $115 for services for which Medicare would allow participating physicians to charges only $100. In 2008, only 0.5 percent of allowed charges were for Medicare services provided by nonparticipating physicians who did not accept assignment.

The Centers for Medicare & Medicaid Services has the authority to sanction any physician who knowingly, willfully, and repeatedly charges in excess of the balance billing limits. States also may protect some or all beneficiaries from physician balance billing by "mandating assignment"—that is, requiring all physicians to accept Medicare's approved reimbursement as payment in full.

Although the average annual beneficiary liability for balance billing is small, the extent of balance billing varies by specialty and geographic location and is not publicly reported. Anecdotal reports suggest that enforcement of balance billing limits have been lax.

Private contracting—For Medicare-covered services, physicians and other practitioners are not allowed to bill beneficiaries more than the allowed

charges unless they have a private contract. (There are no restrictions on a consumer's ability to purchase services the program does not cover.) Physicians are allowed to enter private contracts, also referred to as opt-out or concierge care contracts, with Medicare beneficiaries for Medicare-covered services only if the physician agrees, in writing, to forgo all reimbursement from Medicare for at least two years. Under a private contract, the beneficiary must agree to pay 100 percent of the amount the physician charges for contract services with no limit on balance billing. Physicians who enter into private contracts must do so for all Medicare beneficiaries they treat and for all covered services; they may not pick and choose the patients and/or services for which they will bill Medicare.

Physicians who enter private contracts often charge a monthly or annual fee for their services, such as primary care. When private contract physicians refer beneficiaries for outside services, such as lab tests, specialists, or hospitalization, Medicare continues to pay for these services.

These restrictions reduce the potential for fraudulent billing and prevent physicians from picking and choosing beneficiaries on the basis of severity of illness.

Medicare does not restrict billing or payment for non-Medicare covered services, such as cosmetic surgery.

PHYSICIAN BALANCE BILLING AND PRIVATE CONTRACTING: Policy		
Balance billing	FEDERAL STATE	The Centers for Medicare & Medicaid Services should closely monitor and aggressively enforce balance billing limits. States should prohibit balance billing by non-Medicare, as well as Medicare, physicians.
Private contracting	FEDERAL	Congress should not expand private contracting for physician services. Physicians who privately contract with beneficiaries for Medicare-covered services should continue to provide them with complete information on the lack of Medicare coverage for services provided under the contract, the lack of balance billing limits on charges for those services, the cost of the service, the nonapplicability of supplemental coverage for contracted services, the availability of Medicare payment if the services were provided by a physician who accepts Medicare payment, and the physician's status as a provider who does not accept Medicare payment.

Advanced Beneficiary Notices

Under most private insurance contracts, enrollees and providers can request and obtain assurances that a procedure or claim will be covered prior to its submission. This is particularly the case for higher-cost services— in fact, under some circumstances, the health plan may require preauthorization. This has not, however, been the case in Medicare. Instead, when a physician or other provider has a reasonable basis for believing that Medicare will not deem a service he or she has recommended to be "reasonable and necessary" (Medicare's standard for coverage), the provider must notify the beneficiary in advance, both verbally and in writing, that the service may not be reimbursable. This notice, called an "advanced beneficiary notice" (ABN), is intended to facilitate an informed discussion between the doctor and the beneficiary about whether or not to proceed with the service at the beneficiary's expense. ABNs are not considered private contracts. An ABN is not required for services that are categorically excluded from Medicare coverage, such as cosmetic surgery and investigational or experimental procedures.

Unfortunately, ABNs have been misused. Some beneficiaries have been asked to sign blanket notices in which the beneficiary accepts financial liability if Medicare denies coverage for any services. A blanket notice does not fulfill the purpose of the ABN or enable a beneficiary to make an informed choice each time a service is recommended.

As part of the Medicare Modernization Act of 2003, Congress called for implementation of a system of prior determination in Medicare for certain items and services, and the Centers for Medicare & Medicaid Services published final rules for the new system in 2008. Under the system for prior determination, a beneficiary may ask his or her Medicare Contractor about the coverage and cost of certain services and items. Prior determination requests may only be made for physician services with the highest average allowed charges, and plastic and dental surgeries with a Medicare Physician Fee Schedule amount of $1,000 or more.

ADVANCED BENEFICIARY NOTICES: Policy		
Appropriate use of advanced beneficiary notices	FEDERAL	The Centers for Medicare & Medicaid Services (CMS) should ensure that providers and beneficiaries are informed about the appropriate use of advanced beneficiary notices (ABNs). ABNs should clearly indicate the item or service for which Medicare payment is in question, the reason why Medicare payment is in question, and why the provider believes the service is necessary. ABNs also should require the signatures of both the provider and the patient. Routine use of ABNs by providers should be prohibited. CMS should closely monitor the system of prior determination in Medicare to ensure that it is applied as fairly and broadly as feasible.

Coverage of New Medical Technologies

Traditional fee-for-service Medicare covers all items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." The Medicare statute specifically excludes coverage for certain items and services, such as cosmetic surgery. Medicare Advantage plans must cover all items and services covered under Parts A and B and may cover additional services.

The Centers for Medicare & Medicaid Services (CMS) has authority to make national coverage determinations regarding whether and when Medicare will include a new medical technology, such as a medical device, drug or surgical procedure, as a covered benefit. Most commonly, coverage determinations involve items or services that are unusually expensive (e.g., implantable defibrillators), or that represent dramatic improvements or breakthroughs in the standard of care, or that are outmoded or otherwise ineffective. CMS has made national coverage determinations for only a few hundred items and services, although the number is increasing as the agency takes a more active role in establishing Medicare coverage policy. Medicare administrative contractors have authority to make local coverage determinations for categories of services. In the absence of a national or local coverage determination, Medicare administrative contractors (contractors whom CMS uses to pay claims to providers) have discretion whether or not to pay for individual claims on the basis of "medical necessity."

Medicare bases its coverage decisions on clinical effectiveness without reference to cost. This is central to Medicare's emphasis on the medical necessity of services. CMS has attempted to adopt cost-effectiveness analysis (CEA) as a Medicare coverage criterion in the past, but these proposals met strong, broad-based opposition and were withdrawn. Recently there have been renewed calls for CMS to revisit the issue.

Cost-effectiveness is an economic concept aimed at improving efficiency by improving performance and/or reducing cost. A CEA compares at least two alternative clinical interventions, such as a new technology versus routine care, and produces information about the incremental costs and health effects of each intervention, usually expressed as a ratio. For example, if an intervention costs an additional $50,000 and extends life by two years, then its cost-effectiveness ratio is $25,000 per additional life-year. A CEA does not take into account the fairness or distributional effects of trade-offs between alternative interventions.

A CEA does not rely on a standardized methodology that yields reproducible results. Multiple evaluations of the same services and conditions typically produce different results. Critics are concerned that the results may reflect the biases of sponsors that fund the studies and the analysts who conduct them and that the analyses could be used selectively as a rationale for cutting spending or rationing care, particularly in public programs like Medicare and Medicaid (for background and policy on Medicaid coverage issues, see the Medicaid sections of this chapter).

Advocates of CEA assert that it could improve the efficiency of Medicare, leading to better health outcomes at the same or lower cost. They also suggest that CEA can be used to better target coverage for interventions to the specific subpopulations where they will be most effective.

There is disagreement over whether CMS has the legal authority to employ CEA for Medicare coverage determinations in the absence of express statutory authorization. When assessing new technologies for coverage determinations, CMS historically has relied on publicly available information. Recently, however,

the agency has initiated a new approach referred to as "coverage with evidence development." Under this scheme, Medicare coverage is temporarily extended to beneficiaries willing to participate in a clinical trial or data registry. While patients enrolled in clinical trials receive protections afforded human research subjects, such as informed consent, those who enroll in data registries do not, which raises ethical concerns.

During the evidence-development period, which may continue indefinitely, CMS collects additional patient-specific data on clinical conditions and utilization, as well as claims, related to a new technology. The agency has indicated that it may use these data to limit or expand future Medicare coverage criteria for the technology. These data may also have other uses, such as monitoring a technology's safety and effectiveness and assessing the appropriateness of care delivered by providers; the data also may be linked to other data sets for other research and nonresearch purposes. CMS has indicated that in some cases the results of these analyses might not be published.

Coverage with evidence development has raised a number of questions including whether:

- the policy provides Medicare beneficiaries with adequate protection of privacy and informed consent to participate in the evidence-development process,
- changes in coverage under the new process will ensure that beneficiaries have appropriate access to clinically effective technologies based on scientifically rigorous and independently verifiable results, and
- the Medicare coverage determination process should be modified to include public notice and opportunity for comment.

Another technique for considering cost as a factor in coverage is the "least costly alternative" approach. Under this method only the least costly alternatives for clinical interventions that are equally effective, or at least "therapeutically equivalent," would be covered. This implies that some drugs, devices, procedures, and other interventions, while not identical, serve clinically comparable functions and may serve as appropriate substitutes for each other. While not defined in Medicare policy, "therapeutic equivalence" and a similar term, "functional equivalence," are often applied to drugs that are not the generic equivalents of patented medicines but may produce equivalent clinical effects, such as various pain relievers. However, federal courts have denied CMS the authority to pay for functionally equivalent drugs based on the least costly alternative approach, at least in some cases.

The Food and Drug Administration does not assess the relative effectiveness of therapeutically or functionally similar drugs, devices, or procedures. Independent clinical research has been performed regarding the comparative effectiveness of some drugs and technologies, but the extent of this research is limited. The Agency for Healthcare Research and Quality (AHRQ) is researching the comparative effectiveness of interventions for ten health care conditions, nine of which involve pharmaceuticals commonly used by Medicare beneficiaries.

Recent federal legislation greatly expanded funding for comparative effectiveness research and authorized the establishment of a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) to establish a national agenda for comparative effectiveness outcomes research, conduct research, train researchers, build data capacity, and disseminate research findings through AHRQ. The institute is prohibited from publishing practice guidelines or coverage, payment, or policy recommendations.

COVERAGE OF NEW MEDICAL TECHNOLOGIES: Policy		
Cost vs. clinical effectiveness	FEDERAL	AARP supports rapid expansion of the assessment of health care technologies, including medical devices, drugs, procedures, and services, based on studies of clinical effectiveness and comparative effectiveness, in order to enhance decisions on Medicare coverage for the safest and most effective medical interventions. AARP opposes the use of cost as the principal criterion in decisions regarding coverage of new medical technology. Such decisions should be based predominately on clinical effectiveness. AARP supports the development of national goals and priorities to guide research related to Medicare coverage. This priority-setting process should include opportunities for stakeholder input and public comment. One of these priorities should be to identify low-benefit applications of high-cost technologies.

Cost-effectiveness analysis	FEDERAL	AARP supports improving the quality and quantity of independent comparative effectiveness and cost-effectiveness analysis (CEA) research. Such information should be broadly disseminated to Medicare providers and beneficiaries, as well as private payers, clinicians, patients, and the public. This research should take into account the perspective not only of payers, such as Medicare, Medicaid, and private insurers, but also of patients and the broader society. The Centers for Medicare & Medicaid Services (CMS) should not use CEA as a Medicare coverage criterion. Regardless of whether or not CMS has the regulatory authority to do so, it should not adopt CEA as a Medicare coverage criterion without explicit new congressional authorization. Prior to congressional action, an independent panel, including subject-matter experts, ethicists, and consumers, should advise Congress on the appropriate use of cost-effectiveness for determining Medicare coverage.
Coverage determination process	FEDERAL	CMS should continue the present policy of making national coverage decisions, and Medicare contractors making local decisions, based on standard procedures that include public notice and comment periods for the proposed decisions. CMS and contractors should also continue an appeals process that allows patients and other stakeholders, either individually or as a group, to effectively challenge any agency decision regarding coverage determinations. In addition such appeals should apply to related conditions for coverage, such as practice guidelines, that may affect patient access to new technology and related services. AARP supports the development and use of new approaches in the Medicare coverage determination process that ensure appropriate beneficiary access to clinically effective new medical technologies.
Use of evidence in Medicare coverage decisions	FEDERAL	CMS should: • publicly disclose and seek input regarding its plans for changing the Medicare coverage determination process and criteria regarding new technologies based on evidence development, using clinical trials and patient registry data; • allow independent researchers, using evidence development, to review the validity of data and methods that form the basis for Medicare coverage and should publish the results of their findings; and • ensure that Medicare beneficiaries are not unduly influenced to participate in Medicare trials or data registries and that they receive appropriate patient protections, including informed consent and privacy safeguards.
Therapeutic or functional equivalence	FEDERAL	Determinations of a drug's therapeutic or functional equivalence should comply with AARP policy recommendations for drug formularies, such as appropriate oversight and a provision for medical exceptions (for a discussion of drug formularies, see this chapter's section Prescription Drugs). CMS and the Agency for Healthcare Research and Quality (AHRQ) should continue to develop and evaluate policies and procedures for applying research on comparative effectiveness in the context of functional and therapeutic equivalence.

Therapeutic or functional equivalence (cont'd.)	FEDERAL	CMS should determine the conditions under which, and the target populations for whom, Medicare coverage for comprehensive geriatric assessment is warranted. CMS and the AHRQ should fund studies to identify and demonstrate the most clinically efficacious and cost-effective types and uses of assistive technologies. Information about these technologies should be disseminated to Medicare contractors to improve appropriate access by Medicare beneficiaries.

Appeals

An appeals system is essential for correcting payment and coverage errors. Medicare affords its beneficiaries a number of protections that may be enforced through the appeals process. In most cases an appeal requires an affirmative action by the beneficiary. For example, a beneficiary may appeal the denial of a claim for payment by a Medicare administrative contractor (e.g., the Part A intermediary, Part B carrier, or Medicare Advantage plan).

Evidence suggests that Medicare contractors have denied claims for seemingly arbitrary reasons, either as the result of incentives created under their contracts with the Centers for Medicare & Medicaid Services (CMS) or because of inadequate attention to proper procedures. If a claim is denied, Medicare beneficiaries may request a "second look," or redetermination, by the Medicare contractor that made the initial determination. An adverse contractor redetermination is automatically forwarded to an independent review organization, known as a Qualified Independent Contractor. Thereafter, an adverse decision may be appealed sequentially to an administrative law judge (ALJ), the Department of Health and Human Services (HHS) Departmental Appeals Board, and ultimately to federal court, depending on the disputed amount. The results of an appeal apply only to the individual beneficiary's claim.

Medicare also provides a separate appeals process under which a beneficiary may challenge local and national coverage decisions regarding items and services that the beneficiary and his or her physician believe are medically necessary but that the Medicare contractor or CMS has determined are categorically not covered by Medicare (as opposed to not being medically necessary for a particular patient). The right to challenge coverage decisions is distinct from the appeals right for individually denied claims. The new process established the right to appeal which involves examining the entire coverage policy and may lead to changes that affect other beneficiaries. An adverse decision on a Medicare coverage issue may be appealed to the Medicare Appeals Council and ultimately to federal court.

Decisions by Medicare contractors and the Medicare Appeals Council overwhelmingly favor the government, in part because they follow CMS statements of Medicare policy. Decisions by ALJs and federal courts, which are not bound by and may overrule CMS policy, tend to be more balanced because they provide independent interpretations of Medicare statutes and regulations.

A Medicare beneficiary also may file a complaint regarding service quality with a quality improvement organization. The claim may be further appealed to HHS Departmental Appeals Board. If a beneficiary has been harmed by the care in question, he or she may file a civil suit for malpractice against the provider or physician directly in state or federal court.

The Medicare appeals process is complicated and lengthy, particularly at the later stages. Many beneficiaries find the process confusing and sometimes fail to receive or understand information about the reason for a coverage or claim denial or about their appeal rights.

Promulgated in 2005, current regulations relating to appeals, including rules pertaining to the Part D drug benefit, do not provide adequate beneficiary protections. Drug plans, for example, are not required to automatically forward adverse decisions for independent review.

Formerly employed by the Social Security Administration, ALJs who hear Medicare cases now work directly for HHS. The agency has made a number of changes in the status of ALJs and the rules under which they decide Medicare cases, circumscribing their independence and, potentially, their impartiality. In another change, HHS adopted the use of video conferencing, instead of in-person hearings, in most ALJ cases.

The 2010 Patient Protection and Affordable Care Act (ACA) requires commercial insurers and managed care plans to have an effective internal appeals process for claims and coverage determinations and requires an external review process under state law or federal standards to be established by HHS.

APPEALS: Policy		
General	FEDERAL	Appeals procedures should be as simple and streamlined as possible without sacrificing beneficiary protections. They should ensure basic fairness for the beneficiary, including an opportunity for an informal in-person hearing by the Medicare administrative contractor. To facilitate effective appeals, beneficiaries and their representatives should have ready access to all information and documents related to coverage, payment, and quality of care in their case. Medicare administrative contractors should have incentives to reach the correct decision on a claim at the first level of review. All decisions that could result in a beneficiary not receiving the care in question should be made and communicated as rapidly as the beneficiary's medical situation warrants. Medicare beneficiaries and other parties directly affected by coverage or claim denials should receive a timely written explanation of the basis for the decision and of their appeal rights. This information should be understandable to a layperson and sufficiently detailed, including with citations to the legal authority upon which the denial is based, to permit a meaningful appeal. The Department of Health and Human Services (HHS) should publish data on the number and disposition of appeals by service sector (i.e., hospitals, physicians, etc.) for payment claims, beneficiary complaints, and coverage denials at each level, from initial hearing to final disposition, including appeals that reach federal court.
Part D	FEDERAL	The grievance and appeals process for the Medicare Part D drug benefit needs to be streamlined to include faster dispute resolution and access to temporary drug supplies sufficient to last the entire time period of a pending appeal. In the case of adverse decisions, and to avoid further unnecessary delay, Medicare beneficiaries' appeals should be forwarded automatically to the first level of independent review without further action by the beneficiary.
Administrative law judges	FEDERAL	Administrative law judges (ALJs) should remain free from undue influence from HHS and be allowed to continue making impartial decisions in hearings regarding Medicare cases. Medicare beneficiaries who appeal their cases to an ALJ should have an unrestricted opportunity for an in-person hearing, upon request.
Access to federal court	FEDERAL	The appeals process should be streamlined by eliminating the need for Medicare Appeals Council reviews and allowing ALJ decisions to be appealed in a timely manner to an impartial forum, such as federal court.

Quality Improvement in Medicare

Quality problems are found in all types of delivery systems, regardless of payer, including the Medicare program. Poor quality in service delivery results in wasted resources, as well as lost lives or reduced function. A body of literature indicates that there is no relationship between spending and quality, and geographic areas in which Medicare spending is greater do not necessarily manifest better outcomes of care.

The Centers for Medicare & Medicaid Services (CMS) is ultimately responsible for ensuring quality in all Medicare programs. CMS quality strategies include:

- establishing and enforcing quality standards for providers,

- providing technical assistance through quality improvement organizations (QIOs),
- promoting collaborations and partnerships,
- supporting or directly providing consumer assistance and information,
- publishing information in support of accountability and public disclosure,
- structuring payment and coverage to improve care, and
- rewarding better performance.

CMS accomplishes these strategies primarily by managing quality improvement initiatives through partnership with affected stakeholders; identifying priority clinical areas; adopting or developing performance measures; and collecting, analyzing, and publishing data and comparative reports.

In the traditional Medicare program, CMS fulfills its responsibility directly and through contracts with various organizations that monitor, survey, inspect, and review the provision of Medicare services. Medicare quality contractors include state survey and certification units and independent accrediting bodies. The QIOs primarily collect and analyze data on patterns of care and outcomes in order to help physicians and other providers improve the quality of beneficiaries' care.

The Office of Clinical Standards and Quality is CMS's focal point for all quality, clinical, and medical science issues and policies. It coordinates quality-related activities with outside organizations such as the Hospital Quality Alliance and the AQA (formerly, the Ambulatory Quality Alliance). CMS addresses quality in every aspect of the health care system: nursing homes, home health agencies, hospitals, physicians, and end-stage renal disease care. In addition the Medicare Quality Monitoring System (MQMS) is responsible for monitoring and improving the quality of care delivered to Medicare beneficiaries. Features of the MQMS include clinical quality indicators for care, utilization, and outcomes for various clinical and topic areas, as well as performance assessment using administrative data.

Among their other responsibilities, QIOs receive and review beneficiary complaints about quality, hospital-issued notices of noncoverage, and violations of the Emergency Medical Treatment and Active Labor Act, which prohibits denial of treatment by emergency rooms, or "patient dumping." As an alternative to the complaint process, CMS introduced a mediation alternative, in response to findings by the Department of Health and Human Services' inspector general and related litigation that the complaint process is inadequate and unresponsive to beneficiaries' needs. This is a voluntary, no-cost program facilitated by an impartial, trained mediator. Mediation sessions are confidential, and no records are kept of the proceedings. By law nothing said during a mediation session may be used in court or for other purposes.

To promote quality improvement and public reporting, CMS develops and tests measures applicable to physician and hospital care.

QUALITY IMPROVEMENT IN MEDICARE: Policy		
Funding and quality improvement and oversight	FEDERAL	Congress should make a significant investment in the infrastructure and operating capacity of the Centers for Medicare & Medicaid Services (CMS) so it can meet its responsibilities for quality oversight and improvement, in part by providing technical assistance to participating providers. CMS should develop and maintain adequate data systems so it can assess the quality of care delivered to beneficiaries in the traditional Medicare program. CMS should: • continue to conduct and support the development of measures that address important clinical areas, cross-cutting issues (e.g., complication rates and care coordination), patient experience and engagement, and episodes of care that span care settings; • ensure that health care quality improvement programs regularly evaluate if measurable improvements in outcomes and related processes are achieved. All participating providers and practitioners should be required to implement patient safety programs;

Funding and quality improvement and oversight (cont'd.)	FEDERAL	• closely manage and hold accountable the contractors it uses to conduct quality reviews and inspections on its behalf, such as payment contractors, state survey agencies, independent accrediting bodies, and quality improvement organizations; • address beneficiary complaints and pursue national clinical projects to measure access to and timeliness of care and the appropriateness of setting, treatment, and discharge; • continue making useful information about quality available to the public, including data that permit comparisons between the traditional Medicare program and private health plans, as well as information that compares the cost and quality of plans, physicians, and hospitals to help beneficiaries and others assess efficiency, continuity of care, and care coordination; • exercise its enforcement authority in all cases where actions against providers or practitioners are necessary to protect beneficiaries from substandard care and practices; and • continue its Healthy Aging Initiative and its partnership with other agencies to promote improvements in beneficiary care and well-being.

Prevention

Medicare's traditionally limited Part B coverage for preventive services has been expanded in recent years to include vaccinations for pneumonia, hepatitis B, and flu; pap smears and pelvic examinations once every two years (or more frequently for those at high risk); annual mammography screenings for women over age 40; and annual glaucoma screenings for people at high risk. Other covered preventive services include annual prostate screenings for men over age 50, colorectal cancer screening, outpatient diabetes self-management training, glucose monitoring equipment, bone-density measurement for those at high risk of osteoporosis, and nutrition therapy for beneficiaries with certain medical conditions. Deductibles and/or coinsurance have been waived for some of these services to ensure that financial considerations are not a barrier. In 2005 the Part B program began covering initial preventive physical examinations for new enrollees, as well as cardiovascular and diabetes screening.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) gave the Centers for Medicare & Medicaid Services (CMS) the authority to consider US Preventive Services Task Force (USPSTF) recommendations—an independent panel of experts in primary care and prevention that is convened by the federal Public Health Service—without Congressional review.

The 2010 Patient Protection and Affordable Care Act (ACA) gives the Department of Health and Human Services (HHS) authority to modify the coverage of preventive services as long as the modifications are consistent with the recommendations of the USPSTF. This includes the authority to modify which services may be included in initial preventive physical examinations. HHS may also determine that no payment be made for a preventive service that has not received a grade of A, B, C, or I by the USPSTF. The ACA also eliminates financial barriers to receipt of Medicare preventive services by eliminating cost sharing for preventive services that receive an A- or B- rating by the USPSTF.

When rating services, the USPSTF typically makes recommendations that are specific to an indication or population, at times including characteristics such as gender, age, or health status characteristics. The ACA only requires coverage without cost sharing for A- and B-rated services. The law is silent on whether the elimination of cost sharing should be associated with other qualifying factors recommended by the USPSTF. Thus, HHS could either decide to give all A- and B-rated services to all Medicare beneficiaries without cost sharing; or decide to make them available without cost sharing only for those beneficiaries for whom the USPSTF finds that the evidence supports.

The ACA also creates a new prevention benefit—an annual wellness visit—that includes a comprehensive health risk assessment and a personalized prevention plan with no copayment or deductible. The personalized prevention plan is required to include a comprehensive health risk assessment, including medical and family history. In a proposed regulation issued by HHS, medical and family history includes the following: past medical and surgical history, medication use, and family medical history.

Although many proven preventive services are underutilized by the Medicare beneficiaries for whom they are indicated, there are also significant racial and ethnic disparities among those who use preventive care. For example, among Medicare beneficiaries, African-Americans and Hispanics have lower immunization rates for flu and pneumonia than their white counterparts. The causes of these disparities are not well understood. In an effort to better address disparities in health care, the ACA requires HHS to ensure that any federally conducted or supported health care or public health program, activity, or survey collects and reports data on, among other things, race, ethnicity, and primary language. The data is required to be collected in a way that will generate statistically reliable population estimates. HHS is tasked with developing standards for such data collection.

PREVENTION: Policy		
Community outreach	FEDERAL STATE LOCAL	To increase the number of Medicare beneficiaries who take advantage of covered preventive services and screenings, federal, state, and local governments should fund community-based outreach, education, and promotion efforts that include targeted initiatives for at-risk beneficiaries. States and localities have a vested interest in doing so because they provide funding, often through care coordination arrangements, for dual-eligibles (e.g., Medicare beneficiaries who are also eligible for Medicaid).
Cost-sharing for preventive services	FEDERAL	The Department of Health and Human Services should make A and B rated preventive services available without cost sharing only for those beneficiaries for whom the US Preventive Services Task Force finds the evidence supports.
Research	FEDERAL	Congress should continue to adequately fund research to identify and evaluate appropriate preventive and screening services that Medicare does not cover.
Comprehensive risk assessment	FEDERAL	The federal government should ensure that an assessment of medical and family history for purposes of developing a comprehensive risk assessment includes the following: diet and exercise history, depression screening, substance use history, and social and sexual history.
Research on utilization of preventative services	FEDERAL STATE LOCAL	Federal, state, and local governments should take a leadership role in funding research to identify and address the causes of underutilization of proven Medicare-covered preventive services in the general Medicare population and among racial and ethnic minorities. In addition each level of government should fund targeted research to identify the cause(s) of underuse of clinically indicated preventive services among the general population and racial and ethnic minorities. In developing standards for the collection of data on race and ethnicity, the federal government should take steps to ensure that such data reflect statistically reliable population estimates by, among other things, developing criteria for whether and how such methods as geocoding and surname analysis may be used as well as when the use of such strategies are contraindicated.

Access to Services

As of 2009 the Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office concluded that Medicare beneficiaries' access to physicians is generally good and that most physicians remain willing to participate in the Medicare program. In fact, 95 percent of physicians and other practitioners who billed Medicare had participation agreements, and physicians who billed Medicare agreed to accept the

Medicare fee schedule amount as payment in full for more than 99 percent of claims. In prior years MedPAC found that access problems were more likely to occur for beneficiaries who are Hispanic or African-American, lack supplemental insurance, or have both Medicare and Medicaid coverage. In general these beneficiaries were more likely than others to report having trouble receiving health care services, having delayed care because of cost, or not having a usual source of care or doctor. Beneficiaries moving into a new area also reported access problems.

AARP has heard anecdotal reports of access in certain geographic areas. In some cases these seem to reflect general shortages of providers; in other cases this may signal a Medicare problem. Reports of problems seem to be most common among beneficiaries seeking primary care providers. If MedPAC analyses identify a national problem, a broader discussion of workforce and payment policies should take place. Even if the problem is more localized, it may merit the development of policies that help beneficiaries find available providers.

ACCESS TO SERVICES: Policy		
Monitoring	FEDERAL	The Centers for Medicare & Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC) should regularly and in a timely manner evaluate and monitor Medicare beneficiaries' access to quality care, including physician services and Part B-covered services, in all Medicare settings, regionally as well as nationally.
Adequacy of payment	FEDERAL	Congress should enact a long-term fix to the Medicare physician payment system to ensure that physicians continue participating in the Medicare program and beneficiaries continue to have access to providers (see this chapter's section Provider Payment: Physicians and Clinicians).
Public information and special populations	FEDERAL	CMS should continue making public the Medicare Current Beneficiary Survey data on access, health care utilization, and other relevant information. The agency also should pay particular attention to access problems of special populations, including beneficiaries in rural areas and US territories and commonwealths, people with disabilities, low-income individuals, minorities, beneficiaries with end-stage renal disease, and people living in institutions and in communities where access problems are common because of a shortage of health care personnel.
Research	FEDERAL	Both CMS and MedPAC should increase research into the causes of access problems, especially those the commission identified in its analyses.
Mental health and substance abuse	FEDERAL	CMS should ensure Medicare beneficiaries' access to appropriate and high-quality mental health and substance abuse services, such as outpatient services and partial hospitalization services. CMS should ensure that Medicare beneficiaries with mental or addictive disorders, particularly those residing in nursing homes or enrolled in managed care plans, have access to appropriate services. Data collection and other oversight activities must preserve beneficiary privacy and confidentiality.

Private Health Plans in Medicare: Medicare Advantage

Private health plans have been available in Medicare almost since the program's inception. Among its original objectives in authorizing private plans in Medicare, Congress sought to contain the growth in Medicare spending, improve the payment method for certain providers, and provide beneficiaries, including those residing in rural areas, with more choices and enhanced benefits. In general, these objectives remain relevant.

Medicare Advantage (MA) (also known as Medicare Part C) is Medicare's private-plan program. All MA plans are required to offer the Medicare benefit package. Some plans may also provide additional benefits. MA enrollees may save money through enhanced benefits or lower out-of-pocket costs. Most types of MA plans offer Part D drug coverage as well. To be eligible for an MA option, a Medicare beneficiary must have Medicare Parts A and B.

MA consists of several plan types:

- **Health maintenance organizations (HMOs)**—An HMO may also offer a point-of-service option that allows a beneficiary to obtain services out of network for higher out-of-pocket costs.
- **Provider-sponsored organizations (PSOs)**—Similar to HMOs, PSOs are organized and operated by physicians and hospitals and provide most services within their organized network.
- **Preferred provider organizations (PPOs)**—PPOs are networks of physicians and hospitals that have agreed to discount their rates for plan members. Enrollees may obtain services from non-network health professionals whenever they want but must pay higher out-of-pocket costs to do so.
- **Regional PPO plans**—Similar to local PPOs, regional PPOs cover a larger service area. They also feature a single deductible for Part A and B services and include an out-of-pocket limit for in-network care and on expenditures for benefits under the original Medicare fee-for-service program.
- **Special needs plans (SNPs)**—SNPs were created to specifically focus on the needs of individuals who are institutionalized, dually eligible for Medicare and Medicaid, or have severe or disabling chronic conditions. Most SNPs are HMOs.
- **Private fee-for-service (PFFS) plans**—PFFS plans are risk-based plans that closely resemble the traditional Medicare program but are operated by private insurance companies. They permit Medicare beneficiaries to go to any Medicare-approved doctor or hospital willing to accept the plan's payment. Unlike in other MA options, physicians in PFFS plans may balance bill 15 percent above the plan's fee schedule. This and other PFFS plan features have the potential to cause confusion for Medicare beneficiaries and make it difficult for them to distinguish this option from traditional Medicare.
- **Medical savings accounts (MSAs)**—MSAs have two components. The first is a Medicare Advantage plan with a high deductible (yearly deductible varies by plan) with premiums paid by Medicare; the plan pays for covered benefits once the deductible has been met. The second is a tax-free savings account to which both Medicare and enrollees contribute; it may be used to cover deductibles and coinsurance or to pay for health services that Medicare does not cover. Beneficiaries who choose the MSA option may not have Medicare Supplement (Medigap) insurance.

Private health plans in the Medicare program pose both opportunities and risks for the program and beneficiaries. On the one hand, having a wide array of private health plan options gives beneficiaries greater opportunity to find plans that meet their needs and preferences, possibly with additional benefits, and a range of cost-sharing arrangements.

On the other hand, by giving beneficiaries more choices, the task of selecting coverage is more complicated and may be so confusing to some beneficiaries that it invites inertia or poor decisions. Although consumers value choice, it is necessary to balance the desirability of a wide range of choices with the cognitive burden of having to select from among too many choices. Indeed, experts advise that one strategy to improve consumer decision making is to reduce the cognitive burden they face by simplifying choices through accessible formats and other techniques. Moreover, many beneficiaries may not be aware that MA plans may terminate their relationship with Medicare for any given year, change the benefits they offer (including drug coverage) or the premiums and cost-sharing they charge, or drop providers.

The Medicare risk pool is inevitably segmented by the inclusion of multiple coverage options. There is evidence that the healthiest beneficiaries are likely to enroll in an MA option, leaving the sicker, more expensive beneficiaries in the traditional Medicare program. Among the various MA plan options, PFFS and MSA plans are likely to attract the healthiest beneficiaries of all.

This skewing of healthy beneficiaries toward MA plans underscores the importance of risk-adjusting Medicare payments to contracting plans. An accurate risk-adjustment mechanism can help to mitigate the effects of risk segmentation by increasing payments to health plans for high-cost or high-risk beneficiaries and reducing payments to plans with healthier enrollees. Without these kinds of corrections, Medicare will overpay providers for healthier enrollees while underpaying them for those who are sicker.

MA plans are an important alternative for many Medicare beneficiaries, especially minorities and those with lower incomes, although the lowest-income beneficiaries—those with both Medicaid and Medicare coverage—are less likely to join. A study using data from the 2007 Medicare Current Beneficiary Survey found that 41 percent of MA enrollees had incomes of $20,000 or below. (Beneficiaries report that the two primary reasons for selecting an MA plan are lower cost and better benefits or coverage.)

PRIVATE HEALTH PLANS IN MEDICARE: MEDICARE ADVANTAGE: Policy		
Choice of Medicare coverage options	FEDERAL	Medicare beneficiaries should have a genuine choice among health plans. The traditional Medicare program should remain a viable and affordable option, while a reasonable number of private health plan options, such as health maintenance organizations, preferred provider organizations, provider-sponsored organizations, and point-of-service plans should be available. Congress and the Centers for Medicare & Medicaid Services (CMS) should monitor carefully the effects of private plan options by plan type and payment rules on beneficiary access, the stability of Medicare beneficiaries' health coverage, and their out-of-pocket spending, as well as the impact on total Medicare spending. AARP does not support medical savings accounts (MSAs) or private fee-for-service (PFFS) plans as Medicare coverage options. Congress should consider whether PFFS plans and MSAs provide added value in the Medicare program, particularly whether they are likely to attract healthier enrollees than other coverage options or prove costly for the Medicare program to sustain. The value of multiple plan types and an excessively large number of plan choices should also be assessed.
Consumer protection	FEDERAL	Congress and states should protect beneficiaries in private health plans that significantly increase their premium or cost-sharing charges by directing CMS to facilitate the transition from one Medicare coverage option to another and ensuring access to Medigap policies for beneficiaries seeking to change their enrollment to the traditional Medicare program. In managed care models that contract with multiple medical groups, enrollees should be allowed to select providers from among all participating medical groups. If this is not feasible, beneficiaries enrolled in health plans offering multiple medical groups must be fully informed about limitations on access to providers. Plan enrollees should be permitted to change providers whenever they choose. To ensure that Medicare beneficiaries understand the implications of enrolling in any of the options offered, Congress should provide CMS with adequate funding and other necessary resources, including trained personnel, to conduct public education and outreach programs. These programs should advise beneficiaries about the right of a private health plan to: terminate its relationship with Medicare on an annual basis; annually change the benefits (including

Consumer protection (cont'd.)	FEDERAL	drug coverage) it offers or the premiums and cost-sharing it charges; and drop providers during the contract year. Beneficiary education also should include information comparing the benefits, cost, and quality of the available coverage options.
Ombudsman programs	FEDERAL STATE	Consumers should have access to an independent, nonprofit ombudsman program that receives federal and/or state funding. Ombudsman programs would assist consumers in understanding a plan's marketing materials and coverage provisions, educate members about their rights within health plans, help identify and investigate enrollee complaints, assist enrollees in filing formal grievances and appeals, operate and staff a telephone hotline, and report to and advocate before appropriate regulatory bodies on issues of concern to consumers. Health plans should be required to cooperate with such programs.
Insurance counseling	FEDERAL STATE	Government-supported insurance counseling programs should have sufficient funding to provide adequate staff training and meet the demand for assistance among beneficiaries.

Medicare Advantage Payments and Beneficiary Rebates

The 2010 Patient Protection and Affordable Care Act (ACA) significantly changed the Medicare Advantage (MA) payment approach to address multiple flaws in the previous payment system, including the fact that MA payments exceeded the amount Medicare would have paid for beneficiaries had they received care in the traditional program. In addition to gradually reducing MA payments so that they more closely approximate fee-for-service payments, the new approach better aligns payment with desired performance by providing MA plans with financial incentives to improve quality and efficiency.

Under the provisions of ACA, payments for 2011 will be frozen at 2010 levels. Then, starting in 2012, new benchmarks gradually will be set at different percentages of fee-for-service spending rates ranging from 95 percent of Medicare fee-for-service spending in higher-cost areas to 115 percent in low cost areas. Plans that provide high quality, as determined by a star-rating system established by the Centers for Medicare & Medicaid Services (CMS), will be eligible for bonuses. Qualifying MA plans located in certain locations (generally low-payment urban areas) will be eligible to have their bonuses doubled.

The new law also reduced the amount of money available for beneficiary rebates, also known as "extra benefits." Beneficiary rebates enable an MA plan to offer additional benefits that are not included in the basic Medicare benefit package, such as dental or vision care, or reduced cost sharing. Money to provide these benefits is available when a plan's bid is lower than the applicable benchmark payment amount set by Medicare to determine the plan's payment. For the first time, MA rebates will be linked to plan performance. Starting in 2014, when the new rebate approach is fully implemented, a plan earning at least 4.5 out of 5 stars on CMS' star rating system will be eligible to receive 70 percent of the difference between its bid and the benchmark payment rate; plans with 3.5-4.5 stars will have a rebate of 65 percent; and plans with fewer than 3.5 stars will have a rebate of 50 percent. Thus, the higher performing plans receiving higher rebate percentages will be better positioned to provide enrollees with additional benefits.

MEDICARE ADVANTAGE PAYMENTS AND BENEFICIARY REBATES: Policy		
Payment	FEDERAL	Medicare payments should be neutral with respect to coverage option. Congress should set the benchmarks upon which Medicare Advantage (MA) plan payments are based so that they do not exceed fee-for-service costs. Congress should periodically evaluate the impact of the MA reimbursement methodology to ensure reasonable private health

Payment (cont'd.)	FEDERAL	plan participation in the Medicare program and appropriate Medicare payments to participating plans. To ensure that payments to MA plans are set correctly and recognize appropriate risk factors, the Centers for Medicare & Medicaid Services should continue to refine the methodology that adjusts MA plan payments. Payment methodologies should align payment with desired performance as determined by an assessment of quality, resource use/efficiency, and beneficiaries' experiences.

Medicare Advantage Standards

When administered properly private health plans can oversee total patient care effectively and discourage unnecessary use of services. However private plans receive the same level of reimbursement regardless of the number of services they provide, and participating providers therefore may have incentives to skimp on care. Safeguards must be in place to ensure that: a plan's cost controls do not adversely affect beneficiaries' access to or quality of care; and Medicare resources are used properly.

Under the provisions of the 2010 Patient Protection and Affordable Care Act (ACA), Medicare Advantage (MA) enrollees will be allowed to switch to the traditional Medicare program and elect a Medicare prescription drug plan between January 1 and February 14th of each year. This brief disenrollment period is in addition to the annual election period that occurs in the fall when enrollees may change plans.

Besides the opportunity to disenroll, beneficiaries have the right to an independent review of plan decisions, including an expedited appeal within 72 hours of when they believe their condition requires rapid review. In addition, the Centers for Medicare & Medicaid Services can terminate a private plan's Medicare contract or impose intermediate sanctions, including monetary penalties, when circumstances warrant.

All MA enrollees (indeed, all Medicare beneficiaries) need strong quality-of-care standards and other consumer protections so they can be confident they are receiving the high-quality care to which they are entitled.

MEDICARE ADVANTAGE STANDARDS: Policy		
Federal standards	FEDERAL	All participating health plans in the Medicare program must be initially certified as having met the federal standards designated by the Centers for Medicare & Medicaid Services (CMS) and subject to federal oversight to ensure ongoing compliance with the standards.
Financial stability	FEDERAL	All participating health plans must be financially sound. Financial standards should contain solvency requirements, including on capital reserves, that take into account the plan's level of risk and service-delivery capabilities and that are set at adequate levels to protect beneficiaries in the event of a plan's insolvency.
Pharmacy benefits	FEDERAL	AARP does not oppose health plans' use of drug formularies and preferred drug lists, because they can be an effective cost-containment and quality-enhancement tool. However, in providing drug benefits, health plans using drug formularies and preferred drug lists should: • ensure participation of plan physicians and clinical pharmacists in the development of formularies and preferred drug lists; • publicly disclose the nature of formulary and preferred drug list restrictions and utilization management policies; • allow the use of nonformulary drugs, or those not on the preferred drug list, when they are medically necessary and ensure that plan members are aware of how such alternatives can be obtained;

Pharmacy benefits (cont'd.)	FEDERAL	• provide any prescription drugs that are exceptions to the health plan formulary and preferred drug list to enrollees requiring such drugs, under the same terms and conditions, including cost-sharing requirements, as drugs in the formulary; and • subject disagreements between an enrollee and a health plan about prescription drug coverage to the plan's internal complaint process and external appeals process.
Emergency care	FEDERAL	In the event of an emergency, enrollees in Medicare Advantage (MA) plans with networks should not be required to obtain care through the plan's network of providers. "Emergency care" must be defined using the "prudent layperson standard," that is, coverage for emergency care should include services provided where the enrollee presents to a provider outside the health plan with symptoms, including severe pain, that a prudent layperson would reasonably believe to be an emergency medical condition. Health plans should be contacted once MA enrollees who present to emergency departments are stabilized to determine follow-up treatment, and the plan should be prepared to assume the care of the patient. In any event patients should be covered for all necessary care in connection with the emergency. Health plans should be prohibited from requiring prior authorization for emergency services. The special needs of people with mental illness and substance abuse should be taken into account when coverage decisions are made concerning emergency services or urgently needed care.
Marketing	FEDERAL	Health plans should be required to provide standardized information to prospective and new enrollees, including: • information on benefits, limitations, exclusions, restrictions on use of services, and plan ownership; • a summary of physicians' financial incentive arrangements, written in terms that an average beneficiary will understand; • the stability and composition of the provider and practitioner network, including a list of the participating physicians and hospitals with their credentials and licensing data; • comprehensive information on patients' experience with care in the plan, and the plan's clinical performance (as measured by the Consumer Assessment of Health Plans Study and the Health Plan Effectiveness Data and Information Set, respectively) and on the performance of participating physicians, hospitals, skilled-nursing facilities, home health agencies, and pharmacies; • whether the plan is accredited by a national organization whose standards have been deemed acceptable by CMS; • disenrollment experience; • data on grievances and appeals filed by beneficiaries; and • disclosure of any sanctions imposed by CMS due to a plan's failure to comply with statutory and regulatory requirements. Federal authorities must approve all marketing materials before their use. Materials must be written at a sixth-grade reading level and available in languages other than English when the plan serves or will serve substantial numbers (more than 5 percent) of enrollees whose native language is not English. Marketing presentations implying that a beneficiary's failure to enroll will result in the loss of Medicare entitlement must be prohibited. Other prohibited

Marketing (cont'd.)	FEDERAL	marketing activities should include door-to-door solicitation, offering beneficiaries inducements to enroll, and discriminatory activities designed to recruit healthier-than-average enrollees. To avoid discriminating against population groups based on place of residence, plans should serve a complete market area.
Enrollment practices and procedures	FEDERAL	Ideally all enrollment in Medicare private health plans should be conducted by a CMS third-party contractor. No health plan should be permitted to enroll beneficiaries directly. All health plans, including fee-for-service, Medicare Advantage, and Medigap insurers, should be required to participate in an annual, coordinated open-enrollment period during which plans must accept all eligible applicants without regard to their health status, previous claims experience, medical history, or lack of evidence of insurability, to the extent plan capacity will allow as determined by CMS.
Disenrollment	FEDERAL	Medicare beneficiaries enrolled in private health plans should have the opportunity to disenroll at any time, effective the first day of the following month, for cause or not for cause, and change their enrollment to the Medicare fee-for-service program or any other health plan CMS offers. Medigap carriers should be required to sell insurance coverage to any beneficiary who applies for supplemental coverage after disenrolling from an MA plan.
Rates and payments	FEDERAL	Premiums charged by health plans participating in the Medicare program must be community-rated for the Medicare population. Payments to plans should be risk-adjusted so that payment reflects the risk undertaken by the plan on behalf of the beneficiaries enrolled. Current Medicare balance billing limitations should apply to all Medicare-covered services provided to Medicare beneficiaries for care in and out of the network.
Accessibility	FEDERAL	Health plans must be able to demonstrate that appropriate and necessary services are reasonably available and accessible 24 hours a day, seven days a week. Health plans must have sufficient numbers of practitioners, providers, and facilities and sufficient distribution of providers by specialty and location within the plan's service area to serve enrolled members. The adequacy of a network should be assessed in relation to the health plan's model type, the prevailing patterns of provider distribution in the plan's geographic service area, and the needs of the plan's enrollees. Women should have direct access to obstetricians and gynecologists and should be allowed to designate them as their primary care providers. Health plans should be required to refer beneficiaries to specialists affiliated with the plan or recognized specialty-care centers affiliated with the plan pursuant to treatment plans. Referrals should include provisions for standing referrals, as determined by the referring practitioner. Health plans should be required to provide out-of-network referrals at no additional cost to the enrollee if the plan does not have a network physician with appropriate training and experience or affiliation with a recognized specialty-care center to meet an enrollee's covered medical needs. Patients with mental disorders should receive appropriate referrals to mental health specialists.

Continuity of care	FEDERAL	To facilitate continuity of care, health plans must notify affected enrollees at least 90 days before the termination of a provider, as long as the termination is not for cause. Enrollees who are undergoing an active course of treatment for a life-threatening disease or condition or a degenerative and disabling disease or condition, or who have entered the second trimester of pregnancy at the effective date of enrollment, should be able to receive covered medically necessary care from their physician specialists for up to 90 days (or through postpartum). This should apply to enrollees if their employer drops a plan that includes the patient's treating physician specialist and to existing enrollees if their previous physician specialist is terminated by the health plan for reasons other than cause. Health plans should facilitate the coordination of care and transition to new providers. In addition private health plans should be encouraged to coordinate their services with long-term care services and supports, particularly for people with chronic conditions.
Quality improvement and performance assessment	FEDERAL	All MA plans must demonstrate adequate performance as measured by their scores on quality indicators developed specifically for the Medicare population and on other applicable measures. These indicators should address a range of services, including preventive care and care for chronic illness, and should assess care coordination (including across care settings) and other issues. In addition MA plans should routinely assess the performance of their practitioner and institutional contractors and make this information available to participating providers and enrollees. Quality measures should be evidence-based and wherever possible should measure outcomes of care or processes that have a known relationship to outcomes. All private health plans participating in the Medicare program should be engaged in ongoing quality-improvement programs and should participate in quality improvement activities with Medicare quality improvement organizations.
Utilization review/utilization management (UR/UM)	FEDERAL	Written clinical review criteria must be developed with the involvement of health plan practitioners and made available to plan practitioners and enrollees. Utilization review/utilization management (UR/UM) plans must be designed to detect underutilization as well as overutilization. Adverse UR decisions must be made by clinically qualified personnel and reviewed by active practitioners in the same or a similar specialty. Reviewing clinicians need not be residents of the state in which the enrollee whose claim is being reviewed resides. Reviewers must not receive financial compensation based directly or indirectly on the number or volume of certification denials. Certification decisions must be made at least as rapidly as the beneficiary's medical situation requires to protect her health and permit a meaningful appeal. Denials must be accompanied by clear information on the reasons for denial as well as instructions on how to appeal the denial.
Grievances and appeals	FEDERAL	Health plans should have a system for receiving beneficiaries' grievances about furnished services for which the beneficiary has no further liability for payment, such as physician behavior, waiting times, and quality of care. Health plans also should have an appeals process to address disputes that involve the denial, termination, or

Grievances and appeals (cont'd.)	FEDERAL	reduction of services or payment. Grievance and appeals procedures should include provisions in the following areas: • information—When a requested service or payment is denied, or when needed care is reduced or terminated, beneficiaries must receive timely, clear information about such decisions; the specific reasons for the decision; and a description of the right to appeal and the procedure for doing so. Information must include the medical criteria relied on and the process followed by the plan in reaching its decision. The methods of communicating information about the denial and appeals process must meet the specific needs of an older population, taking into account vision or reading difficulties and language and cultural differences. • independent review—Beneficiaries must have the right to have their claims reviewed by independent entities that are not appointed or selected by the health plan, including an external review by medically qualified reviewers of plan decisions about medical necessity, followed by a hearing before an administrative law judge and access to the federal courts. There should be no charge to the enrollee for gaining access to such independent review or for the review itself. • fairness—Plans must give adequate advance notice before terminating or reducing any services that a beneficiary is already receiving, with specific reasons for the termination or reduction and clear instructions on how to appeal the decision. Ongoing services, particularly hospital inpatient services and skilled-nursing or rehabilitation services, should be covered until the reconsideration is complete. The beneficiary should not be responsible for the costs of the appeals process, including the cost of external medical review. The appeals process must include an opportunity for the beneficiary to attend the review in person, testify, submit evidence, and call and question witnesses. • timeliness—There must be specific time limits for appealing a service denial, termination, or reduction that reflect beneficiaries' medical needs. Expedited review must be available in cases where the regular time limits would jeopardize the beneficiary's life or health or ability to regain or retain maximum function. In addition fast-track appeals should be available for those enrollees requesting immediate review of a plan's discharge decision from a skilled-nursing facility, comprehensive outpatient rehabilitation facility, or home health agency. Such cases should be resolved as rapidly as the situation requires and never exceed a specified maximum amount of time. A plan's failure to meet specified deadlines or provide necessary information should result in automatic approval of both expedited and regular appeals. Health plans should collect and report data on grievances and appeals in standardized formats.
Private health plan liability	FEDERAL	All private health care plans should be held accountable for their actions. In cases where a health plan has been involved in a decision to delay or deny needed health care services, and the decision has had medical consequences, the plan should be liable for any injuries or harm an enrollee sustains. The right to seek meaningful judicial

Private health plan liability (cont'd.)	FEDERAL	redress for decisions that contributed to injury or death should be available to all MA enrollees regardless of the source of their health care coverage. State laws on the corporate practice of medicine that prevent holding managed care organizations accountable for harm caused by inappropriate treatment decisions should be revised to afford the injured enrollee access to state court.
Coverage for experimental services	FEDERAL	Health plans should have an objective and expeditious process for considering experimental treatments, including new drugs, devices, procedures, and therapies. In addition health plans should be required to participate in an external, independent review of coverage denials, to be conducted by a panel of experts selected by an impartial, independent, and accredited entity.
Coverage for care in clinical trials	FEDERAL	Enrollees in private health plans should have appropriate access to, information about, and protections within clinical trials. Private health plans should cover routine patient care costs (e.g., hospital services, physician services, and diagnostic tests) associated with the participation of plan enrollees in clinical trials that are: • funded by the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare & Medicaid Services (CMS), Department of Defense (DOD), and Department of Veterans Affairs (VA); • supported by centers or cooperative groups funded by the NIH, CDC, AHRQ, CMS, and DOD; and • sponsored by the VA and conducted under an investigational new drug (IND) application reviewed by the Food and Drug Administration (FDA), exempt from needing an IND application under FDA regulations, or deemed by CMS to meet the qualifying criteria developed by the appropriate multiagency federal panel. These services should be covered even if the provider participating in the clinical trial is not part of the managed care organization's network. However, the following services related to clinical trials need not be covered by the managed care organization: the investigational item or service itself and items and services provided solely to satisfy data collection needs or by the trial sponsor without charge.
Credentials	FEDERAL	Each practitioner must be credentialed before participating in a health plan and recredentialed every two years. The medical director or other plan representative authorized to act on the plan's behalf must be responsible for the credentialing process. There must be a credentialing committee, with representation of plan practitioners. Credentialing information must be subject to review and correction by the practitioner being credentialed. Information about the credentialing process and policies must be available for review by providers and enrollees upon request. Information on practitioner credentials must be available to plan enrollees. The plan also must obtain primary verification of current license, malpractice coverage, hospital privileges, board certification (if any), Drug Enforcement Agency certificate, medical degree, and residency training, as well as secondary verification of license, malpractice, and National Practitioner Data Bank history. The plan also must conduct an on-

Credentials (cont'd.)	FEDERAL	site office visit and review of medical record-keeping practices. For recredentialing, in addition to all the procedures required for initial credentialing, the plan must review member complaints, results of quality assurance and utilization review activities, and member-reported experience with care.
Provider and practitioner contracting	FEDERAL	Plans should be required to provide services through contracts with providers and practitioners. If a health plan denies a physician's application to participate, terminates its agreement with the physician, or suspends its contract with the physician, the plan should provide the physician with a written explanation for the action and afford the physician the right to appeal. Contracts should encourage open communication between providers and enrollees concerning all treatment options and other issues concerning patients' health care. Each contract should clearly identify the services to be provided and include provisions that: • hold enrollees harmless for payment for covered services in the event of nonpayment by the health plan; • require continuation of covered services to enrollees for the period for which a premium has been paid, regardless of the health plan's insolvency or nonpayment; • prohibit collection of any payments, other than required cost-sharing, from enrollees for covered services provided by the practitioner or as a result of the practitioner's authorized referral; • prohibit balance billing; • require the practitioner to participate in and cooperate with quality assurance and utilization review activities of the health plan and of federal agencies conducting external quality reviews; • prohibit any physician incentive plan that directly or indirectly bases payment on the reduction or withholding of medically necessary services to enrollees; • require medical records to be maintained in an appropriate manner; • require providers or practitioners to report specified data; and • require the practitioner or provider's office or facility to be subject to inspection by the plan.
Confidentiality	FEDERAL	Private health plans must prevent improper use or release of personally identifiable medical information and must adopt appropriate protections on the use of electronic information and nationally based payer and provider systems.
Data collection and reporting	FEDERAL	All health plans serving Medicare beneficiaries must collect and report comparable, independently audited data that will demonstrate compliance with national standards. Health plans must report: • medical costs or expenditures on a per capita basis by type of expenditure (physician, inpatient, outpatient, home health, skilled-nursing facility, etc.); • plan administration costs; • beneficiary experience with care; • complaints and grievances and their resolution;

Data collection and reporting (cont'd.)	FEDERAL	• physician satisfaction; • health care quality as assessed by performance on standardized measures, including performance of participating physicians, hospitals, skilled-nursing facilities, home health agencies, and pharmacies; • credentialing; • utilization management or appeals regarding use of out-of-plan services; • accessibility, including wait times for appointments and numbers of practitioners accepting new patients; • rates of physician turnover; and • enrollment and disenrollment rates.
Enforcement of standards	FEDERAL	CMS should monitor the activities of all private health plans participating in the Medicare program to ensure compliance with all requirements. In the event CMS detects violations, the agency must enforce the requirements through use of intermediate sanctions or contract termination.

Medicare Advantage: Quality Improvement and Accountability

As administrator of the Medicare program, the Centers for Medicare & Medicaid Services (CMS) uses several approaches to ensure that high-quality care is provided and that care is assessed and improved. These approaches include setting conditions of participation, providing technical assistance through the quality improvement organization program, expanding public reporting initiatives, tying payments to quality improvement, encouraging the adoption of health information technology, and promoting the creation and use of information about the effectiveness of health care technologies and treatment interventions. Medicare requires Medicare Advantage (MA) plans to have ongoing quality improvement programs, which must include a chronic care improvement program. In addition each MA plan must collect and report data on quality, as specified by CMS. To facilitate data collection, plans are required to have a health information system that enables them to collect, analyze, and integrate the data necessary to implement quality improvement activities, although this capacity varies among contracting MA plans. CMS requires plans to report to the Health Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Health Plans Study, and Health Outcomes Survey.

In addition, the 2010 Patient Protection and Affordable Care Act (ACA) contains several MA payment provisions designed to encourage high performance by MA plans (see Medicare Advantage Payments and Beneficiary Rebates).

MEDICARE ADVANTAGE: QUALITY IMPROVEMENT AND ACCOUNTABILITY: Policy		
General	FEDERAL	Given the financial incentives integral to the operation of private health plans that are risk-based, the federal government should strictly monitor compliance with Medicare program requirements, including those on quality of care. Congress should hold all plans in the Medicare program accountable for sustained quality improvement, regardless of model type. Further Congress should establish a level playing field in the Medicare program by requiring all health plans to collect and report similar information on performance to permit valid comparisons among plans. All plans must have the capacity to collect, analyze, and integrate data for public reporting, accountability and quality improvement activities. The quality assurance/quality improvement system should

General (cont'd.)	FEDERAL	have the capacity to identify both exemplary and problematic patterns of health care in the aggregate, as well as for individual practitioners, and to take direct action, including referrals to enforcement agencies, in the event of serious or persistent poor-quality care.
Quality improvement organization (QIO) programs	FEDERAL	In addition to their own internal quality improvement activities, health plans should participate in quality improvement projects conducted by designated professional review entities that have no conflicts of interest, such as the quality improvement organization (QIO) program. QIO programs should: • provide feedback on performance benchmarks that offer comparisons among plans, identify improvement opportunities, and allow plans to give individual practitioners feedback on their performance in relation to the benchmarks; • educate practitioners about new practice guidelines and outcomes research; • combine state-of-the-art technical expertise with a thorough knowledge of local medical practice to help each plan achieve the highest quality care; • advocate on behalf of Medicare beneficiaries in matters concerning quality of care; • make data available to beneficiaries to promote informed health care choices; • refer cases that show seriously poor-quality care to state licensing and regulatory authorities and/or federal authorities, as appropriate; and • propose and facilitate implementation of systems to prevent medical error. The Centers for Medicare & Medicaid Services (CMS) should provide the public with provider-specific information about QIO findings concerning the performance of Medicare Advantage (MA) contractors. AARP supports efforts to evaluate and improve oversight procedures to ensure that quality assurance programs, including the QIO review system, are effective.
Deeming by private accrediting organizations	FEDERAL	Health plans that have achieved accreditation from private accrediting organizations (PAOs) should not be subject to redundant review by CMS, as long as the agency has judged the PAO's standards to be comparable to the required federal standards for participating health plans. When CMS authorizes a PAO to deem a health plan as in compliance with one or more of the state's requirements, it must ensure that: • it retains full authority to enforce all regulatory requirements, whether or not it relies on the PAO's information, processes, or standards, and to initiate enforcement actions based on the results of a PAO's processes and standards; • the use of or reliance on a PAO's assessment is subject to full and open public comment; • a PAO's standards and measures are readily and publicly available at no or nominal cost;

Deeming by private accrediting organizations (cont'd.)	FEDERAL	• information about individuals who conduct reviews on behalf of PAOs is publicly disclosed, including the individuals' qualifications and affiliations; • PAO surveys are periodically validated; • the results of the PAO review process are public; and • the PAO has no conflicts of interest with and is independent from those entities it accredits. Private accreditation should not be a condition of participation in the Medicare program. Compliance with federal standards or deeming by a PAO should not obviate the requirement for health plans to undergo external quality review by designated professional review entities.
Staffing the Centers for Medicare and Medicaid Services (CMS)	FEDERAL	Congress should establish an adequate staffing level within CMS and provide adequate funding to permit effective monitoring of MA organizations.

Provider Payment in Traditional Fee-for-Service Medicare

Medicare uses a number of different payment systems to reimburse providers for services in the traditional fee-for-service program. The payment systems are defined by Congress, while the Centers for Medicare & Medicaid Services is responsible for designing functioning payment mechanisms within the legislated framework. Payment systems in the fee-for-service program include prospective payment, episode-based payment, and fee schedule payment systems. Under a prospective payment system, providers receive a predetermined amount based on the patient's diagnosis, with the payment intended to reflect the average cost of providing service to all patients with a similar diagnosis. In episode-based payment, providers receive a single payment for all services provided during a specified period of time. Like prospective payment, the payment amount depends on the patient's diagnosis. In fee schedule payment systems, providers are reimbursed a set amount for each service provided. The payment amount for a service reflects the average costs of providing the service, along with the relative cost of one service compared with all other services included in the fee schedule.

PROVIDER PAYMENT IN TRADITIONAL FEE-FOR-SERVICE MEDICARE: Policy		
Payment rates	FEDERAL	Medicare payment rates should be fair and encourage efficiency among providers while maintaining beneficiaries' access to affordable, high-quality care.
Access to care	FEDERAL	CMS and the Medicare Payment Advisory Commission must monitor the effects of Medicare payment reforms. In particular, CMS must monitor provider payments and alert Congress if they are inadequate and discourage providers from offering services to Medicare beneficiaries, especially in rural areas (see also this chapter's section, Medicare—Access to Services).

Provider Payment: Hospitals

Medicare pays for hospital inpatient and outpatient services using a prospective payment system (PPS), which typically provides a single payment for a group of related services (e.g., a hospital discharge or care related to an outpatient procedure). In addition to paying for beneficiary services, Medicare provides special subsidies to teaching hospitals, uncompensated care costs of facilities that serve a disproportionate share of low-income and uninsured people, and certain rural hospitals paid under the PPS. One category of subsidy, graduate medical education, which includes payments for medical

education's direct and indirect costs (about $9.5 billion in fiscal year 2008), was designed to increase the number of and specialties among medical residents, create incentives for teaching hospitals to treat Medicare beneficiaries, and augment the overall financial resources of teaching hospitals.

In its March 2010 report to Congress, the Medicare Payment Advisory Commission found that access to hospital services was not a problem for most beneficiaries. Most hospitals have low occupancy rates, which suggests that hospitals have sufficient capacity to treat Medicare beneficiaries. Large reductions in the growth of Medicare's hospital payments, however, could result in some hospitals reducing staffing levels or closing, particularly those with low operating margins, such as rural hospitals, inner-city teaching hospitals, and public hospitals. These changes affect all who use hospital services, including Medicare beneficiaries.

Under the 2010 Patient Protection and Affordable Care Act Congress has slowed the Medicare payments to hospitals. It reduced PPS payment updates to account for expected improvements in productivity and reduced future disproportionate share hospital payments to reflect lower uncompensated care costs due to anticipated increases in the number of insured patients.

PROVIDER PAYMENT: HOSPITALS: Policy		
Access to care	FEDERAL	The Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare & Medicaid Services (CMS) should continue researching how Medicare payments to hospitals are affecting access to and quality of care in inpatient and outpatient settings, especially in rural areas. For example, CMS should monitor whether hospital closings and the reductions in the number of beds due to Medicare's fiscal policies adversely affect access to care. MedPAC and/or CMS should continue to monitor the adequacy of Medicare subsidies to hospitals that treat a disproportionate share of low-income patients.

Provider Payment: Physicians and Clinicians

Since 1992 Medicare has set physician payment rates according to a reimbursement fee schedule based on factors such as the time, skill, and intensity required for medical care. This system has reduced much of the unjustified variation in physician fees. "Physician fees" refers to those billed from the Medicare physician fee schedule. Other health practitioners, including nurse practitioners, nurse midwives, and others may also bill from the physician fee schedule and are similarly affected by the issues and policies discussed here.

While the fee schedule allocates Medicare funds for physician services among doctors, the target total spending amount for Medicare physician services is based on a complex formula known as the sustainable growth rate (SGR), whose purpose is to control overall spending. The SGR, which represents the allowable rate of growth in spending for physician services, is a function of the percentage change in input costs for physician services and other factors, including growth in the number of Medicare beneficiaries, changes in laws and regulations that affect spending, and per capita growth in the real gross domestic product (GDP). Under the SGR formula, a decline in GDP could reduce the increase in physician payment rates, despite a rise in physicians' input costs.

The SGR has proven problematic, with the formula calling for significant declines in payment rates over the past nine years. Since 2002 Congress has acted to delay the cuts, but has failed to enact a long-term fix for the problem. The ongoing threat of large decreases in Medicare payment rates causes problems for both providers, who constantly face uncertain payments and delays in payments as temporary fixes are debated in Congress, and for beneficiaries, who worry about whether their doctors will opt out of the program.

Health reform failed to fix the SGR problem, largely because a long-term fix is costly. The Congressional Budget Office projects that updating physician payment rates by inflation for the next 10 years would cost $330 billion.

The 2010 Patient Protection and Affordable Care Act (ACA) does provide temporary bonuses to physicians who provide primary care services and general

surgeons working in physician shortage areas. The law also requires the Centers for Medicare & Medicaid Services (CMS) to periodically review the system for assigning relative values to all physician services and identify potentially overvalued services. Overvalued services are a problem because they may provide incentives for physicians to increase the volume of such services, thereby driving up costs, and because they distort the system of relative values that serves as the basis for Medicare's physician payment system. Historically, primary care services have been under-valued in this system, causing some physicians to move away from primary care in favor of more lucrative specialties.

As of 2009, reports from the Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office concluded that Medicare beneficiaries' access to physicians is good and that most physicians remain willing to participate in the Medicare program. Recently some physicians who participate in Medicare in various geographic areas have adopted "boutique medicine" or "concierge care" arrangements. These require patients to pay an annual fee for services, such as annual physicals and other preventive benefits, not covered by Medicare. Patients who do not pay the additional fee are typically no longer able to see the physician. Physicians who have adopted such practices contend that they allow doctors to devote more attention to the patient. Critics argue that these arrangements discriminate against lower-income beneficiaries, who might have difficulty paying the annual fee. Paying an annual fee, they also argue, might violate Medicare regulations, because physicians are not permitted to collect a fee from a patient and also bill Medicare for the service.

CMS is required to monitor annually the impact of payment reform on beneficiaries' access to care. The information is needed to identify policy changes to ensure continued access. However , CMS historically has been slow to develop and implement the monitoring program.

PROVIDER PAYMENT: PHYSICIANS AND CLINICIANS: Policy		
Physician payments	FEDERAL	Congress should require Medicare to implement a physician payment policy that reduces incentives to increase service use in response to payment changes, or provide medical services of little or no value. The policy also should foster shared accountability among physicians for program goals. Policymakers should scrutinize the reasons for continued increases in the volume of physician services and their geographic variation. Congress should protect beneficiaries from unreasonable premium and copayment increases. Congress should implement a long-term fix for the sustainable growth rate system of updating Medicare's physician payment rates. Congress should improve payments to primary care providers to reflect the valuable services they furnish. The Centers for Medicare & Medicaid Services (CMS) should monitor the impact of Medicare "concierge care" or "boutique medicine" arrangements on access to care. CMS should develop and publish clear rules that specify when extra fees are allowed, what types of extra fees are permitted under Medicare law, and guidelines for beneficiaries who encounter concierge care practices.

Provider Payment: Durable Medical Equipment

Medicare covers many types of assistive technologies, known as durable medical equipment (DME), that improve beneficiaries' health and functioning. The most common are mobility devices such as wheelchairs and walkers. Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are reimbursed under Medicare Part B. The Medicare program is estimated to have spent $8.9 billion on DME in 2009. Medicare covers other types of assistive technologies, such as artificial limbs and braces, if they are medically necessary. Newer or less well-known forms of assistive technology, such as speech generators, may not be covered even when medically appropriate due to questions about their clinical efficacy and potential inappropriate use.

Unfortunately fraud and abuse have become associated with DMEPOS coverage, and a number of steps have been taken to deal with the problem. Beginning in October 2009, with some exceptions, DME suppliers must be accredited and post a surety bond. In addition, the 2010 Patient Protection and Affordable Care Act expanded the requirement that a provider must have a face-to-face visit with the beneficiary to establish medical necessity before certifying the need for DME items, including power wheelchairs. DME suppliers will be screened more carefully using such techniques as finger printing, criminal background checks, and unannounced site visits. The Centers for Medicare & Medicaid Services will be allowed to withhold DME payments for 90 days to investigate suspected fraud.

In an effort to slow the growth of Medicare spending for DME, DMEPOS suppliers are being required to submit competitive bids in 10 geographic areas. This competitive bidding program will be expanded nationally over time. There is some concern that, particularly in the early stages, regulatory implementation of these provisions could adversely affect Medicare beneficiaries' access to DMEPOS.

PROVIDER PAYMENT: DURABLE MEDICAL EQUIPMENT: Policy		
Access and integrity	FEDERAL	AARP supports the reforms implemented to reduce fraud and abuse associated with durable medical equipment (DME). The Department of Health and Human Services (HHS) should continue to monitor and control the incidence of fraud and abuse associated with DME, while also monitoring Medicare beneficiaries' access to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). HHS should strictly enforce regulations on accrediting and minimum quality standards for DMEPOS suppliers in order to deter unnecessary utilization of devices, while ensuring Medicare beneficiaries access to safe, high-quality, medically necessary, and appropriate DMEPOS. Competitive bidding should be used for pricing all DMEPOS, as long as quality and access are not compromised by the competitive bidding process. HHS should ensure that the competitive bidding process provides for exact individual specifications for DMEPOS. The agency also should monitor and publicly report on whether Medicare beneficiaries and the DMEPOS program are receiving appropriate quality of service and value from DMEPOS, as indicated by their safety, cleanliness, and cost.

Provider Payment: Postacute and Subacute Care

"Postacute" care under Medicare generally refers to services, such as skilled-nursing care and rehabilitation therapy, that beneficiaries need after inpatient hospitalization. The most common postacute care providers are home health agencies and skilled-nursing facilities (SNFs), although hospital outpatient departments, rehabilitation facilities, and long-term care hospitals also provide postacute care. Many beneficiaries require care in multiple postacute settings after an acute illness. They may be discharged from the hospital to an SNF and later from the SNF to the care of a home health agency.

The Medicare benefit for postacute institutional care is conditioned upon a prior hospitalization of at least three days. During the first 20 days of a covered SNF stay, Medicare pays the full amount. In 2010, beneficiaries in SNFs had to pay coinsurance amounting to one-eighth of the Part A hospital deductible, or $137.50 a day, from the 21st day to the 100th day. Thereafter, beneficiaries are liable for the full cost of skilled or custodial care, which in 2010 averaged about $67,525 per year for a semiprivate room, according to industry sources.

Prior hospitalization is not required to receive home health care through Medicare, including the services of a home health aide. However Medicare does require that a beneficiary be homebound—that

is, able to leave home only with great difficulty and for short, infrequent absences (e.g., to visit the doctor)—and in need of skilled care, including skilled nursing care or physical, occupational, or speech therapy. Such home health users who require services because of a severe chronic condition, disability, or a combination of severe health conditions, are sometimes referred to as subacute patients. Home health visits must be ordered by a physician or other practitioner but are not subject to deductibles or coinsurance.

All of the four main types of postacute care providers are paid under prospective payment systems (PPSs), most of which were implemented in the 1990s. Outpatient rehabilitation services are paid under a fee schedule. Medicare limits annual payments for rehabilitation therapy in outpatient settings, except hospital outpatient departments, while the Centers for Medicare & Medicaid Services (CMS) allows many beneficiaries to exceed these payment caps through an exceptions process. CMS collects data on patient assessments in home health care, skilled-nursing facilities, and inpatient rehabilitation facilities, and uses the data to monitor quality measures and adequacy of PPS payments. The data do not exist for long-term care hospitals.

Based on the following program characteristics, AARP is concerned that current Medicare coverage is inadequate to provide reasonable access to postacute or subacute care in SNFs or at home:

- The SNF coinsurance amount, which is computed on the basis of the Medicare hospital deductible, is much higher than the 20 percent coinsurance required for most Medicare services.
- Medicare does not pay for SNF services beyond 100 days, leaving beneficiaries potentially responsible for the full cost of SNF care.
- The requirement of prior hospitalization for SNF eligibility means that Medicare beneficiaries with legitimate skilled-care needs but who are not admitted as hospital inpatients will not be covered by the Medicare SNF benefit (e.g., patients who have been receiving home health care or who are discharged from an emergency room even if held for observation for several days). In addition the requirement creates a perverse incentive to hospitalize Medicare beneficiaries so they can qualify for the SNF benefit.
- The "homebound" requirement for Medicare coverage of home health services is too restrictive, leaving many beneficiaries with serious health conditions who are not technically homebound without needed care.
- Although there is no statutory limit on the total number of home health visits for those who meet eligibility criteria, Medicare's coverage of home health care is limited to part-time and intermittent care. The program's PPS encourages home health agencies to avoid high-cost users and limit the number of home visits.
- Payment caps on rehabilitation therapy in the outpatient setting may artificially limit access to these services and/or force beneficiaries to seek care in inconvenient locations.
- Traditional Medicare does not cover care management or care coordination among various providers or across care settings, other than requiring limited physician oversight of home health care.

The 2010 Patient Protection and Affordable Care Act (ACA) slowed the growth of Medicare spending for postacute care services and added a number of demonstrations to test improvements in Medicare's delivery and payment for postacute services. These include a value-based purchasing program for SNFs and home health agencies, quality reporting for long-term care hospitals and inpatient rehab facilities, extension of the exceptions process for Medicare rehab therapy payment caps, a national program of bundled payments for acute and postacute care services and a Medicare community-based care transitions program.

PROVIDER PAYMENT: POSTACUTE AND SUBACUTE CARE: Policy		
Ensuring quality and access	FEDERAL	Congress, the Centers for Medicare & Medicaid Services (CMS), and other government agencies should closely monitor the impact of Medicare payment policies on the quality of and access to postacute and subacute care (home health services, skilled-nursing facility (SNF) care, long-term hospital care, and outpatient therapy services) and the appropriateness of care in various settings. The incentives of postacute payment methods must safeguard access to necessary, high-quality covered services for all beneficiaries, without regard to the intensity or duration of care required.

Ensuring quality and access (cont'd.)	FEDERAL	CMS should educate the postacute provider community about beneficiaries' rights and join with state and federal enforcement officials to take strong action against postacute providers that inappropriately deny, reduce, or restrict services. Beneficiaries must have the right, and be advised of the right, to appeal decisions such as denials of, cutbacks in, and discontinuation of postacute care.
Improving postacute benefits	FEDERAL	Congress should mandate improvements in postacute benefits, safeguard beneficiaries' access to benefits, and avoid shifting the costs of postacute care to beneficiaries. The highest priority should be given to reform proposals that: • protect beneficiaries from exposure to high out-of-pocket costs by reducing the Medicare SNF coinsurance obligation, • increase the number of Medicare-covered SNF days, • remove Medicare's prior-hospitalization requirement for new SNF admissions, • maintain home health benefits free of copayments, and • repeal payment caps for outpatient rehabilitation therapy. Future reform proposals should be informed by careful research on access to and delivery of care, including design options for Medicare-covered care management or care coordination for postacute and subacute beneficiaries.
Quality of care	FEDERAL	CMS should take strong steps to ensure the quality of postacute care and promote quality improvements where necessary. The agency should place particular priority on: • pursuing initiatives to improve the quality of nursing home care; • using data sets, such as the Outcome and Assessment Information Set (OASIS) and others, to measure and improve home health outcomes; • reestablishing the OASIS reporting requirement for all patients, not just Medicare and Medicaid beneficiaries; • working with quality improvement organizations to improve quality of care in postacute settings; and • improving methods of coordinating care among multiple providers while maintaining or enhancing beneficiaries' choice of providers and access to needed care. Efforts to streamline OASIS must ensure its role in outcome measurement and quality improvement and not dilute it into a tool used only for determining payment amounts.

Mental Health

At least one in five older Americans suffers from a mental disorder. Among Medicare beneficiaries age 65 and older, the most common mental disorders, in order of prevalence are anxiety, dementia or other cognitive impairments, and depression. By 2030 the number of older people with such disorders is expected to double, to 15 million, equaling or exceeding the number of younger people with such conditions. Moreover, a substantial and growing percentage of older adults are misusing illicit drugs, alcohol, and prescription drugs. Demand for mental health and substance abuse services is also expected to grow as the baby-boom cohort, which has tended to use such services more frequently and feel less stigmatized by seeking care, continues to age. Nevertheless there is a substantial unmet need for mental health and substance abuse services for older adults.

Older adults requiring mental health services are more likely than younger adults to receive inappropriate or inadequate treatment, due in large

part to insufficient training in geriatrics among clinicians in routine settings. Most Medicare covered mental health services are provided by primary care physicians, not specialists. General mental health clinicians may lack training in basic assessment and treatment of mental disorders connected to aging. Personal reticence by older adults to acknowledge mental health problems, as well as the perceived social stigma against those who do, further compound appropriate recognition of and treatment options for mental disorders.

In addition there may be limited adoption of proven practices as part of usual care, or little evidence of treatments' effectiveness. For example there is scant research on the effectiveness of treatments for anxiety, especially for older populations.

A 2006 Institute of Medicine (IOM) report, "Improving the Quality of Health Care for Mental and Substance-Use Conditions," found that mental disorders seldom occur in isolation. This is particularly true for older adults. About one-fifth of patients hospitalized for a heart attack suffer from major depression; depression and anxiety are strongly associated with symptoms such as headache, fatigue, dizziness, and pain.

Further, people with mental health or substance abuse problems are more likely to suffer from heart disease, high blood pressure, diabetes, and arthritis—all afflictions common in older adults. The IOM also noted that mental health is a key component in self-perceptions of overall health, a factor that becomes increasingly important with age. Thus, attention to mental health and substance abuse is required in order to improve the general health of the Medicare population.

Cognitive disorders are frequently undiagnosed or are misdiagnosed in older patients. Although geriatric mental health assessment tools exist, they are often not integrated into routine practice. Further, some physicians and other providers may be less likely to diagnose alcohol and substance abuse disorders among older adults. Many older people are also reluctant to seek counseling to help them cope with the challenges of later life such as bereavement, disability, loneliness, and isolation.

The significance of these challenges is grimly evident in the fact that older Americans are disproportionately likely to die by suicide. Of every 100,000 people ages 65 and older, 14.3 died by suicide in 2007; the national average was 11.3 suicides per 100,000 people. Non-Hispanic white men age 85 or older had an even higher rate, with 47 suicide deaths per 100,000 people.

While Medicare's coverage of mental health and substance abuse services has gradually improved over the years by adding a partial hospitalization benefit, eliminating the payment limit on Part B mental health services, and phasing out a Part B copayment disparity between outpatient mental health services and other types of medical care, coverage continues to reflect restrictions that do not apply to other health services. For example, there is a 190-day lifetime limit on psychiatric care in freestanding psychiatric hospitals. In addition, despite growing evidence supporting community-based geriatric mental health treatment teams that are composed of a variety of providers (e.g., physicians, social workers, nurses, psychologists, and pharmacists), access to such care in the community remains limited by an institutional bias in Medicare's mental health policy.

An additional source of concern is that many mental health providers currently cannot be reimbursed under Medicare. Some Medicare beneficiaries, particularly those who live in rural areas, may only have access to providers that are not covered under Medicare. In such cases, beneficiaries' only options are to pay out-of-pocket or forgo care entirely.

The 2010 Patient Protection and Affordable Care Act, however, made a small but important improvement to Medicare's mental health services. For example, Medicare Part D will now cover barbiturates and benzodiazepines. Both drug types were originally excluded from Part D coverage, though the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mostly reversed this. The ACA expanded this coverage by preventing states from excluding barbiturates and benzodiazepines from Medicaid coverage starting in 2014. Since Part D covered drugs are defined generally as those drugs covered under Medicaid, this provision will effectively eliminate the remaining coverage limitations for barbiturates set forth in MIPPA.

(For a broader discussion of mental health-related issues, see this chapter's section, Specific Needs and Services—Mental Health.)

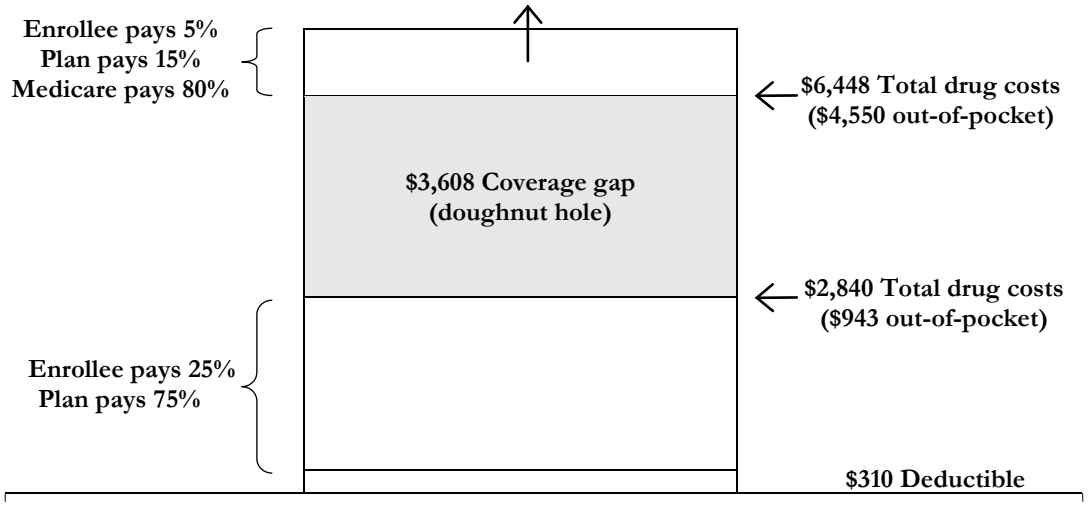
MENTAL HEALTH: Policy		
Access	FEDERAL	Medicare should reimburse for mental health and substance abuse services more adequately and eliminate the 190-day lifetime limit on inpatient psychiatric care in freestanding psychiatric hospitals under Part A. Medicare should expand the list of mental health professionals that can be reimbursed under Medicare to cover all providers who are fully licensed by their state for independent practice. Medicare should expand its coverage of outpatient services that have been shown to help individuals with mental illnesses remain in the community.

Prescription Drugs

Medicare's outpatient prescription drug benefit, Part D, took effect in January 2006. The standard Medicare Part D benefit consists of a deductible; an initial coverage period in which enrollees are responsible for 25 percent of their prescription drug costs; a coverage gap in which enrollees are responsible for 100 percent of their prescription drug costs; and catastrophic coverage in which enrollees are responsible for 5 percent of their prescription drug costs (see Figure 7-2). In 2010, enrollees fall into the coverage gap after their total prescription drug spending reached $2,830 and enter catastrophic coverage after their total out-of-pocket spending reaches $4,550.

Figure 7-2

Standard Medicare Part D Benefit, 2011



Source: US Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Announcement of Calendar Year (CY) 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter,* April 5, 2010.
Prepared by AARP Public Institute.

Over 27.6 million Medicare beneficiaries were enrolled in Part D plans in 2010 (17.7 million in stand-alone plans, and 9.7 million in Medicare Advantage plans). An additional six million were in employer or union-sponsored plans with equal or better benefits, and 7.8 million had prescription drug coverage from the Department of Veterans Affairs and other sources.

In 2010 there were more than 1,570 prescription drug plans serving regional or national areas. In most states, prospective and current Part D enrollees can choose from more than 45 plans. However, more than three-fourths of all Part D enrollees have historically gravitated to about a dozen national plans. That is, a few plans have a large majority of enrollees.

Medicare Part D's most generous coverage is reserved for the one-third of enrollees who qualify for the low-income subsidy. Indeed, 55 percent of program costs cover these enrollees. However, almost one-quarter of non-low-income subsidy enrollees experienced the Part D coverage gap ("doughnut hole") each year from 2006–2009, where they faced the full cost of their prescription drugs, and less than 2 percent reached catastrophic coverage. In 2007, 15 percent of people who fell into the gap stopped taking their medicines for a common chronic condition. The 2010 Patient Protection and Affordable Care Act (ACA) takes several important steps to protect current and future enrollees who fall into the coverage gap: (1) a $250 rebate was sent to all non-low-income subsidy enrollees who fall into the gap in 2010; (2) starting in 2011, brand-name drugs will be discounted by 50 percent for prescriptions filled during the gap; (3) generic drugs will also be discounted in the gap. These discounts will increase each year so that by 2020, the coverage gap will be eliminated.

In addition to gradually closing the doughnut hole, the ACA addressed future opportunities for approval of generic versions of biologic drugs or biosimilars. Biologics are derived from living organisms; they may require special handling and are usually administered by injection. Monitoring tests may be required to ensure that a biologic is working as intended. Such drugs are increasingly used for chronic diseases such as rheumatoid arthritis, multiple sclerosis, and certain cancers. These factors, combined with the current lack of generic options, lead biologics to be among the most expensive prescription medicines on the market.

The ACA established a regulatory pathway that will allow the Food and Drug Administration to approve biosimilars, which are in their infancy in the US (but are becoming a growing option in Europe, the United Kingdom, and a few other countries). The ACA provides innovator biologic manufacturers with 12 years of exclusivity before biosimilars can be approved. Presently, a very small but growing proportion of enrollees use these most-expensive therapies that are commonly assigned to a drug plan's "specialty" tier. In 2008, three biologics represented almost half of all Part D biologic costs: Enbrel® and Humira® (both used for conditions such as rheumatoid arthritis, Crohn's disease, and psoriatic arthritis), and Procrit® (used for anemia caused by chronic kidney failure or chemotherapy). Users of biologics and other specialty drugs pay coinsurance that ranges from 25-40 percent. These drugs' full cost ranges from $1,500 per dose to tens of thousands of dollars, or more. Not only are out-of-pocket costs substantial for these drugs, but their prices are rising at a much faster rate than those of nonspecialty drugs.

PRESCRIPTION DRUGS: Policy		
Medicare negotiating authority	FEDERAL	Medicare, in addition to private Part D plans that currently negotiate with pharmacy benefit managers and pharmaceutical manufacturers, should have statutory authority to use its purchasing power to obtain drug price discounts directly on behalf of beneficiaries.
Quality and safety	FEDERAL	Medicare Part D should include quality measures that focus on clinical improvements, not just plan administrative quality components. Part D medication therapy management programs, especially pharmacist-led interventions, should be broadened to help minimize medication-related errors and encourage appropriate prescribing, monitoring, and safe use of medications.
Low-income subsidy	FEDERAL	Congress should eliminate the asset test for low-income subsidy beneficiaries and ensure coordination of benefits for "dual-eligibles," who are also enrolled in Medicaid.

Program Administration and Beneficiary Information, Education, and Outreach

Medicare beneficiaries can be confused by the complexities of the system's benefits and payment rules, as well as the broad array of choices involving the traditional fee-for-service program, Medicare Advantage plans, and prescription drug plans. As the Medicare program becomes more complex, there is a greater need to provide beneficiaries with accurate, concise, and comprehensible information about the availability, quality, and cost of Medicare services. Also necessary are efficient and responsive systems and beneficiary services, including outreach and assistance programs.

Educational materials such as "Medicare and You," are periodically distributed to all Medicare beneficiaries. Also, the Centers for Medicare & Medicaid Services (CMS) has made significant investments in developing consumer-oriented information for its website, www.Medicare.gov. However many beneficiaries, particularly the oldest and frailest, do not make use of the Internet.

CMS management of Medicare information is intended to educate beneficiaries and the public, comply with legal notice requirements, and control program costs. However, data management technology, including computer hardware and software used by CMS and its Medicare administrative contractors to administer the program and communicate with beneficiaries and providers is seriously out of date and overburdened. CMS's efforts to adopt updated information technology have been hampered by inadequate funding and difficulty coordinating various parts of the program for Medicare beneficiaries and for those who are dually eligible for Medicare and Medicaid. More broadly, CMS budget for administration, including beneficiary education and outreach, program operations and research has not kept pace with the growing size, complexity, and mandated activities of its mission.

The 2010 Patient Protection and Affordable Care Act provides the Department of Health and Human Services (HHS) with one billion dollars for implementation of various aspects of the legislation as well as for making improvements in Medicare program administration. CMS is required to develop a plan to make Medicare data available to support providers' efforts to better manage and coordinate care and evaluate payment and delivery system reforms. CMS will receive one billion dollars per year to operate an Innovation Center that will develop and test payment and delivery system arrangements to improve quality of care and reduce program costs. In addition, HHS will develop a national strategy to improve delivery of health care services, patient health outcomes, and population health. CMS will also establish an office to improve coordination and more effectively integrate benefits for dually eligible beneficiaries.

PROGRAM ADMINISTRATION AND BENEFICIARY INFORMATION, EDUCATION, AND OUTREACH: Policy		
Data systems	FEDERAL	The Centers for Medicare and Medicaid Services (CMS) should continue modernizing its data systems. Congress should ensure adequate funding to support this work.
Processes and services	FEDERAL	CMS should reinforce its methods for evaluating the performance of Medicare administrative contractors. The agency should ensure that Medicare beneficiaries are provided with: • clear, accurate, and easily accessible information; • prompt and accurate claims processing; • an explanation of the Medicare benefits form for all claims; • effective follow-through on beneficiary fraud and abuse complaints; • claim-by-claim enforcement of the law that limits charges (see section on Physician Balance Billing and Private Contracting); and • timely processing of appeals (see Medicare—Appeals).

Processes and services (cont'd.)	FEDERAL	To further support beneficiaries' information needs, CMS should: • maintain at an adequate level the toll-free line for beneficiaries with questions about benefits or claims; • encourage federal and state agencies with jurisdiction over programs for beneficiaries (e.g., Medicare, Medicaid, and State Health Insurance Programs) to intensify their outreach and assistance programs; • simplify the billing process for beneficiaries and providers, including through coordination of Medicare and Medicare supplemental insurance; and • implement a process that ensures quick remedies for Medicare denials that result from incorrect primary-payer information (see section on Medicare appeals). Congress should increase program budgets for CMS administration, including beneficiary education and outreach, program operations and research.
Consumer information	FEDERAL	Publicly reported information about consumers' experiences with their care should be standardized and collected by an external entity. CMS should continue to expand the use of the suite of Consumer Assessment of Health Plans Study instruments to measure hospital, medical group, and physician performance. Further research should be conducted to learn more about consumer preferences with respect to the types of information consumers want and how data are communicated to them. Literacy, health literacy, and numeracy levels should be taken into account when developing consumer information. CMS should work with consumer organizations and experts in the field of consumer information and education to develop ways to present data on quality in formats useful to consumers. These should be tested to ensure their effectiveness. To ensure that Medicare beneficiaries receive information to make informed health care choices, Congress must provide CMS with sufficient funds and personnel.
Medicare Advantage	FEDERAL	Federal standards should be established and followed for reporting consumer information, including on the frequency and format of reports. Information must be collected in a manner that will ensure comparability across plans and providers and should include data that is useful to beneficiaries, such as information on benefits, coverage restrictions, costs (including out-of-pocket liability), member and provider satisfaction, quality of care, credentialing, utilization management, grievances and appeals, and enrollment and disenrollment. Data should be available to the public unless disclosure is prohibited by federal law or regulation, based on the compelling needs of Medicare quality improvement and quality oversight efforts.
Prescription drugs	FEDERAL	CMS should ensure that the comparative plan information it and the drug plans provide to beneficiaries is accurate and easy for beneficiaries to understand. CMS should regularly evaluate and improve the quality of this information.

Prescription drugs (cont'd.)	FEDERAL	Any major change in the Medicare program should be accompanied by extensive education and outreach to beneficiaries. For example, restrictions on when beneficiaries can enroll in a Medicare prescription drug benefit must be coupled with an aggressive education and marketing program to help beneficiaries understand their options and the limitations on their choices. Beneficiaries who involuntarily lose drug coverage provided by a non-Medicare source must have a period during which they could enroll in a Medicare drug benefit without penalty.

Medicaid

Medicaid is the nation's largest publicly financed health insurance program for low-income parents, children, elderly, and disabled people. Low-income children may also gain access to Medicaid coverage through the state Children's Health Insurance Program (CHIP). Low-income adults without dependent children who are not elderly, blind, or disabled are generally not eligible.

As a means-tested entitlement program, Medicaid requires states to provide coverage for individuals as long as they are members of a specified group and meet financial requirements.

There is evidence that some potentially eligible individuals are not enrolled in Medicaid, and many barriers to Medicaid enrollment have been identified. These include lack of information about the availability of Medicaid benefits, complex eligibility rules and enrollment processes, shortages of bilingual materials and program staff, fears related to immigration status, and reluctance by some to receive publicly funded benefits. Recently some states have begun imposing enrollment barriers to slow down program enrollment and expenditures.

Medicaid beneficiaries are entitled to have payment made on their behalf for covered services that are medically "necessary." With the exception of the Early and Periodic Screening Diagnosis and Treatment service, "medical necessity" is not defined in federal statute or regulation. Consequently states have discretion to define the term, and their definitions vary widely.

The federal government matches legitimate state Medicaid expenditures at a rate determined by the federal medical assistance percentage (FMAP). This formula, which has remained essentially unchanged since Medicaid's inception in 1965, is based on the relationship between each state's per capita personal income and the national average per capita personal income over three calendar years. FMAPs are based on per capita income data that have a multiyear time lag. Thus a state could receive a low FMAP based on per capita income data that reflect a strong economy at a time when the state has a weak economy. Conversely, states may get a higher FMAP during better economic times if the data used to determine the percentage are from a period when the state economy was in recession. These are known as countercyclical effects.

From time to time policymakers suggest financing Medicaid through a block grant. This is seen by some as a solution to rising program costs, a way to increase program flexibility, and a mechanism to improve program integrity. A block grant, sometimes referred to as global financing or a lump-sum allotment, is a fixed amount that the federal government gives to states for a specific program. If state costs for the program are higher than anticipated under the grant, the state has to make up the difference without additional federal assistance.

AARP is concerned that making Medicaid a block-grant program would undermine the fundamental nature of the program as a safety net, because states may not be able to respond to increased needs for health care during economic downturns.

Health Reform Expands Coverage

Beginning in 2014, the 2010 Patient Protection and Affordable Care Act (ACA) creates a national floor of 133 percent of the federal poverty level (FPL) ($14,403.90 for an individual and $29,326.50 for a family of four in 2009) for Medicaid eligibility. Because the law eliminates the historical income disregards for these new groups (see below) and establishes a new across-the-board 5 percent income disregard, the effective income eligibility threshold is 138 percent of the FPL.

Before the enactment of the ACA certain adults (nonelderly adults who are not disabled, not pregnant, or not parents of dependent children) were generally not eligible for federally financed Medicaid benefits no matter how poor they were. States could cover this group with their own funds, or they could

obtain federal Medicaid waivers to cover them, in which case they would receive federal financial participation. Fewer than half of the states currently provide Medicaid to low-income childless adults, and their levels of coverage range from being comparable to the Medicaid benefit package to far less comprehensive coverage. Beginning January 1, 2014, the ACA extends coverage to childless adults with income at or below 133 percent of the FPL.

Before the ACA, the federal income threshold for covering parents in Medicaid was tied to eligibility for cash assistance under the former 1996 Aid to Families with Dependent Children (AFDC) program. Consequently, most states only cover parents with income less than 100 percent of the FPL ($22,050 for a family of four in 2009), with 34 of these states limiting parental eligibility to less than 50 percent of the FPL ($11,025 for a family of four in 2009).

Under the ACA states will receive enhanced federal dollars to finance the Medicaid expansion. Those states that undertook comprehensive expansions prior to the enactment of the ACA receiving less of an increase than those states that did not. However, by 2020, all states will be receiving 90 percent of the financing for the expansion from the federal government. In return for these extra federal dollars, all states are required to maintain eligibility standards for adults in Medicaid until January 1, 2014, when the new health exchanges are operational; and for children in Medicaid and CHIP until October 1, 2019. Failure to comply with the "maintenance-of-effort" (MOE) requirement will result in a state losing all Medicaid funding, including funding for children, parents, pregnant women, seniors, people with disabilities, and administrative costs. The MOE requirement went into effect on March 23, 2010.

State Option to Expand Medicaid Before 2014

The ACA gives states the option to expand Medicaid coverage to nonelderly adults who are not disabled, not pregnant, or not parents of dependent children with income up to 133 percent of the federal poverty level prior to January 2014 when the mandatory expansion takes effect. States will not receive an enhanced FMAP for providing this coverage; the federal government will match state expenditures at the state's regular FMAP. States are not required to go as high as 133 percent of the FPL as long as they do not cover higher income people before they cover lower income people.

Health Reform and Legal Immigrants

Legal immigrants who have not lived in the US for at least five years are not allowed access to the Medicaid program unless the state pays 100 percent of their costs. Consequently, most legal immigrants are subject to a ban on the receipt of Medicaid until they have lived in the country the requisite number of years. In 2009, federal law gave states the option to lift the five-year bar on Medicaid for children and pregnant women.

The ACA does not lift this bar for other low-income adults. However, the law will allow legal immigrants who are subject to the bar to purchase coverage and receive subsidies through the health insurance exchanges. In addition, the ACA gives states an option to establish basic health programs for some low-income individuals who are not eligible for Medicaid. This option would be available for people to use instead of seeking subsidies through health insurance exchanges. Immigrants subject to the five-year bar may be able to access coverage through basic health programs in states that elect this option.

Health Reform, Medicaid, and the Territories

Beginning January 2014, the US territories are required to provide coverage to childless adults who meet income eligibility standards consistent with the current eligibility levels for parents in the territories. The cost of covering this new mandatory group will *not* count against their spending caps.

Health Reform, Medicaid, and Prevention

The ACA expands the current Medicaid option to provide other diagnostic, screening, preventive, and rehabilitation services to include: (1) any clinical preventive services assigned a grade of A or B by the US Preventive Services Task Force; (2) any adult immunization recommended by the Advisory Committee on Immunization Practices; and (3) any medical or remedial services recommended by a doctor or other licensed practitioner for reduction of physical or mental disability, and restoration to optimal functional levels. A state that elects this option without beneficiary cost sharing will receive a one percentage point increase in its federal medical assistance percentage.

Health Reform, Medicaid, and Health Care-Acquired Conditions

The ACA disallows Medicaid payments for certain health care-acquired medical conditions. The law directs HHS to develop a list of health care-acquired conditions (HCACs) for Medicaid based on those defined under Medicare and current state practices. The proposed rule would allow Medicaid to disallow payments in settings other than in-patient hospital settings.

Health Reform, Medicaid, and the Health Home Option

Beginning January 1, 2011, the ACA gives state Medicaid programs the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would include a comprehensive set of medical services, including care coordination. HHS will establish standards for qualified providers. To be eligible for the option, a beneficiary would have to:

- be Medicaid-eligible; and
- have at least two chronic conditions; or have one chronic condition and be at-risk for a second chronic condition; or have one serious and persistent mental health condition.

Medicaid Enrollment Simplification Requirements under Health Reform

The ACA requires states to meet the following requirements regarding Medicaid and CHIP enrollment procedures by January 1, 2014 in order to obtain federal Medicaid financial participation:

- Create procedures that allow people to apply for, become enrolled in, or renew enrollment in Medicaid or a waiver on an Internet website that is linked to the state's exchange website and the state's CHIP website.
- The website must allow individuals to compare benefits, premiums, and cost sharing available to them under the state plan or waiver to those available to them under a qualified health plan offered through the exchange.
- Allow people to consent to enrollment or reenrollment using an electronic signature.
- Create procedures to use its website to enroll individuals who have been identified by the exchange as being Medicaid eligible under a state plan, or waiver, or CHIP-eligible without any further enrollment determination on the part of the states.
- Ensure that people who apply for Medicaid under the state plan or a waiver and those who apply for CHIP but are found ineligible are screened for eligibility for a qualified exchange plan and any premium assistance. If the person is found eligible for an exchange plan, the state must ensure that the person can enroll without submitting additional paperwork.
- Ensure that the state Medicaid agency, the CHIP agency, and the state exchange agency use a secure electronic interface that can make eligibility determinations for Medicaid, CHIP, premium assistance, or enrollment in a qualified health plan.
- Conduct outreach and enroll members of vulnerable and underserved populations that are eligible for Medicaid or CHIP.

Health Reform, Medicaid, and Presumptive Eligibility

The ACA allows hospitals to be entities qualified to make presumptive Medicaid eligibility determinations for children, pregnant women, and certain other populations, based on preliminary information. During the presumptive eligibility period (i.e., the period of time before the individual's full Medicaid application is processed by the state agency), applicants are granted full Medicaid benefits. Presumptive eligibility begins on the date a provider finds that an individual "appears" to be eligible for Medicaid and ends either on the date a formal determination is made or, if the individual is found ineligible, the last day of the month following the month when the presumptive eligibility period began. Erroneous payments made due to a hospital's determination of presumptive eligibility are not included in determining excess payments.

Health Reform, Medicaid, and Disproportionate Share Hospital Payments

Under the ACA, states' disproportionate share hospital (DSH) allotments are reduced by 50 percent (low DSH states' allotments are reduced by 25 percent) once the rate of uninsurance decreases by 45 percent. As the rate of uninsurance continues to decline, states' DSH allotments will be reduced by corresponding amounts.

Health Reform and the Medicaid and CHIP Payment and Access Commission

The Children's Health Insurance Program Reauthorization Act of 2009 created the Medicaid and CHIP Payment and Access Commission (MACPAC). The original purpose of the MACPAC is to review policies governing Medicaid and CHIP access for children. The ACA expands the duties of the MACPAC to include coordinating with the Medicare Payment Advisory Commission (MedPAC), especially with respect to dual-eligible beneficiaries. In addition, the ACA changes the MACPAC's reporting requirements and provides funding for the body.

Medicaid Fraud, Waste, and Abuse Provisions in Health Reform

The ACA contains several provisions aimed at ensuring the integrity of the Medicaid program. Examples include the following requirements:

- Certain Medicaid and CHIP providers (those at high risk for fraud) will be subject to new

enrollment screening (e.g., criminal background check, fingerprinting, unannounced site visits, database checks, and others as identified by HHS) and revalidation requirements. Providers will be assessed a fee ($200 in 2010 adjusted by Consumer Price Index thereafter) to cover the cost of the screening.

- CMS must include claims and payment data from various programs (including Medicaid and CHIP) in its integrated data repository to combat fraud and abuse, in addition to overpayment and identifier requirements to enhance program integrity.
- HHS is allowed to enter into data-sharing agreements to identify fraud, waste, and abuse in Medicare and Medicaid, as well as to perform enforcement and oversight activities with appropriate federal agencies.
- Federal matching payments will be withheld from a state when the state does not report enrollee encounter data in a timely manner to the state's Medicaid management information system.
- Information system. Providers and suppliers will be subjected to exclusion from Medicare or Medicaid for providing false information about any enrollment applicant. Civil money penalties may be imposed against excluded individuals.
- HHS has the authority to subpoena documents or testimony for program exclusion investigation.
- HHS may suspend payments to a Medicare provider or supplier during a pending fraud investigation if a state fails to suspend such payments.

MEDICAID: Policy		
General	FEDERAL STATE	The federal and state governments should: • ensure that all people living at or below the federal poverty level are covered by Medicaid; • increase Medicaid participation among eligible people of all ages; • ensure that crowd-out policies (e.g., policies designed to prevent people from dropping private coverage in favor of public coverage) do not result in loss of health insurance coverage for low-income children; and • ensure the highest level of Medicaid participation among all health care providers, including dental providers. Efforts to restructure Medicaid should: • maintain the government's benefit guarantee, so that all who qualify for Medicaid will be covered and maintain the entitlement nature of Medicaid funding—Medicaid funding should not be furnished through a block grant or limited for necessary services; • maintain and improve current federal and state consumer protections; and • adopt financing policies and payment strategies that enhance and improve access and quality.
Option to expand Medicaid before 2014	STATE	Where financially feasible, states should take up the option to expand Medicaid coverage before 2014. They should especially consider expanding coverage up to 100 percent of the federal poverty level for all adults.
Option to cover preventive services without cost sharing	STATE	Where financially feasible, states should take up the option to provide recommended screening services, immunizations, and certain medical or remedial services to Medicaid beneficiaries without requiring cost-sharing.

Federal medical assistance percentage (FMAP)	FEDERAL	The federal government should enact legislation so that the FMAP will respond to state economic cycles on a permanent and ongoing basis.
Enrollment expansion and outreach	FEDERAL STATE	Enrollment and outreach activities must be tailored to meet the needs of the culturally diverse eligible population, including legal immigrants.
Access	FEDERAL	To improve health care access for low-income people, Congress should: • ensure continuous Medicaid coverage for vulnerable people of all ages, including people with disabilities and the working poor; • require all states to have a medically needy program that provides full Medicaid benefits to people of all ages when they have exhausted their own financial resources for meeting their health care needs; and • expand state options to allow the uninsured to buy into Medicaid coverage. The federal government should take steps to ensure that states do not eliminate Medicaid optional eligibility categories or alter eligibility criteria to reduce the amount of their Medicare payments (known as a "claw-back" strategy) and in the process deny or withdraw needy beneficiaries' access to important health benefits.
Expanding eligibility and services	STATE	States should maximize all appropriate opportunities for Medicaid-eligible individuals to receive benefits and alternative coverage from all third-party sources. States should use Medicaid's significant market power to foster the highest quality of health care for vulnerable citizens at the most reasonable price. States should exercise available options for expanding Medicaid eligibility and services by offering: • a medically needy program as generous as the federal government allows; • coverage for pregnant women and infants whose household income is between 133 percent and 185 percent of the poverty guideline; • full Medicaid coverage for people with disabilities and elderly people living at or below 100 percent of the federal poverty guideline; • coverage using less restrictive income and asset tests, as authorized under Sections 1902(r)(2) and 1931(b) of the Social Security Act; • coverage to low-income working adults, to the extent federal law allows (e.g., by disregarding the number of hours worked for two-parent households with dependent children); • coverage to other groups, such as individuals who receive state support payments but are ineligible for federal Supplemental Security Income benefits because of income levels; • Programs of All-Inclusive Care for the Elderly (PACE) for people age 55 and older;

Expanding eligibility and services (cont'd.)	STATE	• all available federal options to provide access to Medicaid through buy-in programs; and • coverage for optional dental care for adults. To improve Medicaid participation among those currently eligible, states should: • conduct outreach activities and promote Medicaid and the State Children's Health Insurance Program (SCHIP) as a single, coordinated program of health insurance; • not adopt policies that create barriers to continued enrollment (e.g., require more frequent recertification periods) during difficult economic times; • monitor Medicaid participation rates and report enrollment rates on an ongoing basis, giving particular attention to underserved areas; and • develop action plans to ensure that Medicaid and SCHIP coverage is appropriately maintained in geographic areas that either are underserved or have large numbers of people no longer eligible for welfare benefits.
Legal assistance	STATE	States should establish legal assistance programs for Medicaid beneficiaries who have trouble obtaining services or paying their medical bills or who believe a Medicaid claim was incorrectly processed or inappropriately denied.
Provider contracting	FEDERAL STATE	Federal and state governments should conduct annual reviews to ensure that Medicaid's rules for paying providers and managed care plans do not threaten health care access. While preserving access, states should contract with cost-efficient, high-quality hospitals, physicians, and other providers to serve Medicaid beneficiaries. Payment incentive systems that reward high quality and improvements should be considered. Beneficiaries should be able to choose among providers who practice near beneficiaries' homes.
Medical necessity	FEDERAL STATE	AARP opposes the use of cost as the principal or determinative criterion in findings of medical necessity for Medicaid coverage. Where cost is a factor, it should be taken into consideration that higher initial costs may result in future savings.

Dual-Eligibles

Individuals eligible for both Medicaid and Medicare are referred to as dual-eligibles. There are several categories of dual eligibility (Figure 7-3). The largest consists of Medicare beneficiaries who are also eligible for full Medicaid benefits. These individuals tend to be either users of long-term care services or acute care users who depend on Medicaid for services that Medicare does not cover.

Another important category of dual-eligibles receives assistance from Medicaid only to pay a portion of Medicare expenses. Under the Qualified Medicare Beneficiary (QMB) program, Medicaid pays the Medicare premiums, deductibles, and coinsurance for Medicare beneficiaries who have annual incomes at or below 100 percent of the federal poverty guideline and assets below a specified threshold.

Figure 7-3

Medicaid Protections for Low-Income Medicare Beneficiaries

Program	Who's eligible	What Medicaid covers	Entitlement?
Full Medicaid benefits	74% of poverty* (Supplemental Security Income eligibility level)	Wraparound benefits, long-term care, and Medicare Part B premium & cost-sharing	Yes
Qualified Medicare Beneficiary	<100% of poverty	Medicare Part B premium & cost-sharing	Yes
Specified Low-Income Medicare Beneficiary	100%–120% of poverty	Medicare Part B premium	Yes
Qualifying individuals	>120%–135% of poverty	Medicare Part B premium	No

*Some states (the "209(b)" states) are permitted to set lower levels; states have the option to go up to 100% of poverty.
Note: Individuals must have limited assets to receive full benefits (below $2,000 for an individual and below $4,000 for a couple).
Source: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, *Dual-Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries,* March 2001.
Prepared by AARP Public Policy Institute.

Medicare beneficiaries with incomes between 100 percent and 120 percent of the federal poverty guideline and with limited assets—known as Specified Low-Income Medicare Beneficiaries (SLMBs)—are eligible to have their Medicare Part B premiums paid through state Medicaid programs.

Qualifying individuals (QI) are an additional category of dual-eligibles created by the Balanced Budget Act of 1997. Under the current QI program, which Congress must regularly renew, Medicare beneficiaries with incomes between 120 percent and 135 percent of the federal poverty guideline may have their Part B premiums paid by Medicaid. Because federal funding for the QI program is capped and allocated to states as grants, eligibility is extended on a first-come, first-served basis until each year's funds are expended. The QI program has not been made permanent and is scheduled to expire on December 31, 2011.

The QMB, SLMB, and QI programs together are known as Medicare Savings Programs (MSPs). Fewer than about two-thirds of people eligible as QMBs or SLMBs are enrolled, but precise federal program statistics are unavailable. People receiving Medicare and full Medicaid benefits are eligible for and automatically enrolled in the low-income subsidy (LIS) for Part D drug coverage, which covers most drugs costs, except for nominal copayments. People enrolled in MSPs are also eligible for the LIS. States have the option to use less restrictive income-counting rules to raise income and asset limits for their MSPs, making more people automatically eligible for the LIS.

The Creation of the Federal Coordinated Health Care Office

The 2010 Patient Protection and Affordable Care Act required the Department of Health and Human Services to establish a Coordinated Health Care Office (CHCO) within the Centers for Medicare & Medicaid Services by March 1, 2010. The purpose of the CHCO is to bring together Medicare and Medicaid program officials to more effectively integrate benefits and improve coordination for dual-eligibles so they will have full access to the services to which they are entitled.

DUAL-ELIGIBLES: Policy		
Funding	FEDERAL STATE	The Medicaid program should be fully funded to ensure that all people eligible for the Medicare Savings Programs (MSPs) can receive Medicaid coverage.
Implementation	FEDERAL	The Centers for Medicare & Medicaid Services (CMS) should require states to ensure that the MSPs are fully implemented and that Medicare beneficiaries and social services personnel are adequately informed of the programs' eligibility requirements and benefits.

Coordinated Health Care Office (CHCO)	FEDERAL	The federal government should ensure that the CHCO takes a comprehensive approach to addressing issues that affect the ability of dual-eligibles to access the high-quality care they are entitled to.
Asset test	FEDERAL STATE	The asset test for MSPs should be eliminated or made less restrictive. In the absence of new federal law, states should use existing statutory flexibility to eliminate or modify the asset test. A state can introduce less restrictive resource requirements by disregarding all resources or by allowing additional exclusions from countable assets.
Qualifying individuals	FEDERAL	The federal government should permanently extend the qualifying individual (QI) program with sufficient funding or expand the Specified Low-Income Medicare Beneficiary (SLMB) program to pay Medicare premiums for low-income Medicare beneficiaries with household income between 120 percent and 135 percent of the federal poverty guideline.
Enrollment	FEDERAL STATE	Federal and state governments should monitor Qualified Medicare Beneficiary (QMB), SLMB, and QI participation rates; report enrollment levels on an ongoing basis; and develop action plans in areas with low QMB, SLMB, and QI enrollment to ensure improved participation rates. Special attention should be given to problems of access in rural areas. Federal and state policymakers should work together to identify viable ways to use existing data sources to identify and enroll MSP-eligible individuals.
Medicaid buy-in	FEDERAL	Medicaid buy-in protection for Medicare premiums, deductibles, and coinsurance should be extended to Medicare beneficiaries with incomes of up to 200 percent of the federal poverty guideline.
Outreach	FEDERAL STATE	CMS should continue funding state outreach and enrollment efforts for the MSPs. Federal agencies with jurisdiction over programs for low-income seniors, including the Social Security Administration, should ensure that the individuals they serve are aware of Medicaid, especially its QMB, SLMB, and QI protections. These agencies must lead efforts to develop intensive outreach initiatives and simplified application processes. Outreach efforts that are more effectively or efficiently performed at the federal level should be implemented by the appropriate federal agencies and funded adequately. States should: • simplify their administrative procedures so that eligible beneficiaries will more likely enroll in MSPs; • develop simplified applications and consumer-friendly application sites, institute passive renewal processes, and eliminate burdensome documentation requirements; • conduct innovative grassroots outreach to educate seniors about Medicaid, particularly the MSPs—Innovations should include new outreach methods and sites, including by involving volunteer organizations; and • make use of all available data to identify and enroll people eligible for MSPs.

Cost-sharing	FEDERAL STATE	The federal and state governments should be required to examine the extent to which nonpayment of the full Medicare deductibles and copayments for QMBs threatens access to care for these beneficiaries.
Income test	STATE	Where fiscally feasible, states should take advantage of the opportunity to increase income eligibility for their MSPs.

Managed Care

States look to managed care as a means of controlling costs while improving access to care and frequently mandate enrollment in a managed care program as a condition of receiving Medicaid benefits. Concerns about mandatory managed care focus on the lack of individual freedom to select the most suitable type of coverage and whether managed care plans can meet the unique needs of Medicaid's poorest and sickest beneficiaries. In addition, some critics believe that the administration of managed care may be in conflict with individuals' desire to direct their own care.

Quality assurance and other consumer protections are essential in Medicaid managed care plans to ensure that each beneficiary receives an appropriate level of service. The Balanced Budget Act of 1997 provides standards for managed care plan capacity and consumer protections. Implementation of quality performance standards for Medicaid managed care is a promising development that can help states monitor access and quality.

MANAGED CARE: Policy		
Choice	STATE	Medicaid beneficiaries should have a choice of fee-for-service or managed care plans. States should require enrollment in managed care plans only if there is a choice among plans that have adequate staff and provider networks to meet enrollees' needs. In addition beneficiaries should have the right to disenroll from a managed care plan "for cause."
Enrollment	STATE	To ensure that Medicaid beneficiaries make informed choices about health coverage in a stress-free environment, states should either conduct enrollment directly or contract with third-party enrollment brokers. States should allocate sufficient resources to ensure that the enrollment process is conducted smoothly and in a timely, efficient manner.
Plan standards	STATE	States must take strong steps to ensure that the plans they select to participate in their Medicaid programs meet the same comprehensive standards that apply to health plans offered by all other payers. These standards should include a full range of consumer protections. Plans must include a fair, rapid appeals process that allows Medicaid beneficiaries to have decisions that incorrectly deny, reduce, or terminate care overturned.
Dual-eligibles	FEDERAL STATE	Mandatory enrollment in Medicaid managed care programs must preserve the Medicare rights of dual-eligibles. For qualified Medicare beneficiaries enrolled in Medicare Advantage plans, states should pay all appropriate cost-sharing. The Centers for Medicare & Medicaid Services must enforce the prohibition on plans that bill beneficiaries for these amounts.
State program contractors	STATE	In selecting health plans, providers, and practitioners, state Medicaid programs should take into account the performance of potential contractors on a standardized set of quality measures.

Facility review	STATE	States should ensure that public regulation and private accreditation of health and long-term care facilities and services include regular, frequent, random, and unannounced inspections. Inspection reports should be widely disseminated to the public.

Waiver Programs

Strategies to reform Medicaid at the state level rely in part on exemptions from certain federal laws and regulations. These exemptions are collectively known as Medicaid waivers. There are a variety of waivers, each designed to allow states to accomplish specific policy objectives, such as covering services for some groups of people but not others, changing the delivery system, covering more people or a different mix of people, defining a new benefit package, and/or imposing new cost-sharing obligations.

The Medicaid statute gives states broad authority to waive many federal requirements. The waivers allow states expanded program flexibility so they can implement comprehensive or incremental reforms. The most fundamental requirement for all waivers is that they have a neutral effect on the federal budget. That is, federal Medicaid spending under the waiver cannot be more than federal spending without the waiver.

Under Section 1115 of the Social Security Act, the Department of Health and Human Services can waive Medicaid eligibility, benefit, and service-delivery requirements in the context of research and demonstration projects to promote program objectives. Many states have sought Section 1115 waivers to expand coverage to low-income individuals who may be ineligible for Medicaid because of the program's categorical or financial limitations. States also have sought waivers to integrate health and long-term care services using both Medicare and Medicaid funding, through programs such as social health maintenance organizations.

More recently states are seeking waivers to, among other goals, impose limits on spending for services to certain populations, offer different benefits to different populations, establish and/or increase enforceable premium and cost-sharing obligations for certain populations, and establish incentive accounts. Incentive accounts might allow a beneficiary to accrue points for engaging in healthy behaviors, and those points could be used to access services not normally provided by Medicaid.
States can also impose enforceable cost-sharing (above the nominal limit) on certain populations and offer different benefits to different populations through the state plan amendment process. They also have the authority to enroll most Medicaid beneficiaries in managed care without going through the lengthy federal waiver process.

Current Medicare waiver authority is limited to demonstration projects involving waivers of reimbursement requirements.

Health Reform, Medicaid, and Extension of Demonstration Period for Dual-Eligibles

The 2010 Patient Protection and Affordable Care Act (ACA) extends the Medicaid waiver period for any 1915 (b), (c), (d), or 1115 waiver that included dual-eligibles to up to 5 years.

Health Reform, Medicaid, and Transparency in the Section 1115 Waiver Process

The ACA created a transparency and public notice procedure for experimental, pilot, and demonstration projects approved under Section 1115 of the Social Security Act relating to Medicaid and Children's Health Insurance Program (CHIP). The new law would increase the degree to which information about Medicaid and CHIP demonstration applications and approved demonstration projects are publicly available and promote greater transparency in the review and approval of demonstrations.

WAIVER PROGRAMS: Policy		
General	FEDERAL STATE	State waivers from certain aspects of the Medicare and Medicaid statutes are appropriate and even desirable under certain circumstances. However, in order to safeguard existing coverage and maintain important protections, the criteria in this waiver programs section must be met. The waiver process should not be used to limit or cap spending for important benefits or necessary care.

General (cont'd.)	FEDERAL STATE	Budget neutrality should not be achieved by threatening existing services for eligible beneficiaries.
Eligibility	FEDERAL STATE	The entitlement nature of Medicaid should apply to expansion populations. Current prohibitions against enrollment caps, exclusions for preexisting conditions, or waiting periods should not be waived. Eligibility expansions should be consistent with the principle of covering those more in need before covering those less in need. For example, programs should not extend coverage to some people with income at 200 percent of the poverty guideline while not providing coverage to those below that level.
Transparancy	FEDERAL STATE	The federal and state governments should adopt laws and policies that create and enhance transparency in the state plan amendment (SPA) process.
Consumer input	FEDERAL STATE	The waiver process and the SPA process must provide meaningful opportunities for public involvement at both the federal and state levels. As a precondition of waiver and SPA approval, states should demonstrate that there has been a meaningful public process and that the state has addressed public concerns. The Department of Health and Human Services (HHS) should provide an opportunity for public comment on waiver requests as part of its approval process. Public comment and the state's response should be included in the application and made part of the administrative record. The Centers for Medicare & Medicaid Services (CMS) should establish a waiver review panel that consists of consumers, providers, and federal and nongovernmental technical experts to receive testimony and comments and to recommend approval or disapproval of the waiver or any modification to it.
Beneficiary impact statement	STATE	States' waiver and SPA applications should include a beneficiary impact statement, analyzing the applications' expected effect on each beneficiary category, and a detailed explanation of the state's plan to monitor these effects continuously. CMS should define the categories and give the states guidance on monitoring.
Cost-sharing	FEDERAL STATE	New cost-sharing and premium requirements should be permitted only if HHS makes a reasonable determination that they do not deny access to needed care or create service barriers. Premium contributions should not be required of people with income at or below 100 percent of the federal poverty level. This population should have nominal cost-sharing obligations only if they do not hinder access to care. Premiums for people with income above 100 percent of the federal poverty guideline should not hinder access to needed services.
Coverage	FEDERAL STATE	Mandatory Medicaid services must be covered in the same amount, duration, and scope for all eligible people, regardless of eligibility category. Changes in benefits should not deny access to necessary care.

Adequacy of provider networks	FEDERAL STATE	Federal and state governments should provide incentives to ensure an adequate and robust primary care provider network. Expansion populations should have adequate access to the same or comparable provider networks as those available to other nonexpansion populations. Waivers that include Medicaid beneficiaries with disabilities, mental illness, or other complex health care needs must demonstrate adequate protections for these populations, including the adequacy of provider networks.
Personal incentive programs	FEDERAL STATE	Personal incentive programs created in waivers or by an SPA should not: • be funded by redirecting money for necessary services, • be administered in ways that penalize people who do not use such programs, or • create incentives for people to deny themselves or their children necessary care.
Dual-eligibles	FEDERAL STATE	Individuals eligible for both Medicare and Medicaid (dual-eligibles) must maintain their Medicare rights. There should be no mandatory enrollment in managed care.
Integrating health and long-term care services and supports	FEDERAL STATE	Existing Medicare and Medicaid waiver authority should be used to integrate health and long-term care services and supports (LTSS) under the following conditions: • Beneficiaries must retain their rights to full Medicare and Medicaid benefits. • There must be voluntary enrollment and disenrollment at any time. • The ability of consumers to direct their own care must be ensured. • Cost-sharing should be permitted only if it is not a barrier to receipt of services. • Cost-sharing and other participation requirements must not result in coercive inducements to enroll or disenroll. • Strong consumer protections, including an independent ombudsman program and external grievance procedure, must be in place. • The state and CMS must provide strong and timely oversight. • Consumers must participate in the development, implementation, and oversight of the waiver program. • There must be strong quality assurance standards, including measures of functional and medical outcomes. • Eligibility criteria for long-term services and supports should consider and appropriately measure the need for these services among people with physical impairments, mental impairments, and chronic illnesses. Determination of need should be based on measures of physical and mental functioning. Individuals should not have to meet medical criteria to be eligible for LTSS. Contracting specifications should be adopted to ensure that a wide range of organizations are able to compete for the opportunity to

Integrating health and long-term care services and supports (cont'd.)	FEDERAL STATE	manage the integrated systems. The organizations could include nonprofit, public, and community-based organizations; entities experienced in delivery of LTSS; and managed care plans.
Quality and consumer protection	FEDERAL STATE	Quality assurance standards should include, at a minimum, internal and external quality review, meaningful grievance and appeals procedures, strong state monitoring and oversight (e.g., by an ombudsman), and strong sanctions for violations of quality standards.
Research design	FEDERAL STATE	The research design component of Section 1115 waivers must be adequate to support waiver evaluation. At a minimum states should be required to demonstrate that the research goals to be achieved through the waiver are measurable and that states have actual capacity to collect relevant data.

Quality and Consumer Protection

Health Reform and Quality

The 2010 Patient Protection and Affordable Care Act (ACA) requires the Department of Health and Human Services (HHS) to publish a recommended core set of adult health quality measures for Medicaid-eligible adults. These measures are to be published not later than January 1, 2011. By January 1, 2013, HHS, in consultation with states, is required to develop a standardized format for reporting information based on the core set of adult health quality measures. HHS is also required to create procedures that encourage states to use the measures to voluntarily report on such measures.

Health Reform, Medicaid, and Quality Demonstration Projects

The ACA establishes four demonstration projects designed to improve Medicaid quality for patients and providers:

- A demonstration to evaluate integrated care around a hospitalization by studying the use of bundled payments for hospital and physician services under Medicaid;
- A Medicaid global payment system demonstration project (in coordination with CMS Innovation Center) that would allow participating states to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure;
- A Pediatric Accountable Care Organization demonstration project; and
- A Medicaid emergency psychiatric demonstration project in which participating states would be required to pay certain institutions for mental diseases for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.

QUALITY AND CONSUMER PROTECTION: Policy		
General	FEDERAL STATE	Efforts to restructure Medicaid should ensure that: • long-term care services and supports reflect the needs and preferences of beneficiaries and their families and provide a choice between home and community support services and services in nursing facilities; • quality protections are given the same priority as cost and access issues; and • consumers have a strong voice.
Fraud and abuse	FEDERAL STATE	In addressing fraud, waste, and abuse, federal and state governments should identify and implement strategies that do not threaten access to program benefits for low-income people and that direct savings back into the program.

Managed care	STATE	States should adequately monitor contracted managed care entities to ensure that they comply with the quality and consumer protection standards outlined in the Balanced Budget Act of 1997.
Disease management programs	FEDERAL	Congress should require Medicaid and Medicare program administrators to work together to ensure that Medicaid disease management programs continue to function effectively for Medicaid beneficiaries receiving Medicare prescription drug coverage. Both programs should be required to evaluate their impact on health outcomes and ensure protections of beneficiaries' privacy rights.
Funding	FEDERAL	Congress should: • evaluate the federal funding formula for Medicaid programs operating within the US and its commonwealths and territories to determine if it provides access to primary preventive and acute care services for all eligible people, • explore the feasibility of adopting alternatives to the current Medicaid funding formula that will be more responsive to the states' changing financial circumstances, • continue to support Medicaid as a viable insurance option for those unable to find ongoing private health insurance coverage, and • provide enhanced federal matching funds to encourage states to exceed the minimum federal requirements wherever possible.

Expanding Health Care Coverage

Increases in health care costs challenge the continued availability and affordability of health insurance. This harms millions of individuals and families, as well as the US economy. The rising cost of and poor access to high-quality health care make it increasingly difficult for many businesses and manufacturers to compete in a global market. These concerns, together with the growing number of uninsured, spurred the efforts in policy and business circles to enact comprehensive health reform.

The 2010 Patient Protection and Affordable Care Act will greatly increase the availability of health care coverage. The Congressional Budget Office estimates that 32 million uninsured Americans will have health care coverage by the end of the decade as a result of public and private coverage reforms.

Starting in 2010, the new law creates a temporary national high-risk pool program for states to provide health insurance to US citizens and lawfully present immigrants who have a preexisting medical condition and have been uninsured for at least six months. Five billion dollars have been appropriated to help subsidize the cost of claims in the program.

Starting January 2014, for the first time in history, the Medicaid program will cover all people under age 65 who are not otherwise eligible for Medicare with household incomes up to 138 percent of the federal poverty level, regardless of whether they have dependent children.

In addition, individuals and small businesses will have another option for health coverage: they will be able to purchase qualified health plans through health insurance exchanges. To help make coverage in the exchanges more affordable, premium tax credits and cost-sharing subsidies will be available for eligible individuals and families.

And while there is a requirement for individuals to have coverage as of 2014, there are exemptions for those who find coverage unaffordable, live below 100 percent of the federal poverty level, or experience financial hardship.

(For AARP principles governing health care reform, see the principles sections in this chapter and in Chapter 3, Taxation, and Chapter 8, Long-Term Services and Supports.)

EXPANDING HEALTH CARE COVERAGE: Policy		
General	FEDERAL STATE	AARP supports health care reforms that significantly improve access to adequate coverage for those who are either without public or private insurance or at risk of losing coverage. The federal government in partnership with the states should implement the policies enacted in the 2010 Patient Protection and Affordable Care Act (ACA) that expand access to coverage and help make it more affordable. Where states do not implement policies, the federal government should use its authority to provide residents of those states with expanded coverage options authorized by the ACA. Reforms that are not comprehensive must significantly improve access to coverage for a particular population without undermining existing coverage. Strategies for improving access may include: • opening existing public health insurance programs (e.g., Medicare, Medicaid, and public employee benefit plans) or new public insurance programs to additional groups of uninsured people—Coverage could be available on a buy-in basis or, depending on income, with subsidies; • developing health plans specifically for the uninsured; • developing health insurance exchanges that expand access to affordable and portable coverage available to individuals and employers by negotiating with private insurers for packages of benefits and coverage meeting state minimum coverage requirements; • subsidizing a portion of high health care costs insured by private plans; • subsidizing the purchase of private coverage (e.g., through the tax system) for those for whom it is otherwise not affordable; • encouraging employers to offer health insurance to employees or to contribute to the cost of the health care system; • encouraging individuals to enroll in available health coverage options; and • continuing group health coverage at group rates for people whose access to group coverage is ending.
Individual mandates	FEDERAL STATE	Any requirement that individuals have health coverage must also: • be part of a set of policies that requires employers and government to bear their fair share of financial responsibility for health coverage and/or a health care safety net; • ensure that options providing adequate coverage are both available and affordable, to prevent people from being unable to afford care under their coverage; and • not impose a penalty on individuals who cannot afford coverage.
State reforms	STATE	States should develop health care plans that work toward access to adequate coverage for all residents. Any state plan for universal access should conform to AARP's health and long-term care services and supports principles and have viable and sustainable financing built on government, employer, and individual funding. States should take full advantage of federally funded programs to deliver health care services. States should pay particular attention to

State reforms (cont'd.)	STATE	meeting elderly people's health-related needs through block grants (such as those available for community health services) focused on preventive health and health services, including for alcohol abuse, drug abuse, and mental health.
Near elderly and older adults	FEDERAL	Proposals to extend Medicare or other federal coverage to older adults who are not yet eligible for Medicare should: • include sufficient subsidies to make coverage affordable to low-income individuals unable to afford the full premium and cost-sharing, • not affect the financial stability of the existing Medicare or other federal program, and • protect against the erosion of existing employer-sponsored coverage.
Private market reform	FEDERAL STATE	Reforms that rely on expansion of private coverage must ensure that affordable and adequate coverage is accessible to all individuals targeted by the expansion, regardless of health or age. Reform of market rules is a necessary component of coverage expansion.
Tax policy	FEDERAL STATE	Tax policies that relate to health coverage, health savings, and health spending should be evaluated in the context of fiscal policy, as well as health policy objectives, priorities, and equity. Tax incentives to support the purchase of private health coverage should: • give priority to groups currently without coverage and not benefiting from current tax incentives; • adjust incentives to recognize the high cost of coverage in private markets faced by people who are older, have health problems or histories of poor health, and have low incomes; • include assistance for those who make too little in income to pay taxes and who may have insufficient resources to pay premiums out-of-pocket during the tax year; • guarantee access to policies offering adequate coverage in the private market; and • conform to AARP's taxation principles.

Health Care Infrastructure and Safety Net

Many people in the US lack "meaningful" access to basic health services. These vulnerable populations tend to be disproportionately low income, uninsured, and in the case of rural areas, older. Several factors account for the failure of these groups to secure "meaningful" access to health care. Among them are lack of health insurance coverage, insufficient numbers of providers, physical barriers to reaching providers, and the unavailability of providers who are culturally competent and/or proficient in the population's spoken language.

To increase access to and better integrate care for Medicare beneficiaries in rural communities, the 2010 Patient Protection and Affordable Care Act (ACA) expands the rural demonstration project that was created in 2008 by the Medicare Improvements for Patients and Providers Act (MIPPA). Eligible entities in rural states are reimbursed on a reasonable cost basis by Medicare.

The enactment of the ACA, which expands Medicaid coverage and provides subsidies for low-income people will help vulnerable populations access insurance coverage. However, more needs to be done to ensure that all of the enabling services that help people achieve "meaningful" access to care are in place. Traditionally, safety net providers, including community health centers, have been at the forefront of providing the enabling services that help people achieve "meaningful" access to health services.

To promote culturally competent providers, the ACA authorizes the Health Resources and Services Administration (HRSA) to award grants, contracts, or cooperative agreements to public and nonprofit entities to conduct a range of activities designed to enhance the training of health professionals in the following areas: cultural competency, public health, prevention, reducing health disparities, and working with individuals with disabilities.

In an effort to shore up the health care safety net, the ACA created an Individualized Wellness Plan Pilot Program that requires the Department of Health and Human Services to enter into 10 contracts with community health centers (CHCs) to conduct activities that test the impact of providing at-risk populations who use CHCs with individualized wellness plans designed to reduce risk factors for preventable conditions.

Despite growing numbers of people gaining access to health insurance coverage because of health reform, there will always be some people who will be uninsured and therefore likely to need care through safety net providers. Therefore, the ACA requires the federal government to set aside $34 billion over 5 years for community health centers. These centers will be allowed to contract with federally certified rural health clinics, critical access hospitals, sole community hospitals, or Medicare disproportionate share hospitals to provide whatever primary health care services they offer to people who are eligible for free or reduced-cost care and who are eligible to receive those services at community health centers. This additional funding is viewed as essential to ensuring that the health care safety net in this country remains viable.

To further shore up the health care safety net, the ACA establishes a new training program for community health workers to promote positive health behaviors and improve risky behaviors (e.g., improved nutrition, decreased tobacco use) among medically underserved populations. Medically underserved populations are defined as those that are deficient in the provision of personal health services, such as too few primary care providers or high infant mortality. The program also targets areas with health professional shortages.

HEALTH CARE INFRASTRUCTURE AND SAFETY NET: Policy		
Language access	FEDERAL STATE LOCAL	Governments should adopt policies that ensure that those who do not speak English or are limited in English proficiency have adequate language access to their health care provider. Governments should also ensure that those who provide professional language services be adequately trained and compensated.
Safety net facilities	FEDERAL STATE LOCAL	Notwithstanding the fact that millions will receive access to health insurance coverage because of health reform, federal, state and local governments should take steps to ensure adequate funding for safety net providers so that the needs of those who remain uninsured are met. Publicly funded interventions should be sensitive to communities' special needs and preferences.
Providers	FEDERAL STATE	Federal and state governments should provide incentives for health educators to conduct training in medically underserved areas and for programs that encourage physicians, nurses, and other health care personnel to practice in medically underserved areas. Incentives might include targeted scholarships and grants, student loan forgiveness programs, training stipends, and other financial innovations. Federal and state governments should establish programs to recruit and train health care providers to work in rural and urban underserved areas. In addition federal and state governments should target education subsidies to health care professions in which practitioners are in shortest supply.

Providers (cont'd.)	FEDERAL STATE	Federal and state governments should take steps to ensure that grants awarded to public and nonprofit entities to address the following curriculum issues among health providers—cultural competency, public health, prevention, reducing health disparities, and working with individuals with disabilities—be rigorously evaluated and best practices quickly disseminated.
Access in rural areas	FEDERAL STATE	Federal and state governments should help rural communities improve local access to health care by facilitating community-based discussions aimed at identifying potential solutions for access problems and by providing: • relevant demographic and utilization data, • appropriate incentives for managed care plans to extend needed coverage to rural areas, • incentives and assistance in recruiting and retaining all types of health care personnel, and • technical assistance to rural and underserved communities seeking to develop delivery systems and identify alternative options for providing access to health care (such as telemedicine systems and improved transportation resources).
Uncompensated care	FEDERAL STATE	Federal and state governments should adopt policies that: • encourage nonprofit hospitals to provide free care to people who are indigent and lack access to health insurance coverage, • either require or encourage for-profit and nonprofit hospitals to charge uninsured people discounted prices comparable to those negotiated with insurers and prevent both types of hospitals from engaging in onerous debt collection practices against people who are indigent or uninsured. Federal and state governments should require hospitals to freely disclose information about charity care and discounts available to qualified patients. In addition, federal and state governments should require hospitals to make information about their charges available to patients so they can anticipate the costs of care. States should monitor the level of uncompensated care and other community benefits provided by nonprofit hospitals and evaluate whether those benefits are commensurate with the value of the tax exemptions the hospitals receive.
Individualized wellness plans	FEDERAL	The federal government should take steps to ensure that those who receive individualized wellness plans through community health centers are monitored to ensure that the plans adequately respond to their health needs. Special attention should be given to plans where the patient has multiple chronic illnesses.
Training for community health workers	FEDERAL	Community health worker training should include training in working with an older adult population.
Volunteers	FEDERAL STATE LOCAL	Until health care coverage is attained for all, federal, state, and local governments should support efforts to create and maintain access to health care for the uninsured through innovative community-based approaches, such as the use of volunteer health care personnel and donated medical equipment.

Volunteers (cont'd.)	FEDERAL STATE LOCAL	In all cases where health care is offered through voluntary efforts or donated equipment, consumer protections should be maintained by checking the adequacy of professional licenses, ensuring practice competencies, retaining a patient's right to full and just compensation for injuries resulting from inappropriate care, ensuring adequate malpractice insurance coverage for volunteers, and implementing other appropriate quality control measures. Volunteer efforts cannot fully or adequately address the problem of the uninsured, but they are a valuable component of the safety net.

Fraud and Abuse

Fraud and abuse can be found in all segments of the health care system. Fraudulent and abusive practices include overcharging or double-billing health insurance companies or the government for services provided, charging for services not provided, and rendering inappropriate or unnecessary care. Beneficiaries who suspect Medicare fraud are encouraged to report it (at 800-HHS-TIPS), taking care not to report simple misunderstandings and errors in billing by first calling their physician, provider, or supplier.

Our current health care system, with its multitude of payers and providers, makes detection and pursuit of wrongdoers extremely difficult. The simple fact that there are more than 1,000 payers and billions of annual claims to be paid to hundreds of thousands of providers illustrates the enormity of the task. In the past, government efforts have been frustrated because detection and prosecution have been underfunded. Private-sector payers have met with even less success in combating fraud and abuse because they lack the legal and administrative tools available to the federal government.

Fraud and abuse cost the Medicare program and beneficiaries billions of dollars annually. However, the actual amount is unknown. The lack of empirical evidence on the extent of fraud and abuse and the effects of antifraud activities on the incidence of illegal practices is a serious deficiency in the battle against such practices.

Over the last few years a number of legislative and regulatory actions have changed the way health care fraud and abuse is being combated. Since its inception in 1997, the national Health Care Fraud and Abuse Control Program has returned more than $11 billion to the Medicare Trust Fund. Broader federal efforts to close loopholes, reduce improper payments, and discourage inappropriate conduct saved about $30 billion for Medicare during fiscal year 2007.

Enforcement efforts are supported, in part, by funds recovered from inappropriate Medicare and Medicaid reimbursement, together with related fines and penalties received by federal investigators and prosecutors. According to government reports, however, recovered funds cannot be fully accounted for and may have been spent by federal agencies for activities unrelated to Medicare and Medicaid.

The 2010 Patient Protection and Affordable Care Act increased funding for the Medicare and Medicaid Health Care Fraud and Abuse Control Fund by about $350 billion over 10 years.

FRAUD AND ABUSE: Policy		
Enforcement	FEDERAL STATE LOCAL	Restrictions on physician self-referral and provider-kickback schemes must be strengthened and enforced. Adequate resources should be provided to support antifraud and anti-abuse efforts at all levels of government, as well as within the private sector, and to educate consumers to become involved in these efforts. A balanced approach should be taken to ensure that antifraud and anti-abuse activities do not have unintended negative effects on patient health care, e.g., by adversely affecting access to care or resulting in the withholding of medically necessary treatment.

Enforcement (cont'd.)	FEDERAL STATE LOCAL	The Department of Health and Human Services (HHS) and the Department of Justice should continue enforcement activities, including research to determine the extent of fraud and abuse and the effects of initiatives to combat them. Both agencies must continue investigations, operations, and prosecutions to reduce the impact of fraud and abuse on federal health care programs and beneficiaries. Congress should continue to oversee the effectiveness of these enforcement activities to ensure that they are appropriate and do not adversely affect access to care. HHS should expand and intensify its efforts to educate health care providers regarding compliance with Medicare billing rules and assist them in preventing and correcting billing errors. Medicare and Medicaid funds and related fines and penalties recovered as the result of enforcement efforts should be spent for the benefit of the Medicare and Medicaid programs, including on continuing enforcement activities to reduce fraud and abuse in these programs, and not redirected to unrelated programs.

Antitrust

Federal antitrust laws protect open competition in economic markets. Antitrust laws reflect the general principle that competition results in the best-quality goods and services at the lowest price. In recent years courts have made clear that these laws apply to entities involved in the delivery of health care, and federal enforcement agencies—the Department of Justice and Federal Trade Commission—have published guidelines for applying antitrust laws and principles to the health care market. The guidelines partially grew out of physicians' and hospitals' complaints that antitrust laws prevented them from pursuing collaborative efforts that could result in more, not less, cost-effective health care. The guidelines, which distinguish between legal, pro-competitive collaboration and illegal, anticompetitive collaboration, show an understanding of the dynamics of the health care market, as do the enforcement actions the agencies have taken.

ANTITRUST: Policy		
Legislation	FEDERAL STATE	The need for health care providers to have statutory exemptions from federal antitrust laws remains undemonstrated. Therefore AARP opposes exempting health care providers and activities from these laws.

FINANCING HEALTH CARE

AARP has long supported and worked toward improving our nation's health care system. Proposals to reform the overall financing structure of health care range from incremental changes, such as modifying tax or regulatory policies, to comprehensive overhaul (see Chapter 3, Taxation, for AARP's principles on tax policy).

The successful enactment of the 2010 Patient Protection and Affordable Care Act (ACA) and the changes it will bring to the health care of US residents build on the already existing combination of private and public coverage and financing. The law also affects and involves a number of changes in health care financing.

Private health insurance, which is primarily employment-based, constitutes the single largest means by which Americans finance their personal health care. However, employer coverage is becoming less available and often provides less in benefits than it did in years past. As of 2014, large employers will have a shared responsibility if their employees receive subsidies for coverage through an exchange. The same year, individuals who don't have minimum coverage will also be liable for a tax

penalty, with some exceptions. Public health care programs, including Medicare, Medicaid, and programs for veterans, federal workers and retirees, and military personnel, are the other major source of coverage. Health reform expands financing and coverage through Medicaid.

The federal share of financing for public and private health insurance comes from a combination of direct taxes, such as the income and Medicare payroll tax, and tax preferences that reduce the amount of taxes employers and individuals pay to federal and state governments. The tax preferences are:

- the deduction businesses can take for money spent on employee health care benefits,
- the exclusion of the value of those benefits from employees' income and payroll taxes,
- the individual deduction for health care expenses in excess of 7.5 percent of adjusted gross income, and
- the deduction of individually purchased health insurance premiums by self-employed individuals.

The ACA required additional revenues to finance coverage expansion and other reform elements. The financing comes from a combination of savings in the growth of Medicare costs and revenue provisions.

Among the revenue changes are:

- raising the floor for individual deduction for health care expenses from 7.5 percent to 10 percent in 2013 (those 65 and older are exempt through 2016),
- increasing the Medicare payroll tax for high-income workers on the portion of their earnings above $200,000 for an individual and $250,000 for a couple in 2013,
- adding a 3.8 percent tax on net investment income for high-income taxpayers in 2013;
- annual fees on different segments of the health industry,
- a 40 percent excise tax on the value of health coverage above threshold amounts as of 2018, and
- limiting contributions to flexible spending accounts as of 2013.

It is important that all reforms be adequately financed over both the short and long term.

FINANCING HEALTH CARE: Policy		
Financing	FEDERAL STATE	Policymakers should evaluate health care reform's financing sources to make sure they are broad-based, stable, capable of growing with enrollment, progressive, and consistent with furthering public health objectives.

Specific Needs and Services

Prescription Drugs

Appropriate use of prescription drugs may prolong life, improve the quality of life, and postpone or replace the need for intensive, often expensive medical treatments. Prescription drugs have increasingly become a mainstay for many people: in 1997, 2.3 billion retail prescriptions were dispensed, and by 2009 that number had increased to 3.9 billion. The rate of growth in prescription drug expenditures, which totaled $300.3 billion in 2009, represented a 5 percent growth rate from 2008 versus only a 1.8 percent rate of growth from 2007 to 2008. Analysts have noted that stronger patient demand in 2009 (including that generated by enhanced access through the Medicare Part D benefit) underscores the resilience of prescription drugs in today's health care equation.

This growth rate is especially dramatic considering that 74 percent of all prescriptions dispensed in 2009 were for generic drugs. On average, the retail price of generics is about one-fourth to one-third that of their branded counterparts. However, the rate of increase in manufacturers' prices for many widely used brand-name prescription and specialty drugs persists at more than double the rate of inflation.

Specialty drugs like biologics, once reserved for rare conditions but today commonly prescribed for chronic conditions that typically affect older populations such as multiple sclerosis and rheumatoid arthritis, account for over one-fifth of all pharmaceutical expenditures. From 2008 to 2009, the proportion of total drug expenditures devoted to specialty drugs grew 7.5 percent. Patient cost-sharing, which as recently as five years ago was typically based on a nominal copayment (perhaps $5 to $40 depending on if the drug was a generic or brand), recently shifted to a coinsurance model for these most expensive specialty tier drugs and biologics. Thus, patients may face a 25 percent to 60 percent cost-share on a drug priced at $1,500 to $15,000 per dose, or more. Innovator (branded) products will likely continue to dominate the specialty drug market for the next decade, given the 12-year

period of market exclusivity granted to brand-name biologics under the 2010 Patient Protection and Affordable Care Act (ACA). (This provision also grants the Food and Drug Administration (FDA) the authority to approve generic versions of biologic drugs, or biosimilars; for more on biologic and biosimilar drugs, see this chapter's section, Medicare—Prescription Drugs.)

Levels of cost-sharing are known to be one key factor in adherence to medication therapy. Other factors involve clinicians' and patients' understanding of and appreciation for the often delicate benefit/risk balance associated with all medicines. Expanded medication therapy management services, especially those provided by pharmacists and for patients with multiple chronic conditions, are essential to fine-tuning this balance. Together, these factors must be managed carefully to ensure that the true value of pharmaceuticals is achieved for each patient.

For example, efforts to promote useful communication about medicines' safe, appropriate use have accelerated, especially since the prescription pain reliever Vioxx was withdrawn from the market (2004) due to safety concerns. New research (2010) about the safety of the popular diabetes drug Avandia further points to the growing need for both systematic post-marketing drug surveillance and unbiased comparative effectiveness research to help inform sound prescribing decisions. (The former is addressed in part via the FDA's "Sentinel" initiative and the Institute of Medicine's 2010 report on safety of approved drugs; the latter, via the Patient Centered Outcomes Research Institute that was created as part of health care reform in 2010.)

Parallel initiatives to drive value in the pharmaceutical system include: utilization management tools such as prior authorization and quantity limits; formularies and preferred drug lists; academic detailing to provide unbiased, evidence-based research about prescribing choices; tracking quality through enhanced medication adherence and reduced adverse drug event-related hospitalizations and medical visits; and innovative value-based insurance design that reduces barriers to high-value therapies.

PRESCRIPTION DRUGS: Policy		
Access to drug therapies	FEDERAL STATE	Federal and state governments should implement proven programs to increase access to Food and Drug Administration approved and appropriate drug therapies, including comparative effectiveness research and academic detailing. They also should adopt value-based approaches to reduce prescription drug costs, such as price negotiation, well-designed preferred drug lists, and easily accessible and timely clinical and economic information for consumers, providers, and third-party payers.
Drug selection and utilization management	FEDERAL STATE	As a major payer (through Medicare Part D and Medicaid) for prescription drugs, the Department of Health and Human Services and state governments should promote informed prescribing choices through unbiased comparative effectiveness research and academic detailing programs. Utilization management should reflect value-based insurance design principles that promote access to high-value therapies. Broader access to medication therapy management services, particularly those delivered by pharmacists to patients with multiple chronic conditions, should be evaluated for its effect on improved health outcomes and reduction in adverse drug event-related medical visits and hospitalizations.
Prices	FEDERAL STATE	AARP supports competition that enables purchasers to obtain price discounts from pharmaceutical manufacturers. Resultant cost savings achieved through negotiation and/or competition should be passed on to consumers via lower prices, cost-sharing and/or enhanced benefits. States should use the purchasing power of Medicaid, other state-funded prescription drug benefit programs (such as state employee benefits), and private purchasers (to the extent they choose to participate) to obtain prescription drug price discounts from manufacturers and pharmacies.

Prices (cont'd.)	FEDERAL STATE	States should pursue both intra- and interstate prescription drug buying pool agreements that can reduce drug benefit costs for health plans and offer price discounts to all residents who currently pay entirely out-of-pocket for drugs. States should encourage price competition by developing online prescription drug price postings for consumers based on retail pharmacy information by zip code. For prescribers, relative prices within therapeutic categories should be easily accessed through electronic prescribing systems. Market access to biosimilars (generic biologics) should be accelerated through an FDA regulatory pathway that would reduce the 12-year market exclusivity period granted to innovator biologics under the 2010 Patient Protection and Affordable Care Act.
Assistance programs	STATE	State pharmaceutical assistance programs that combine enhanced access with pharmacist-led medication management services can help to optimize prescription drug use beyond immediate concerns of filling the next prescription. Such state programs, especially for Medicare-eligible people who do not qualify for the Part D low-income subsidy, should be maintained. Pharmaceutical manufacturer-sponsored assistance programs should utilize a standardized application form to simplify the enrollment process.
Formularies and preferred drug lists	FEDERAL STATE	AARP supports the use of well-designed drug formularies and/or PDLs, because these mechanisms can enhance quality and conserve resources.
Appeals of coverage decisions	FEDERAL STATE	A clinically sound and well-communicated exceptions and appeals process must be in place. The process should allow appeal to an independent, objective third party and require as prompt a decision as a patient's condition mandates. Data should be collected to permit at least annual evaluation of the process's appropriateness in terms of clinician and consumer burden and effects on patient health outcomes. Insurers should be required to show cause before denying payment for a particular drug when the prescribing physician has deemed the insurer's recommended substitute to be medically inappropriate. Step-by-step directions for initiating the exceptions and appeals process should be clearly identified to consumers. Patients who obtain a nonpreferred drug through the exceptions process should obtain that drug at the cost-sharing tier level associated with preferred drugs, if the prescriber determines that therapeutically similar preferred drugs are medically inappropriate for the enrollee.
Pharmacy benefit managers (PBMs)	FEDERAL STATE	The Federal Trade Commission (FTC) should monitor relationships between PBMs and vertically integrated acquisitions for effects on consumer choice, clinical outcomes, and retail price. AARP supports guarantees of patient confidentiality in the sharing of any claims records among PBMs, insurers, health plans, pharmaceutical manufacturers, and pharmacies.
Marketing	FEDERAL STATE	To help counter increasing pharmaceutical marketing influence, such as through expanding channels for direct-to-consumer advertising and industry payments to health care providers, evidence-based

Marketing (cont'd.)	FEDERAL STATE	clinical decisions support systems should be broadly integrated. State and federal efforts to limit gifts to prescribers through mandatory reporting could also help prioritize drug therapy classes where such evidence-based decision support is most needed. Further, states should limit the dollar value of gifts that drug manufacturers can give to prescribers.
Detailing	STATE	States should adopt legislation to prohibit the sale of prescriber profiling data for commercial "detailing" purposes. States should implement "academic detailing" programs to educate prescribers through unbiased evidence-based research. These should be supplemented by related consumer awareness and educational outreach campaigns.
Consumer education	FEDERAL	Patient medication information (PMI) should be supplemented by oral counseling by pharmacists at the point of dispensing and by other clinicians at the point of prescribing (including with drug samples). Patient and caregiver preferences for PMI delivery method, format, font size, and language preference should be established prior to dispensing a medication and delivered accordingly.
Mail-order pharmacies	STATE	States should not adopt laws and regulations that would impose unnecessary and costly burdens on out-of-state mail-order pharmacies. States should prohibit insurers, health plans, and state Medicaid agencies from requiring enrollees to purchase prescription drugs only by mail.
Labeling	FEDERAL	The FDA should develop patient-centered drug labels that emphasize, in readable fonts, the most important details for safe and effective use. Further, the agency should work more deliberately with manufacturers to avoid sound-alike and look-alike confusion with drug names; and should work with prescribers, other clinicians and consumers to establish appropriate responses to emerging labeling and drug safety problems.
Clinical trials	FEDERAL STATE	Registration of all Phase II through Phase IV clinical trials on the federal website www.clinicaltrials.gov, including plain-language summaries of results (regardless of the outcome), should be mandatory.
Research	FEDERAL	Given the enhanced access to prescription drugs through Medicare Part D and ever-increasing utilization of drugs by older adults, funding for the FDA's post-marketing surveillance activities (e.g., Sentinel) and for communication of emerging risk information should be allocated more equitably in relation to pre-marketing approval activities. Given the accelerated implementation of FDA-approved Risk Evaluation and Mitigation Strategies (REMS) for many biologics and other prescription drugs, the Agency for Healthcare Research and Quality should undertake research to determine REMS' effect on appropriate prescribing, patient adherence, and health outcomes. AARP supports the Patient Centered Outcomes Research Institute enacted in the 2010 Patient Protection and Affordable Care Act. The institute's research findings should be made easily accessible to all stakeholders.

Re-importation and importation	FEDERAL	Re-importation and importation of prescription drugs from licensed pharmacies and wholesalers operating in Canada should be permitted. Strong safety standards—including pedigree requirements and anti-tampering and anti-counterfeiting measures—must be implemented as part of any importation system. The FDA should be given sufficient resources and authority to ensure that the safety of drugs imported from Canada or other countries is comparable to the safety of drugs dispensed in the US.
Patents	FEDERAL	AARP opposes "pay-for-delay" practices that allow brand-name drug manufacturers to extend market exclusivity beyond the anticipated patent expiration by paying the would-be generic manufacturer to delay market entry. Such practices should be investigated by the FTC to determine their impact on competition and drug prices.
Antitrust	FEDERAL	The FTC should continue monitoring restraints of trade in the generic drug industry and initiate appropriate action against any brand-name or generic drug manufacturer alleged to have violated federal antitrust laws.

Dietary Supplements

Many consumers, including about half of older adults, take dietary supplements to promote general wellness, improve nutrition, combat aging, and help reduce pain and ailments of certain chronic conditions. A survey of people aged 57–85 years, published in the Journal of the American Medical Association in 2008, found that 49 percent used a dietary supplement. A 2010 survey of people who subscribe to a dietary supplement electronic newsletter found that 32 percent of those aged 65 years and older used 10 or more supplements each day. Between 1994 and 2009, annual sales of dietary supplements—vitamins, minerals, herbs, amino acids, and other ingredients—increased from $8.8 billion to more than $25 billion. Given their increasing popularity, concern is also growing about their quality, safety, and labeling.

Both the Food and Drug Administration (FDA) and the National Institutes of Health (NIH) have dedicated centers or offices to oversee research and provide advice on these products: the FDA's Center for Food Safety and Applied Nutrition was formed in 1984; the NIH Office of Alternative Medicine, then the National Center for Complementary and Alternative Medicine, were established in the 1990s. The Dietary Supplement Health and Education Act (DSHEA), enacted in 1994, defined "supplements," established safety provisions, specified nutrition and labeling information, clarified regulation of health claims and other label statements, set standards for distribution of third-party literature, and required the establishment of good manufacturing practices. More than 15 years later, critics of DSHEA implementation and of oversight by FDA contend that unsafe supplements continue to be marketed. Public health and consumer groups support FDA actions against unsafe supplements like ephedra, colloidal silver, and certain body-building products but fault the agency for taking so long to act. They also claim that DSHEA makes it too difficult for the FDA to take unsafe supplements off the market.

Historically, regulation of dietary supplements is shared between FDA and the Federal Trade Commission (FTC). The FDA does not analyze supplements before they are marketed, but it does assess labeling and health-related claims. The FTC's jurisdiction governs advertising of supplements. The exponential increase over the past decade in Internet marketing of these products—combined with consumers' (particularly older adults') insatiable appetite—has made it especially challenging for these agencies to stay one step ahead of some disreputable manufacturers and marketers. The 2010 Consumer Lab Supplement Survey of dietary supplement users found that 44 percent of respondents purchased them via the Internet, and only one-fourth purchased them at a pharmacy, leaving a large majority without real-time access to a pharmacist to raise questions about potential interactions.

Two Government Accountability Office (GAO) reports, issued in 2009 and 2010, criticized regulation of dietary supplements. The first report called for additional FDA authority to oversee supplements

and to improve consumer understanding of their safety, efficacy, and labels. The second report involved GAO investigators posing as elderly consumers, who were often told that a particular supplement would prevent or cure conditions such as Alzheimer's or high cholesterol. Further, these investigators were told false safety claims, such as that a particular supplement would not cause any problems if used with aspirin, despite scientific evidence showing the opposite; and that a supplement could be used instead of a prescription medicine for a certain condition.

Several provisions of DSHEA and of subsequent laws have taken effect only recently. For example, DSHEA's requirements for good manufacturing practices took effect in 2008. Specific labeling details related to reporting of adverse events, required in a law enacted in 2006, took effect in 2010. Since December 2007, supplement manufacturers and distributors have been required to report to FDA serious adverse events involving supplements. In 2008, the agency received 1,107 such reports and 1,275 reports in 2009. It is likely that these numbers reflect only a small proportion of serious events that actually occur.

Inadequate safety information and false claims on product labels and in advertising, remain principal concerns. The FDA has three categories of dietary supplement claims: health claims, nutrient content claims, and structure/function claims. It is the manufacturer's responsibility—not the FDA's—to ensure the accuracy and truthfulness of these claims. A mandatory FDA disclaimer statement, stating that claims "have not been evaluated by the FDA," is rarely featured prominently on supplement marketers' websites or on packaging. Critics contend that the FDA could do more to ensure that supplement products are truthfully labeled.

Supplement manufacturers continue to challenge FDA labeling restrictions in court. The most significant of these cases invalidated FDA-imposed limitations on health claims for supplements, thereby allowing the inclusion of "qualified" health claims on supplement labels.

Despite setbacks, federal, state, and private entities continue efforts to ensure these products' safety. Testifying before Congress in 2010, the FTC said that they brought more than 100 law enforcement actions over the past decade, challenging claims about the effectiveness of cold and flu products, weight-loss products, and supplements purporting to treat cancer and AIDS. Further, the FDA, the NIH Center for Complementary and Alternative Medicine, and the FTC have implemented consumer education campaigns about safe use of dietary supplements. Studies have shown that physicians do not routinely ask about supplement use. Failure to do so could be especially dangerous for older adults, who are most likely compared to younger consumers to be using multiple prescription and nonprescription medicines plus dietary supplements. Not exchanging such information could result in preventable drug-supplement interactions, and adverse events or otherwise cause patient harm.

DIETARY SUPPLEMENTS: Policy		
The role of the Food and Drug Administration (FDA)	FEDERAL	The FDA should actively ensure consumer access to safe, reliable, and accurately and adequately labeled supplements.
Product safety	FEDERAL STATE	Congress should fund a systematic review of the safety and efficacy of all major dietary supplements, as outlined in the 2004 Institute of Medicine report. Congress should consider changes in the law that would allow the FDA to take action more easily against unsafe supplements.
Labels	FEDERAL	Commonly-used prescription drug-supplement interactions should be listed on supplement labels.

Food Labeling and Advertising

The links between diet and health and between obesity and diet-related health problems such as heart disease, hypertension, and diabetes are well established. With adult obesity rates having doubled between 1980 and 2000, about 60 million adults (30 percent of the adult population) are now categorized as obese. Older Americans face a double threat. Not only does the incidence of diet-related health problems increase with age, but the rate of obesity

among older Americans continues to grow. And the effects of these problems are particularly life threatening for older minorities.

Total annual costs attributable to obesity are estimated at $122.9 billion, representing $64.1 billion in direct costs and $58.8 billion in indirect costs. The need for making sound nutritional decisions at home and when eating out has never been greater.

Government laws and policies in the 1990s made great progress in helping consumers receive information through product labeling and advertising so they can follow more healthful diets:

- The 1990 Nutrition Labeling and Education Act (NLEA) requires mandatory nutrition labeling on all products regulated by the Food and Drug Administration (FDA). The FDA now requires information on trans fat content and the presence of major allergens to be added to product packages.
- The NLEA also established standards for health and nutrition claims on food labels. The FDA, though, relaxed its rules and now allows food labels to include "qualified" health claims (those that are supported by less than the statutory standard of "significant scientific agreement"). Critics of the new policy, including AARP, contend this is inconsistent with the governing law and may confuse consumers, a concern the FDA's own research supports.
- The US Department of Agriculture (USDA) followed the FDA's lead and developed requirements for nutrition labeling and standards for claims about meat and poultry products.
- The Federal Trade Commission, which regulates food advertising, issued an advertising enforcement policy in the 1990s that clarifies the commission's position on nutrient content and health claims.

The FDA and USDA also have been involved in international efforts to harmonize food labeling and safety standards through the Codex Alimentarius Commission. Consumer advocates have sought to use this process to incorporate the strongest features of US standards into international food labeling and safety standards without compromising or weakening domestic requirements.

Americans are eating out more than ever and now consume about a third of their calories and spend nearly half (46 percent) of their food dollars on eating out, nearly double the percentage (26 percent) in 1970. The health consequences are significant. Studies find that when people go to restaurants, they often consume more calories, more fat, and fewer important nutrients, such as fiber. Without realizing it, an individual may consume 50 to 100 percent of an entire day's recommended caloric intake in a single "supersize" entrée.

Consumers seldom have information about the nutritional content of restaurant offerings or can identify the healthful dietary choices on restaurant menus. In fact people may be mistaken when ordering something they assume to be healthful.

While processed foods sold in supermarkets must carry nutrition information on their product labels, there is no such requirement for restaurant food. Several large fast-food chains voluntarily provide some information on brochures, posters, or websites, but it is not always in plain view or, in the case of the website, not even at the point of purchase. Recent surveys show that approximately two-thirds of Americans support requiring calorie labeling on menus.

The situation is addressed in the 2010 Patient Protection and Affordable Care Act (ACA) which requires restaurants with 20 or more locations to post calorie content directly on menus and menu boards of restaurants, retail food establishments and vending machine operations. Other nutritional information must also be made easily available to customers.

A number of other labeling issues still need to be addressed at the federal and state levels:

- The USDA issued a proposal in 2001 to require nutrition information for raw ground beef and poultry products but it has yet to finalize this proposal and is not proposing that the information be included on the labels of raw meat and poultry.
- Government surveys reveal that consumption of sugar—in particular added sugar from cane, beet, and corn—continues to rise along with obesity rates. While the USDA advises people to limit themselves to ten teaspoons of added sugars daily, the average American consumes 20 each day.

To capitalize on consumers' interest in improving their diet, many food companies want to put claims on food labels and in advertisements touting the presence of healthful ingredients, such as whole grains, fruits, and vegetables. These claims are deceptive and misleading when the product in question contains very little of the desirable ingredient.

FOOD LABELING AND ADVERTISING: Policy		
Nutritional labeling of restaurant food	FEDERAL STATE	Federal and state policymakers should establish a reasonable requirement for nutrition labeling of restaurant food. Labeling requirements should apply only to restaurants and similar retail food establishments with multiple outlets and to their standard (or regular) menu offerings. Restaurant labels should list key nutrition information (such as calories, saturated and trans fat, and sodium) on menus and menu boards.
Raw meat and poultry	FEDERAL	The US Department of Agriculture should require nutrition labels for all raw meat and poultry.
International programs	FEDERAL	As part of ongoing efforts to harmonize international food labeling as well as safety standards, the US government should not allow domestic requirements to be weakened.
Label content	FEDERAL	In considering what if any revisions should be made to the nutrition label to help consumers achieve and maintain a healthful weight, the Food and Drug Administration (FDA) should sponsor consumer research to determine which label revisions would best convey the key messages about limiting caloric intake. The federal agencies responsible for food labeling and advertising should adopt consistent standards and definitions for terms and claims that appear on food labels and in advertisements. The FDA should require that nutrition labels disclose the amount of added sugars in a serving of food and should establish a daily value for added sugars, which should be included on the nutrition label along with the maximum intakes for fat, sodium, and other nutrients.
Label design	FEDERAL	Food labels should be written in understandable language and printed in a legible type size, font, and color. Labels in relevant languages should be made available in communities where a language other than English has significant use in retail transactions. States should ensure that shelf labeling (in particular, unit-price labeling) is legible to consumers, including people with poor vision.
Misleading and deceptive claims	FEDERAL STATE LOCAL	Federal agencies should take aggressive action against misleading and deceptive labels and advertisements. In allowing "qualified" health claims, the FDA must ensure that consumers understand the nature and extent of scientific support for any claim allowed on a food label. When labels and advertisements tout the presence of healthful ingredients such as whole grains, fruit, and vegetables, they should be required to disclose the actual amount of such ingredients per serving.
Pricing	FEDERAL STATE LOCAL	States should enact and enforce laws that require item-price labeling for foods and drugs.

Medical Devices

Medical devices are a large class of products that include everything from tongue depressors to heart valves. The authority of the Food and Drug Administration (FDA) with regard to devices includes premarket review, postmarket surveillance, investigation of adverse-event reports, and inspections.

Since the first medical device law was enacted in 1976, the FDA has come under criticism for failing to approve devices quickly enough. Congress attempted to improve the FDA's performance in this area with enactment of legislation in 1990 and 2002. The Medical Device User Fee and Modernization Act of 2002 provides for user fees for premarket reviews, allows accredited third parties to inspect device establishments, and establishes new regulatory requirements for reprocessed single-use devices.

Ongoing agency actions and reorganizations have been aimed at more effective regulation of medical devices.

Over 400 people are seriously injured or die each year due to an adverse event associated with a medical device. FDA has required reporting of medical device problems since 1990. However, data collected in this manner has been criticized as incomplete, untimely, and not readily accessible. In addition, FDA requires manufacturers to track certain medical devices that are implantable, life-supporting, or life-sustaining to facilitate patient notification and recall. However, monitoring of new devices rarely extends beyond three years, even though most of these devices are designed to last much longer.

In order to improve reporting of adverse events, facilitate device recalls, and reduce medical errors, many countries require that a unique identifier be associated with high risk medical devices and that this information be listed in a national device registry. In the US, proposals to establish such a national device registry would link data provided by manufacturers to the FDA with clinical data from multiple sources, such as Medicare claims, Departments of Defense and Veterans Affairs data, and private insurance claims. Such registry data could be analyzed to identify early warning signs, track emerging trends, and minimize the spread of serious injuries associated with malfunctioning medical devices. The registry data and analysis would be made available to the public without revealing private patient data or proprietary information.

In 2008, the Supreme Court held that state lawsuits against medical device manufacturers are preempted by federal law, provided the device underwent FDA premarket approval. This decision had the effect of immunizing manufacturers from liability from suits by individuals injured by certain medical devices, such as implantable pacemakers and heart valves, that have undergone the premarket approval process. Most medical devices are approved through a less rigorous process known as the "510(k)" for the applicable regulatory section which grants approval if a device is "substantially similar" to one already on the market. However, manufacturers of devices approved under the 510(k) process are not shielded from liability even if the device is identical to one that underwent premarket approval. Although devices that are shielded from liability represent only a small proportion of the total market for medical devices, approximately 10 million people, most of them over 65, could be affected and this number is growing. In its opinion, the Supreme Court left open the possibility that similar protection from liability could be extended to pharmaceutical manufacturers as well as medical device manufacturers.

MEDICAL DEVICES: Policy		
Premarket review	FEDERAL	The Food and Drug Administration (FDA), in enforcing its regulations and implementing the Medical Device User Fee and Modernization Act of 2002, must ensure that only safe and effective medical devices are allowed on the market.
Postmarket review	FEDERAL	While the FDA focuses its energies on the premarket review process for approving devices, it must not neglect the postmarket surveillance system, which brings device problems to the agency's attention.
National device registry	FEDERAL	Congress should enact legislation that would establish a national registry to identify, track, and report on malfunctioning high-risk medical devices.

Liability	FEDERAL	Congress should enact legislation that would provide patients with legal recourse if they are injured by a malfunctioning implanted medical device.

Hearing Aids

With almost 28 million Americans suffering from some form of hearing impairment, hearing loss is one of the country's most prevalent chronic health conditions. About half of all hearing-impaired people in the US are over age 65. Thirty percent of people age 65–74, and 50 percent of people age 75 and over, experience hearing loss. Many hearing-impaired individuals can benefit from the amplification provided by a hearing aid.

Most new hearing devices are approved by the Food and Drug Administration (FDA) through a less rigorous approval process known as "substantial equivalency," which means their safety and efficacy are not subject to review, even though hearing aid technology has changed substantially over the years. The absence of FDA requirements and weak incentives for manufacturers to perform clinical testing and evaluation means that it is almost impossible for consumers to evaluate advertising claims concerning background noise or other features of hearing aids.

FDA regulations require that people buying hearing devices have a written statement from a licensed physician who has evaluated the buyer's hearing and need for the device. Buyers can sign a waiver regarding the exam requirement, an option that many vendors encourage, often inappropriately. In many surveys conducted during the last ten years, buyers reported they had not been told about the option for a medical evaluation.

HEARING AIDS: Policy		
Coordination of federal and state oversight	FEDERAL STATE	The Food and Drug Administration (FDA) should at the very least retain its authority over hearing aids by setting minimum standards for state regulators to follow. The FDA, the Federal Trade Commission, state licensing boards, and state attorneys general should coordinate their regulatory activities in protecting hearing aid consumers. The Federal Communications Commission should ensure full and prompt implementation of its hearing-aid compatibility rules to increase the number of wireless phones that can be used effectively with hearing aids and cochlear implants (see Chapter 10, Utilities: Telecommunications, Energy and Other Services: Cell Phones and Hearing-Aid Compatibility).
Labeling	FEDERAL	The FDA should actively ensure consumer access to reliable and accurately labeled hearing aids.
Safety and efficacy testing	FEDERAL STATE	The FDA should carefully review the safety and efficacy of new hearing devices before allowing them to enter the market. If a manufacturer makes any claims about the user benefits of a hearing aid (such as elimination of background noise), the assertion must be based on controlled clinical studies using valid clinical measures. The FDA should develop new regulations to delineate which tests physicians should conduct with each hearing evaluation.
Sales tactics	FEDERAL STATE	The FDA and state agencies should investigate complaints of high-pressure sales tactics that inhibit older people from getting professional counseling before purchasing a hearing aid. Regulators

Sales tactics (cont'd.)	FEDERAL STATE	should also conduct public education campaigns on the importance of such screenings before a hearing aid purchase. States should regulate hearing aid dealers and sales practices, including direct response and mail-order solicitations; require advertising bonding of sellers; require consumer protections, such as contracts or sales receipts that spell out the buyer's rights; and establish regulatory boards to record, hear, and act on complaints.
Trial periods	FEDERAL STATE	The FDA and/or states should require, and states should support, a mandatory 30–60-day trial period (with a prompt money-back guarantee) during which consumers could return hearing aids for a charge that would not exceed 10 percent of the original purchase price.
Waiver of doctor examination	STATE	States should help implement FDA hearing aid regulations, seek an exemption from FDA requirements that permit a waiver of a physician evaluation before a hearing aid purchase, and strengthen prepurchase examination requirements.

Mental Health

Mental health is fundamental to overall health. Mental illness can strike people of all ages and incomes and be as debilitating as any other major medical illness. According to the National Institutes of Mental Health, one in four adults suffer from a diagnosable mental disorder in a given year, or about 58 million people. Yet insurance policies have typically placed additional restrictions on coverage for mental health and substance abuse services, such as higher copayments and deductibles and stricter limits on treatment. In addition, 34 percent of people with mental illnesses are uninsured—twice the rate of the population as a whole.

The 2010 Patient Protection and Affordable Care Act (ACA) will help end many of these disparities. For example, health plans provided through new state health insurance exchanges that will be in place by 2014 will be required to cover mental health and substance use disorder services, and must provide such benefits at parity with medical and surgical benefits. This will effectively expand parity to employees of companies with 50 or fewer workers—whose employers are not required to comply with existing parity law—if their employers opt for the state-run exchange plans, and to those on the individual market.

In addition, new Medicaid benchmark and benchmark-equivalent plans that will be in place by 2014 as part of health care reform must offer mental health and substance abuse benefits, and provide them at parity with medical and surgical benefits; previously only Medicaid-managed care plans faced parity requirements. The law also requires that all benchmark and benchmark-equivalent plans must comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (described in greater detail later in this section), which will be fully implemented in 2011 and extends parity to group health plans with 51 or more employees.

Those who do not qualify for Medicaid and cannot afford to purchase health coverage on their own may qualify for premium and cost-sharing subsidies that will help reduce their costs, an important change given that cost is the factor most often cited by people who recognize that they need mental health treatment but do not get it.

The ACA will also prohibit insurers from denying or taking away coverage on the basis of mental illnesses starting in 2014. Individuals who are currently uninsured because of a preexisting condition—a group that includes many people with mental illnesses—will have immediate access to a high-risk pool, which can provide temporary coverage until state exchanges are in place in 2014. The law also eliminates lifetime and annual limits on the dollar value of benefits by 2014, which will help reduce out-of-pocket expenses for individuals who need ongoing services and medications.

Two other health care reform provisions reflect the growing interest in developing integrated service delivery for people with mental illnesses. People with serious mental illnesses die an average of 25 years earlier than the general population, largely due to co-occurring medical conditions and inadequate access

to medical care. In an effort to provide more effective care for this population, Medicaid beneficiaries with at least two chronic conditions or at least one serious mental health condition will be allowed to designate a provider as a "health home" starting in 2011. Similarly, $50 million in grants was authorized to co-locate primary and specialty care in community-based mental and behavioral health settings. These provisions will help health providers manage all of their patients' conditions simultaneously.

Many of the parity-related provisions in the ACA augment the Mental Health Parity and Addiction and Equity Act of 2008, passed as part of the Emergency Economic Stabilization Act. That legislation requires group health plans for businesses with 51 or more employees to cover mental illnesses and substance abuse at the same level as physical ailments. It does not mandate that insurers or group health plans provide mental health or substance abuse benefits; the provisions only apply to plans that choose to offer such coverage. It also does not require plans to cover all mental and substance use disorders, but they must provide equivalent coverage for the diagnoses that they have selected. The legislation is expected to affect approximately 111 million people in ERISA-covered group health plans and 29 million people in public, nonfederal employer group health plans sponsored by state and local governments.

The Federal Employees Health Benefits Program already requires parity between mental health benefits and benefits for other conditions, and 46 states have some form of parity legislation. The Mental Health Parity and Addiction Equity Act does not supersede any state law that provides stronger consumer protections, benefits, rights, or remedies.

At the state level the delivery and financing of mental health and substance abuse services has been transformed by the use of managed care to deliver both privately and publicly funded services. Approximately half of all insured Americans are enrolled in a managed care plan offering only specialized mental health or substance abuse services.

Effective mental health interventions range from specific medications to treat schizophrenia to specific models for treating depression in primary care to supported housing for homeless people with mental illness. These and other mental health interventions have a proven cost-effectiveness.

Nevertheless, discrepancies occur between the kind of mental health care known to be effective and the care actually delivered. According to a 2006 report by the Institute of Medicine, the challenges to providing care for mental health and substance abuse include the greater stigma associated with a mental health diagnosis, more frequent patient coercion into treatment, a less developed infrastructure for measuring and improving care quality, a greater number of providers needing to be linked, less widespread information technology, and the fact that mental health care typically has been structurally and functionally separated from other components of the health care system. An additional challenge is that diagnostic criteria and treatments are typically developed and validated on young and middle-aged adults and are not necessarily applicable to older adults' lifestyles and physiology.

MENTAL HEALTH: Policy		
Improving services	FEDERAL STATE	The Institute of Medicine's recommendations on improving the quality of the overall health care system should be applied for mental health and substance abuse but tailored to reflect the distinct characteristics of such care. In particular, evidence on effective treatments and services specific to diverse older populations should be synthesized and disseminated, and the competency and capacity of the workforce must be strengthened. States should ensure adequate funding for mental health and substance abuse services, develop comprehensive and coordinated delivery systems for such services, and emphasize special training in cultural and ethnic sensitivity for service providers. States also should ensure that both privately and publicly funded mental health and substance abuse services meet high standards for quality, monitor access to and satisfaction with services, protect clients' due process rights, and involve consumers and family members in planning, implementing, and evaluating services.

Coverage	FEDERAL STATE	Federal and state governments should support proposals to require adequate and affordable mental health and substance abuse coverage. For example the use of advanced practice nurses in the provision of some services to Medicaid patients may increase access to mental health services and prove cost-effective. Mental health services should have parity with (i.e., covered at levels equivalent to) other health services. Federal and state governments should rigorously monitor and enforce parity requirements in plans offered through the state health insurance exchanges and in Medicaid managed care, benchmark and benchmark-equivalent plans.
Costs	FEDERAL STATE	The Department of Labor should rigorously monitor and enforce the implementation of the Mental Health Parity and Addiction Equity Act, particularly with respect to ensuring that businesses accurately estimate implementation costs. Congress should ensure that restrictions on mental health and substance abuse services in all types of health plans that the Mental Health Parity and Addiction Equity Act does not address do not exceed those for physical health services, including day or visit limits and cost sharing levels. States should ensure parity beyond the provisions of the Mental Health Parity and Addiction Equity Act for all plans providing mental health and substance abuse services.
Data collection	FEDERAL	Federally funded programs should collect data on the use and cost of mental health and substance abuse services for older people, including those enrolled in managed care plans.
Workforce	FEDERAL STATE	Primary care providers should be trained to recognize mental and substance abuse disorders in older populations. Mental health and primary care providers should be trained in state-of-the-art treatments. Primary and behavioral health care and related workforce development should be integrated so people with mental and/or substance use disorders receive the same care regardless of setting.
Coverage denials	FEDERAL STATE	Insurers should be required to show cause before denying payment for specific medications prescribed by a physician to manage a mental health condition if the physician deems the insurer's recommended substitute to be medically inappropriate.
Community-based providers	FEDERAL STATE	The federal government should increase funding for community-based mental health and substance abuse services through the mental health block grant. A larger portion of funds should be targeted toward nontraditional providers of services for the elderly, such as hospice programs, adult day care centers, and other community-based long-term care providers. Community mental health centers should be encouraged to reach out to older adults, who typically will not self-refer, by providing services at other sites and establishing affiliations with area agencies on aging. Mental health and substance abuse services should be accompanied by culturally relevant outreach efforts.

Managed care	FEDERAL STATE	Protections are needed for those in managed care plans with mental health or substance abuse disorders in order to ensure their access to necessary services, including emergency services and mental health specialist care. Policymakers should evaluate managed behavioral health care to assess whether enrollees have access to appropriate, high-quality, and timely care.
Research	FEDERAL STATE	Additional funding should be made available for research on the complex epidemiology of mental health and substance abuse problems of older Americans and on preventing and reducing mental disorders and alcohol or substance abuse among older adults. Research should evaluate the impact of specific therapies, with a particular emphasis on prescription drugs, on outcomes for older patients. The Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration, through research and demonstration projects, should encourage innovative service-delivery models for mental health and substance abuse services, such as integrated care, bringing services into homes, senior centers, residential care facilities (including board and care homes), and federally assisted housing sites. Policymakers should support ongoing research to evaluate the impact of specific mental health and substance abuse services on patient outcomes and on the use of other health services. States should evaluate the effectiveness of publicly funded managed behavioral health systems, including various types of carve-outs, with respect to access (e.g., timely service and an array of appropriate services), enrollee satisfaction, outcomes of care (e.g., ability to live independently), and systems integration (e.g., tracking in other systems, such as criminal justice and education, to determine if mental health programs are working).
Medicaid	STATE	Medicaid law and regulations should provide for payment at adequate rates for mental health and substance abuse services. Individuals should be able to choose the same delivery system for mental health and substance abuse services as for physical health services. For example, if individuals select a fee-for-service plan, they should have access to mental health and substance abuse services, as well as physical health services, on a fee-for-service basis.
Quality	STATE	States should set strong licensing standards for community mental health centers.
Prisons	STATE	States should improve mental health and substance abuse services in criminal justice settings through increased funding and better collaboration with the mental health system. For example, states should establish jail-diversion programs, possibly through the use of specially trained police or on-site crisis teams, to minimize the number of seriously mentally ill individuals who are inappropriately incarcerated. Inmates with a serious mental illness should receive psychiatric and substance abuse services while in jail and follow-up care upon release.

End-of-Life Care

The need for high-quality health care does not diminish as individuals approach the end of their life. Yet research has shown that a substantial gulf exists between the type of care people say they want and the type of care they actually receive in their final months.

A number of obstacles make it difficult for patients to receive the end-of-life care they want. Key among these is inadequate physician education regarding death and dying, which prevents doctors from communicating effectively with their patients. In addition a medical culture that emphasizes curing over other care goals too frequently propels doctors to use aggressive care against patient wishes. Another obstacle is the difficulty physicians have in making accurate prognoses for patients with life-threatening illnesses. This discourages the timely initiation of end-of-life care planning, leaves patients unable to make informed decisions, and may prevent or delay the use of palliative care, such as hospice care. Lack of knowledge about palliative care—in particular, adequate management of pain and suffering and psychosocial support—results in an unnecessary degree of suffering by terminally ill patients and an unnecessarily traumatic experience for their loved ones. (For background and policy on advance directives, see Chapter 12, Personal and Legal Rights.)

Studies suggest that end-of-life care is often poorly coordinated among providers leading to increased utilization of acute care services, inadequate pain control and emotional stress for patients and families. Models that promote better coordination of care delivery have been shown to improve quality and decrease cost of end-of-life care.

Medicare policy limits hospice coverage to those with a life expectancy of six months or less and requires beneficiaries to choose between hospice care and curative care. These restrictions may inappropriately discourage or delay people from seeking hospice care. Medicare policy does not permit advanced practice registered nurses (APRNs) such as nurse practitioners to certify patients for hospice care, although APRNs are permitted to serve as the patient's attending physician and to recertify. In addition, government attempts to discourage fraud and abuse in the Medicare and Medicaid programs may have had an unintended chilling effect on hospice utilization.

The 2010 Patient Protection and Affordable Care Act authorized legislation authorized a Medicare demonstration that will allow beneficiaries to receive both hospice care and nonhospice covered services at the same time.

END-OF-LIFE CARE: Policy		
Provider education	FEDERAL STATE	To ensure that people are afforded every opportunity to make informed decisions about end-of-life care and have an appropriate range of medical and palliative options, the knowledge base about such care must be substantially improved. There should be a sensitivity to cultural values and beliefs when end-of-life care interventions are considered.
Palliative care	FEDERAL STATE	Federal and state policymakers should support: • improved palliative care, including better treatment for emotional distress and the elimination of all barriers to the appropriate management of pain and suffering; • improved access to palliative care services regardless of patient setting (e.g., hospital, nursing home, or residence)—All barriers to patients' use of Medicare and Medicaid hospice benefits should be eliminated, including limitations on life expectancy and receiving acute or other curative services; • the reimbursement formula for Medicare hospice care—which has increasingly used costly interventions such as prescription drugs, radiation, and even surgery to relieve symptoms—should be reassessed to ensure that it accurately reflects the current mix of services used by beneficiaries receiving state-of-the-art hospice care; • improved coordination of end-of-life care among providers; and

Palliative care (cont'd.)	FEDERAL STATE	• changes in the way end-of-life care is financed, to facilitate appropriate care, including more appropriate use of important palliative care services outside of hospice benefits. States should legally recognize physicians' and other prescribers' duty to provide palliative care sufficient to relieve patients' pain, limited only by patients' informed wishes and the limits of medical science.
Advance directives	FEDERAL STATE	Policymakers should support programs to help patients plan their advance care and create clear and comprehensive advance health care directives to be shared with providers and loved ones. States should enact laws, such as the Uniform Health Care Decisions Act, that regulate advance health care directives and are enforceable-in-fact, flexible for patient preferences and unpredictable circumstances, and protective of appropriate end-of-life interventions.
Training	FEDERAL STATE	Policymakers should support improved training and continuing education programs for health care professionals in palliative care and in other issues associated with the care of dying patients. Programs that help providers improve their communications skills, particularly in imparting complex information to seriously ill patients and their families, should be part of standard medical, nursing, and social work curricula.
Research	FEDERAL STATE	Policymakers should support research that provides information critical to further improve the quality of end-of-life care. Such research should focus on: • identifying the outcomes most important to terminally ill patients and their families and developing appropriate outcome measures; • identifying the care processes linked to improved outcomes for terminally ill patients and their families, which will assist in the development of clinical practice guidelines; • developing information that improves a physician's ability to make terminal prognoses and determine probable outcomes of treatment options to discuss with patients and their families—In the meantime the best currently available information must be communicated to patients and their families in a timely manner; and • developing a better understanding of the consistency of patient wishes over time (as medical conditions and life situations change) with regard to life-sustaining treatment and of the adequacy of current policies regarding the creation, maintenance, and review of advance medical directives.
Insurance	STATE	Health insurance plans should provide adequate coverage for hospice care.

Public Health

Major improvements in Americans' health are a direct result of public health measures initiated during the 20th century, when the health and life expectancy of the US population improved dramatically. Since 1900 the average lifespan of people in the US has lengthened by more than 30 years—25 years of this gain is due to public health advances. According to the Centers for Disease Control and Prevention (CDC), the ten greatest US public health achievements of the 20th century are the development of vaccines, efforts to improve motor vehicle safety, workplace safety initiatives, control of infectious diseases, efforts to reduce

deaths attributable to heart disease and stroke, food safety laws, maternal and child health initiatives, family planning efforts, fluoridation of drinking water, and recognition of tobacco use as a health hazard.

The public health domain is multifaceted and includes activities such as monitoring disease, preventing and containing communicable disease, promoting health, ensuring air and water quality and food safety, preventing injuries and violence, and protecting workers' health and safety. Strategies to improve the public's health also include broad-based community interventions, such as promotion of sound nutrition, exercise, and healthy behaviors; prevention of disease and disability; research and education; epidemiological work; water treatment; and sewage disposal.

Outbreaks of communicable and environmental diseases, such as HIV/AIDS, West Nile virus, viral meningitis, avian flu, and anthrax contamination, remind us of the importance of shoring up and maintaining a sustained investment in the nation's public health infrastructure at the federal, state, and local levels. Since September 11, 2001, policymakers have a renewed interest in developing state and local capacity to handle the public health challenges facing our nation. The devastating effects of Hurricane Katrina and the heightened threat of bioterrorism and pandemic influenza have reinforced this need. Unfortunately the challenges are increasing at a time when fewer public resources are being allocated for public health activities.

Funds generated through settlements between tobacco companies and a number of states represent an opportunity to enhance public health programs and related health care activities, although some states have diverted these funds to other purposes, including balancing state budgets.

The 2010 Patient Protection and Affordable Care Act (ACA) directs the Department of Health and Human Services (HHS) to conduct a national prevention and health promotion outreach and education campaign that will raise awareness of activities to prevent chronic disease and to promote health. The campaign will be developed and launched through a new public-private partnership. In addition, HHS is required to maintain a website to provide science-based health promotion and disease prevention information for health care providers and the public, as well as a web-based personalized prevention plan tool that individuals can use to determine their risk for disease and receive tailored advice. Finally, HHS must provide guidance to states and health care providers on prevention and obesity-related services available to Medicaid beneficiaries, including dual-eligibles (i.e., Medicare beneficiaries who are also eligible for Medicaid). The CDC is required to establish and implement a national science-based media campaign on health promotion and disease prevention.

The ACA also improves public health policy by taking steps to ensure that all Americans receive critical clinical and community preventive services. The law makes public health and prevention a permanent part of the health care system by investing in state, territorial, and local public health infrastructure and by providing grants to implement recommended services.

Of particular interest to older Americans is the ACA creation of Healthy Aging Programs. These require the CDC to fund state and local year pilot programs designed to improve the health of people age 55 to 64 through community-based public health interventions.

The ACA addresses the public health obesity crisis by requiring chain restaurants with 20 or more locations to post calorie content directly on menus and menu boards of restaurants, retail food establishments and vending machine operations. Other nutritional information must also be made easily available to customers.

The ACA also requires HHS to evaluate community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. Programs that must be considered are those that have demonstrated the potential to help beneficiaries (especially those 65 and older) reduce their risk of disease and disability. In conducting the evaluation, HHS must review published literature, best practices, and resources relevant to programs that promote healthy lifestyles and reduce risk factors for the Medicare population. Areas that must be reviewed include: physical activity, nutrition, obesity, falls, and mental health. HHS must submit a report to Congress by September 30, 2013.

Finally, the ACA requires the Government Accountability Office (GAO) to conduct a study on the ability of Medicare beneficiaries age 65 and older to access recommended vaccines covered under Medicare Part D. This study should shed light on the

extent to which vaccines are being covered by Part D plans and whether Medicare beneficiaries are accessing these vaccines. The study will include recommendations on how to increase access to immunizations among Medicare beneficiaries. A report to Congress on the issue is due June 1, 2011.

Other (selected) public health initiatives created by the ACA include the following:

- Creation of Community Transformation Grants designed to promote individual and community health and reduce disparities.
- Establishment of the National Prevention, Health Promotion and Public Health Council within HHS to develop a national prevention and health promotion strategy and provide recommendations to the President and Congress on pressing health issues.
- Creation of a new Prevention and Public Health Fund designed to expand and sustain the necessary infrastructure to prevent disease, detect it early, and manage conditions before they become severe. This new initiative will increase the national investment in prevention and public health, improve health, and enhance health care quality. The Prevention and Public Health Fund, established as part of health reform, is a 10-year $15 billion commitment to wellness.
- Creation of a demonstration program that will make grants available to state Medicaid programs to test the use of evidence-based incentives for Medicaid beneficiaries to prevent chronic diseases.

Climate Change and Public Health

Public health challenges resulting from climate change include greater exposure to unsafe temperatures (both heat and cold) as well as severe weather events such as hurricanes, increased air pollution, and increased exposure to pathogens secondary to weather events. A 2010 AARP Public Policy Institute study, Affordable Home Energy and Health: Making the Connections, notes that for many older adults, the aggravation of existing health conditions from exposure to even moderate temperature changes is a serious concern. Adverse health outcomes, including death, become more likely as temperatures deviate from a moderate range. Greater numbers of temperature-related deaths occur in warmer regions exposed to unseasonable cold and colder regions experiences atypical warming. Further, lower socioeconomic status is associated with a greater risk of temperature-related death, particularly for older adults. Key to mitigating the health effects of such temperature changes is central air conditioning and home heating. However, unaffordable home energy subjects many older adults to direct and indirect threats to their health and safety. For example, 32 percent of Low-Income Home Energy Assistance Program (LIHEAP) households, which include an older person, report going without medical or dental care as a result of high home energy bills in the past five years. Policies and programs to address the health threats posed by climate change and high home energy costs can build on existing efforts in health and long-term care service to improve patient health status, reduce the economic costs of avoidable health care services, and facilitate independent living.

PUBLIC HEALTH: Policy		
Public health	FEDERAL STATE LOCAL	The federal government should develop a strategy that will assure the public that chain restaurants that are subject to calorie disclosure requirements use a reasonable basis for developing their nutrient content disclosures. The federal government should also make regular public disclosures of whether or not "reasonable" methods are being used to determine caloric values. Governments should work together to develop, fund, implement, and evaluate strategies to improve and protect the public's health. Governments should bring public health issues to the attention of the nation, promote the application of scientific knowledge in policymaking, support the collection and analysis of health data, and strengthen state and local capacity for the delivery of public health services. Public health officials at all levels of government should coordinate their efforts.

Public health (cont'd.)	FEDERAL STATE LOCAL	Sound public health protection and promotion, disease prevention, and intervention strategies should be evidence-based and have proven efficacy. Costs and benefits should be considered but not be determinative. In addition to infrastructure development (such as laboratory capacity, provider education, and surveillance capacity), federal, state, and local strategies to improve the public's health should focus on broad-based community interventions, such as promotion of healthy lifestyles, prevention of disease and disability, research and education, epidemiological work, water treatment, and sewage disposal. Federal, state, and local governments should support policies that promote healthy behaviors, provide incentives for people to engage in them, and strengthen the physical infrastructure that supports health-promoting behaviors.
Funding	FEDERAL STATE LOCAL	Financial resources dedicated to activities that protect the public's health should be strengthened. The federal and state governments should: • increase funding for public health activities at the national, state, and local levels; enforcement of public health, environmental and safety standards; research; and public and professional health education; • direct sufficient financial and technological resources toward solving environmental problems and work cooperatively with the private sector to address environmental concerns; • direct sufficient financial and technological resources toward the timely development and manufacture of safe and effective vaccines—During vaccine shortages the federal and state governments should not adopt policies that allocate vaccines solely on the basis of age; • provide financial support for research into identifying effective strategies to protect the public from biological assaults; and • provide funding to ensure that key public- and private-sector health care personnel are adequately prepared to respond to public health crises relevant to their areas of practice.
Pollution control	FEDERAL STATE	Public agencies should take specific and effective steps to control all forms of pollution (including biological and chemical agents) that threaten health, safety, and quality of life.
Emergency and crisis planning	FEDERAL STATE LOCAL	Governments should work collaboratively to identify, develop, fund, and implement timely and effective plans to respond to national, state, and local public health crises. Governments should develop strategies designed to meet the health care needs of people affected by catastrophic events (e.g., hurricanes, avian influenza, etc.). Such strategies should, at a minimum, finance health care for a reasonable period of time for those without coverage and ensure the availability of needed services. The federal government should require all states to develop comprehensive disaster plans designed to adequately protect the health and welfare of vulnerable populations, including older adults, during a public health crisis.

Emergency and crisis planning (cont'd.)	FEDERAL STATE LOCAL	Congress should review the health care systems of US territories and the adequacy of federal funding to support a health care infrastructure that can promote disease prevention and health promotion.
Health promotion	FEDERAL STATE	When awarding grants to entities to conduct pilot programs designed to improve the health in people age 55–64 through community-based public health interventions, the federal government should develop a method to evaluate the impact of the Healthy Aging Programs on Medicare costs to the extent feasible. When developing and implement a national prevention and health promotion outreach and education campaign, the federal government along with its private sector partners should identify and take into consideration the special needs, concerns, and barriers faced by members of racial and ethnic minority groups. Such strategies should also be designed and delivered in a culturally and linguistically competent manner. When developing web-based tools to disseminate health promotion and disease prevention information and to develop a personalized prevention plan, the federal government should ensure that such tools are developed in a culturally competent manner and make such tools available in as many languages as is feasible and/or provide some sort of web function that allows for easy translation. Federal and state governments should undertake a variety of activities designed to promote public health, including: • identifying health-promoting behaviors, ways in which such behaviors are linked to health improvements, and the costs and benefits associated with health-promoting behaviors; • adequately funding health promotion programs (e.g., nutritional counseling, exercise and weight control programs, and drug-, alcohol-, and tobacco-addiction treatment programs), preventive health education programs for people most in need, and access to preventive health services; • educating individuals about risk factors for prevalent health conditions, behaviors that reduce health risks (e.g., exercise and nutrition), and the importance of preventive care (e.g., mammography, cancer screening, early immunizations for children, and influenza and pneumococcal pneumonia immunizations for older Americans); • educating the public about the effect of guns and violence on the public's health, as well as the widespread human costs of preventable injuries; • supporting the inclusion of prevention and health promotion content in curricula for health care professionals; and • supporting outreach and education about the value of engaging in healthy behaviors, with information targeted to policymakers, consumers, and employers.
Community-based prevention and Medicare beneficiaries	FEDERAL	The federal government should include an identification of barriers to the use and dissemination of promising community-based practices designed to promote healthy lifestyles and reduce risk factors among Medicare beneficiaries.

Research	FEDERAL STATE	Federal and state governments should support research that identifies the effects of health-promoting behaviors on public health (e.g., the impact of exercise on cardiovascular health) and fund cost-benefit research on health-promoting behaviors with regard to both the public and private sectors (e.g., the cost to employers of workers' inactivity).
Personal responsibility	FEDERAL STATE LOCAL	Individuals have a responsibility to safeguard their health by taking advantage of health education opportunities and affordable and appropriate preventive health measures.
Communicable diseases	FEDERAL STATE	Individuals should be educated about behavioral risk factors for contracting and spreading serious communicable diseases such as tuberculosis, hepatitis, and HIV/AIDS. Programs should teach all individuals who know or have reason to believe that they may be infected to protect others from infection and to advise those whom they know to be at risk to seek testing. The outcome of such tests should be confidential, consistent with public health responsibilities, and subject to the requirements of confidentiality standards.
Smoking bans	FEDERAL STATE	Federal and state governments should enact legislation banning smoking in nonresidential public buildings, on public transportation, and in restaurants.
Tobacco settlements	FEDERAL STATE	Preference for allocating government revenues from tobacco company settlements should be given to programs designed to improve public health, including Medicaid and Medicare, antismoking and smoking-cessation programs, and efforts to expand access to long-term care and other health care services. Tobacco settlement funds should not replace existing federal or state funding in these areas. To promote government accountability, states should develop a public process for deciding how tobacco settlement funds should be spent and for disclosing annually how they are spent. The disclosure method should be designed to bring the information to the attention of the general public. State governments should ensure that their public health infrastructures are adequate, strong, and sustainable over the long term before they use tobacco settlement funds to balance state budgets.
Planning for climate change	FEDERAL STATE LOCAL	In planning to prevent and mitigate potentially adverse health effects of climate change on older people, federal, state and local governments should: • expand categorical eligibility for the Low-Income Home Energy Assistance Program (LIHEAP), weatherization services, and other affordable energy programs to target groups identified as most at risk of adverse health outcomes, for example, through their eligibility for state Medicaid waiver programs and the Medicare Part D Low-Income Subsidy. (See also Chapter 10 Utilities: Telecommunications, Energy and Other Services: Low-Income Energy Assistance Programs.); • ensure that intake services for state Medicaid waiver program participation and long-term care case management services

Planning for climate change (cont'd.)	FEDERAL STATE LOCAL	• include referrals for LIHEAP, weatherization, and other affordable energy programs; • support education and outreach efforts to increase awareness – both within the health care community and among older adults, their families, and caregivers—of resources that can help them maintain access to healthy and comfortable temperatures; • give priority to in-home repair or modification programs that serve medically frail participants (such as under a state Medicaid waiver) to cost-effective energy efficiency measures that protect health and safety, for example, special coatings for flat-roofed row houses that lower indoor temperatures in summer. (See also Chapter 10, Utilities: Telecommunications, Energy and Other Services: Low-Income Energy Assistance Programs); and • identify and implement best practices for communicating with the public, especially older adults, their families, and caregivers about the risks of heat waves and cold temperatures, links between temperature and health, and the most effective prevention, education, and response efforts.

Medical Research

The US leads the world in biomedical research. The country's premier research agencies are the National Institutes of Health (NIH), which focuses on biological research, and the National Science Foundation (NSF), which focuses on breakthroughs in basic sciences. A continued national commitment to investing in these areas is essential if the US is to remain at the forefront of medical breakthroughs for illnesses and disabilities that affect Americans of all ages and backgrounds.

The NIH is comprised of 21 institutes and 6 centers. The institutes include: Cancer; Eye; Heart, Lung, and Blood; Human Genome Research; Aging; Alcohol Abuse and Alcoholism; Allergy and Infectious Diseases; Arthritis and Musculoskeletal and Skin Diseases; Biomedical Imaging and Bioengineering; Child Health and Human Development; Deafness and Other Communication Disorders; Dental and Craniofacial Research; Diabetes and Digestive and Kidney Diseases; Drug Abuse; Environmental Health Sciences; General Medical Sciences; Mental Health; Minority Health and Health Disparities; Neurological Disorders and Stroke; Nursing Research; and the National Library of Medicine.

NIH centers include: Center for Complementary and Alternative Medicine; Center for Research Resources; Center for Information Technology; Center for Scientific Review; *John E. Fogarty* International Center, and the NIH Clinical Center.

To accomplish our nation's research agenda, there are times when the participation of human subjects in clinical trials is required. Certain protections are required when human subjects participate in these trials.

In addition to research involving human subjects, other promising fields of study involve stem cell research and genetic research. These areas of research are often the subject of controversy, and like research using human subjects, have many ethical considerations.

The research agenda at the NIH is very broad and includes a focus on such issues as cancer prevention, prevention of aging-related diseases and disabilities, and exploring the uses of complementary and alternative medicines (CAM), such as acupuncture and herbal remedies.

A recent addition to the medical research agenda includes a focus on pain management. The 2010 Patient Protection and Affordable Care Act (ACA) has two provisions that are designed to advance the state of the science related to pain management.

First, the law requires the Department of Health and Human Services (HHS) to enter into an agreement with the Institute of Medicine (IOM) of the National Academy of Sciences to convene a conference on pain. The goal of the conference is to advance research and treatment for pain care management.

In addition, the NIH is encouraged to continue and expand—through the National Pain Consortium—a program of basic and clinical research on the causes of and potential treatments for pain. The NIH Pain Consortium was established to enhance pain research and promote collaboration among researchers across the many NIH Institutes and Centers that have programs and activities addressing pain.

Finally, the 2010 Patient Protection and Affordable Care Act (ACA) requires HHS to establish a Patient-Centered Outcomes Research Institute (Institute) to conduct, support, and synthesize research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed in clinical settings. This research will be supported, in part, by a newly-created Patient-Centered Outcomes Research Trust Fund (PCORTF) funded by fees imposed on insurers of health plans and employer sponsors of self-insured health plans.

The reduction of racial and ethnic health disparities, is one of the nation's top priorities.. So much so that the ACA requires all federally conducted or supported health programs, activities, or surveys to collect, among other things, data on race, ethnicity, and primary language. HHS is tasked with developing methods for the reporting of such data. Such data will be very useful in helping the US develop a targeted research agenda designed to reduce health disparities.

The NSF funds research in the basic sciences, such as mathematics and biology that can contribute to our understanding of a range of issues that impact health. For example, NSF has funded studies that examine molecular and cellular function, biogenetics, and environmental health.

MEDICAL RESEARCH: Policy		
Investment	FEDERAL	Policymakers should provide: • greater investment in research on the aging process, particularly on diseases associated with aging, such as dementia (including Alzheimer's disease) and Parkinson's disease—AARP also endorses continuing research on diseases, such as HIV/AIDS, and chronic conditions affecting both younger and older Americans. Further, AARP supports continued research on complementary and alternative medicine; • adequate funding for the nation's leading health research agencies to carry out a comprehensive health research agenda designed to promote health and wellness in all settings and across settings; • NIH funding for specific diseases should be allocated fairly and equitably; and • adequate support for basic science, stem cell, and genetic research, both to advance research into preventing and treating serious diseases and conditions affecting people of all ages and to ensure that the US remains at the forefront of biomedical research and development.
Allocation of funds	FEDERAL	Policymakers should ensure equitable allocation of funding both for research addressing the health concerns of women and minorities and for research on racial and ethnic disparities in health care, especially with respect to health conditions for which minorities and other special populations have disproportionately negative outcomes.
Prevention	FEDERAL	Policymakers should expand and adequately fund opportunities to test the efficacy of health promotion efforts and disease prevention efforts across all care settings. Best practices should be disseminated among states and localities.
Complementary and alternative medicine (CAM)	FEDERAL	Policymakers should support further study of the safety and efficacy of particular CAM treatments.

Pain research	FEDERAL	The federal government should ensure that its research on pain management takes into consideration cultural differences in attitudes toward pain management, as well as racial and ethnic disparities in the use of pharmacological agents to control pain.
Commercial application	FEDERAL	The federal government should monitor and make public the extent to which publicly sponsored research contributes directly to the development of commercial products by private entities.
Standards	FEDERAL	Policymakers should ensure that the national research agenda, especially projects involving human subjects, is carried out with the highest ethical and safety standards. Clinical trials should include diverse populations, including older subjects, where appropriate. In developing standards for the collection of data of race, ethnicity, and primary language, the federal government should consider whether and how such methods as geocoding and surname analysis may be used as well as when their use is contraindicated.

HEALTH CARE WORKFORCE AND EDUCATION

Financing, Education, and Training

Workforce Composition—An effective workforce is essential to achieving the goals of health care access and equity for all. To be most effective, the health care workforce should be of an appropriate size to ensure access for all without encouraging overuse of services; include the right mix of providers, including physicians, nurses, therapists, direct-care workers, and allied health professionals as well as the right balance of primary care providers and specialists; and have the right skills and education to meet the care needs of the population. (This section addresses the acute and post-acute care workforce. For a discussion of workforce issues related to long-term care, please see Chapter 8.) Finally, our workforce must be allowed to function effectively, with the authority and scope to provide the care they are trained for.

Our existing workforce faces deficits in each of these areas. These deficits threaten the success of health reform implementation and the health care of all Americans, especially older Americans who face higher rates of illness and are more likely to be frail or have cognitive limitations.

The US faces shortages and unequal geographic distribution of various health care personnel, most notably nurses, primary care physicians, pharmacists, and nurse aides. The addition of some 32 million individuals to the insured population under the 2010 Patient Protection and Affordable Care Act (ACA) will exacerbate these shortages. The ACA recognizes the need for more primary care providers and takes a number of steps toward increasing the workforce, including higher pay for primary care providers treating Medicare and Medicaid beneficiaries (though these increases are only temporary), increasing advanced education opportunities for nurses, and expanding loan repayment programs. These efforts are important but are likely insufficient to address the shortages.

The primary care provider shortage is especially problematic because these providers will play an increasingly central role in managing care for chronically ill patients, providing medical homes for Medicare beneficiaries, and offering access to care for the millions of newly insured adults in the coming years. The delivery system reforms discussed previously in this chapter (see this chapter's section Program Administration and Beneficiary Information, Education and Outreach) depend on having enough primary care providers with the necessary training and skills to provide care in interdisciplinary teams and medical homes, and to manage patients with chronic diseases.

Shortages in some categories of health care specialists, particularly those trained to deal with the special needs of older patients, may have an especially deleterious effect on this population, whose numbers are growing rapidly. The number of geriatric specialists, which is already inadequate to meet the needs of older patients, is actually declining in relation to the increasing population of older people.

Shortages in other specialties may also threaten access, especially as the health care needs of the population change. Even in specialties that have enough providers overall, geographic imbalances may result in some patients having reduced access to care.

Graduate Medical Education

Financial support for the graduate medical education (GME) of physicians comes mainly from the Medicare program. In 2009 Medicare paid $9.5 billion to teaching hospitals in GME subsidies. The Medicare Payment Advisory Commission (MedPAC) has consistently found that Medicare's GME subsidies do not result in a provider workforce that is prepared to provide high-quality, high-value, and affordable care now or in the future.

In June 2010 MedPAC issued a set of recommendations for overhauling Medicare's support for GME. The recommendations are based on two key principles: "the need to decouple Medicare's GME payments from fee-for-service payment systems, and the need to ensure that resources for GME are devoted to meeting educational standards and outcomes that can improve the value of our health care delivery system." The recommendations call for establishing performance standards for GME programs, linking Medicare's GME funds directly to achievement of these standards, better reporting of how GME funds are distributed, and more workforce analysis to determine how many residency positions, in total and by specialty, are needed going forward to meet the needs of our changing population.

AARP endorses the Institute of Medicine's (IOM's) March 2008 study, "Retooling for an Aging America: Building the Health Care Workforce," which underscores the need for more medical and nurse educators and increased federal funding for such faculty positions.

Medicare reimbursement to hospitals for the costs associated with operating nursing diploma programs is by far the largest federal source of funding for nurse education. However, while nursing education has changed substantially, Medicare's payment policies have remained largely frozen since 1965. As a result Medicare support for nursing education goes largely to a single type of institution and misses a tremendous opportunity to play a more significant role in solving our nation's nursing shortage. Updating these payments would help contain costs and increase quality by producing more skilled chronic care managers, increasing access to primary care, and expanding the number of health professionals with an expertise in geriatrics.

In addition to having the right number and mix of providers, we need to make sure that all providers have the skills needed to provide high-quality, efficient care to an aging population. All workforce personnel should be able to function effectively in cross-disciplinary medical teams and accountable care organizations, should understand their role in managing chronic illness in patient-centered medical homes, and should be skilled in providing care to a diverse range of patients. The necessary skills for providing high quality care are learned first during medical school and residency, nursing school, or other appropriate training site. Learning should continue throughout one's career. Responsibility for ensuring that providers have the necessary training lies not only with medical or nursing schools, but with state licensing agencies, provider boards, and other professional organizations.

AARP endorses the findings and major recommendations of the IOM's October 2010 study "The Future of Nursing: Leading Change, Advancing Health," a blueprint for action that centers on developing a nursing workforce that is prepared to deliver patient-centered care in the 21st century. The Future of Nursing report emphasizes that nurses are essential to providing higher quality care, both as leaders and clinicians, and that any effort to refine the system requires their comprehensive, continued contributions. Nurses are on the front lines, delivering care where Americans live, work, learn and play—in hospitals, schools, homes, workplaces, long-term care facilities, and community public health centers. To continue to improve health care for all Americans, we need to make significant improvements to the way nurses are educated and empowered to lead change and advance health.

Our society is becoming increasingly diverse, culturally and ethnically. Patients from different cultures and ethnic groups bring with them different traditions and sensitivities that affect the way they interact with the health care system. Providers commonly lack knowledge about the health care views of these patients. This impedes clinician-patient communication and makes successful patient outcomes less likely. In addition, a perceived lack of understanding and respect for varying traditions and sensitivities may discourage people from different cultures and ethnic groups from even seeking appropriate health care. There are few programs in health care education curricula designed to teach future health care professionals about different cultural perspectives on health care.

Efforts to bring more underrepresented minorities into the health workforce have had limited success.

The Association of American Medical Colleges has long worked to increase the number of underrepresented minorities in medical school. Despite these efforts, only about 13 percent of first year medical school enrollees were underrepresented minorities in 2010. According to the 2008 National Sample Survey of Registered Nurses (RNs), just 17 percent of the RN workforce was from a racial or ethnic minority as of 2008, though minority representation is improving with younger cohorts.

FINANCING, EDUCATION, AND TRAINING: Policy		
Graduate medical education (GME)	FEDERAL	Financial support for GME should not be the responsibility of Medicare alone, but should come from all payers in both public and private sectors. Medicare's support for GME should be reduced as contributions from other payers increase. This action should be taken gradually over time to allow the system to adjust. Medicare's support for GME should be tied to specific goals for residency training: physicians skilled in providing high quality, efficient care, who are able to function in interdisciplinary teams, accountable care organizations, and in medical homes. The Department of Health and Human Services (HHS) should establish standards for distributing GME funds that specify ambitious goals for practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice, including integration of community-based care with hospital care. Congress should reduce Medicare's current indirect medical education (IME) payments to fund performance-based medical education subsidies. Only those programs that meet the new standards described above should receive IME funds. Medicare's GME subsidies should be targeted to achieve specific goals related to workforce composition: • GME subsidies should be higher for primary care and specialties such as geriatrics that experience larger provider shortages, and should be higher for those programs that are most successful in training physicians willing to work in underserved areas, including minority, rural, and low-income communities. • GME subsidies should support the training of quality geriatric specialists available to meet the needs of the growing population of older Americans.
Graduate nursing education	FEDERAL	Mandatory funding for graduate nursing education and nurse residencies is necessary to ensure that there are enough primary care providers and chronic care managers in a reformed health care system in which millions of more Americans have access to coverage. Mandatory sources of funding for nursing education should also include incentives to direct advanced degree nurses to be nursing educators.

Graduate nursing education (cont'd.)	FEDERAL	Congress should reform Medicare payments for nursing education to substantially increase the number of nurses educated and entering the workforce. Reforms should provide for more equitable distribution of Medicare payments to all types of nursing education programs, colleges, and universities. The reforms should help to increase access to primary care in shortage areas, expand the number of expert chronic care managers, and increase the number of nurses skilled in geriatrics. Medicare funding for graduate nurse education should be targeted to achieve specific goals related to workforce composition, including nurses prepared to work in interdisciplinary teams, accountable care organizations, medical homes, and nurses working in underserved areas.
Nursing education	FEDERAL	Title VIII* funding should further expand preferential support to nursing education programs that promote education progression and advancement and a more highly educated nursing workforce. For example: • Further and increasingly rapid spread of partnerships between Associates Degree (AD) and Bachelors (BSN) and Masters (MSN) degree programs in nursing. • Rapid cycle increases in the relatively small (and not geographically dispersed) number of community colleges offering baccalaureate degrees in nursing. • Rapid increases in enrollments in AD—Masters nursing programs in the nation's universities. • Increasing BSN—Doctorate in Nursing options. • Accelerated BSN and MSN programs for students with degrees in other fields (accelerated MSN programs are much less common than BSN programs and should be an area of focus). • Online competency-based BSN programs, with local clinical placements and mentoring. • Increased enrollments in generic BSN programs or entry level MSN programs in the nation's universities. • University nursing programs that provide evidence of interprofessional training opportunities. CMS could also incentivize interprofessional teamwork through targeted support of interdisciplinary initiatives from the Center for Medicare and Medicaid Innovation. *States should fund nursing education funding that is synergistic with Title VIII funding and augmented by funding from private sources.
Funding for geriatrics	STATE	States should explore funding and loan forgiveness programs to encourage students to train in geriatrics. When states employ financial incentives, they should be provided for all health professions where there is need.

Funding for geriatrics (cont'd.)	STATE	States should make grants available to establish divisions of, or centers on, geriatric medicine, support biomedical research on aging, and develop geriatric curricula for use in training in chronic care institutions.
Research and educational facilities	STATE	States should establish and expand research and educational facilities to meet the special needs of elderly people and people with disabilities, emphasizing the needs of older minorities and older women.
Partnerships	STATE	States should partner with hospitals, and offer incentives to colleges and universities to partner with hospitals, to create public-private partnerships to fund nursing faculty positions.
Student loans	FEDERAL STATE	The federal and state governments can provide incentives through student loan forgiveness to encourage nurses with masters and other advanced degrees to become faculty members.
Training	FEDERAL STATE	All health care providers should have appropriate training to address the unique health care needs of older patients. More emphasis should be placed on geriatrics and the special needs of older patients in medical and nursing school recruitment and core curricula. To ensure this, significant increases are needed in the number of medical and nursing faculty appropriately qualified to provide education and instruction in the care of older people. More geriatric-specific in-service training is needed to prepare health care workers in both institutional and noninstitutional settings to meet the physical and psychological needs of an increasing elderly population. Both primary care clinicians and mental health professionals should be trained in recognizing, diagnosing, and treating the mental health problems of older people and in how to refer patients with complex needs for interdisciplinary geriatric assessment when appropriate. States should: • mandate that professional schools with health and human services curricula require education in geriatrics and gerontology; • require providers renewing their professional license to submit proof of continuing education in geriatrics if they treat older adults; and • establish and enforce appropriate educational, training, and continuing competency standards for all health care providers, including those who represent themselves as having a specialty in geriatrics.
Diversity training	FEDERAL	In addition to stepping up recruitment and retention of minority students, health professional curricula should increase and improve understanding of, and sensitivity to, cultural and ethnic differences that may affect the health care needs of the increasingly diverse patient population.

Continuing Education and Licensing

Because clinical skills tend to decline over time and because increased clinical experience does not necessarily lead to better outcomes or improvement of skills, continuing education can play an important role in maintaining a well-qualified workforce. Continuing education is important to help clinicians and other health providers maintain their knowledge and skills and helps them remain abreast of changes in their area of training, as well as changes in the health care system as a whole. Continuing education, particularly when it addresses gaps or shortcomings in skills or knowledge, can help ensure competence of providers and improve quality of care for patients. However, participation in continuing education by itself should not be equated with evidence of continuing competence.

State licensing boards and professional boards each have a role to play in ensuring the ongoing competence of health professionals. A number of specialty boards oversee a maintenance of certification (MOC) process that allows providers to demonstrate their continued competence. For example, the American Board of Medical Specialties (ABMS) oversees a maintenance of certification process for 24 medical specialties in which board-certified physicians demonstrate ongoing expertise in six core competencies: patient care, medical knowledge, interpersonal and communication skills, professionalism, systems-based practice, and practice-based learning and improvement. The ABMS MOC process consists of a verification of credentials, a secure examination, and a self-evaluation that considers medical knowledge and practice performance.

Strong protections against poor-quality care and effective grievance and appeals procedures are needed to ensure patient safety. Oversight by licensing boards is essential to ensure compliance with standards. In an effort to assure the quality and competence of practitioners and facilitate the credentialing process, state licensing boards, state and federal enforcement agencies, professional societies and health care providers are required to report medical malpractice payments and adverse fraud and abuse actions taken against licensed health care providers, practitioners and suppliers. Adverse actions include criminal convictions, civil judgments, program exclusions, and adverse licensing and certification actions. These reports are made available through two limited access practitioner databases to federal and state government agencies, state licensure boards, Medicare contractors, health plans, and health care providers but are not available to the public. The 2010 Patient Protection and Affordable Care Act (ACA) eliminated duplication between these two databases and consolidated them into the National Practitioner Data Bank.

Clinician education is also important in the case of complementary and alternative medicine (CAM). Research indicates that a lack of communication between patients and clinicians about CAM can be risky. Dangerous and life-threatening interactions between conventional medicine and CAM can occur when a clinician is unaware of a patient's CAM use. One reason for this communication gap is that many clinicians do not ask about possible CAM use, often because they have limited knowledge of such therapies. Clinicians with proper training can better advise their patients to make safe and appropriate choices about CAM (see also this chapter's section, Medical Research).

The final component of effective workforce policy is making sure that state and federal regulations support all clinicians' ability to provide care to the fullest extent of their training. Because licensure is state-based, there are wide variations in scope of practice across the country for all health professions other than physicians. The lack of uniformity in language, laws, and regulations among the states creates barriers to effective practice, mobility, integrated delivery systems and the full and effective use of health technologies.

Specifically, practice boundaries for health care professionals are defined and enforced through professional credentialing boards and state licensing and scope of practice laws. "Scopes of practice" define the authority given by the state to health professionals who practice in that state. In effect the state, through scope of practice definitions, creates boundaries between professions and gives exclusive domains of control over the delivery of certain services. Defined in statute and regulations and interpreted in state courts, scope of practice acts vary tremendously by profession and state.

Despite opposition by some physicians and specialty societies, the strong trend over the past 20 years has been a growing receptivity on the part of state legislatures to expanded scopes of practice for nurses. For example, in 2007, Pennsylvania expanded the legal scope of practice for advanced practice registered nurses, physician assistants, and dental hygienists, with resultant improved health care outcomes state wide.

Because many of the problems related to varied scopes of practice are the result of a patchwork of state regulatory regimes, the federal government is

especially well situated to promote the effective reforms by collecting and disseminating best practices from across the country and creating incentives for their adoption.

Legislators who craft scope of practice laws must balance the competing interest of quality, cost and access. Increasingly states are confronted with dire access to care problems in areas with inadequate provider supply. There simply are not enough primary care physicians to care for an aging population now, and their patient load will dramatically increase as more people gain access to care. In addition there is growing interest in greater flexibility in use of health professionals because it is necessary for emerging models of care delivery that seek to improve coordination and efficiency.

For example, available evidence indicates that dental hygienists in independent practice are able to provide safe, competent care of a comparable quality to the care provided by dentists. If dental hygienists were allowed to provide the full array of services for which they are qualified based on their education and training, they will be able to help alleviate significant problems with access to oral health care.

In particular nurses are an essential component of the workforce, and there is need for greater professional mobility of nurses and more optimal utilization of nursing skills and training. In addition, direct care workers, particularly in long term care settings, are essential to the delivery of care. Efforts to broaden the scope of their clinical responsibilities are ongoing because they can play an important role in new models of care and there is a need to attract and retain more workers to this profession. Exploring pathways for all health professionals to provide services to the full extent of their current knowledge, training, experience and skills is essential where there are significant access to care issues due to shortages in providers and where new models of care that can improve the quality and efficiency of care delivery require changes in scope of practice.

CONTINUING EDUCATION AND LICENSING: Policy		
Continuing competency and continuing education	STATE	States should require all health professionals to maintain competency in their respective professions. Working with professional organizations, consumers, and other interested parties, states should work to phase in a mandatory continuing competency system for all health professionals that would include procedures to assess the continuing competence of licensees as a condition of periodic license renewal. State licensing boards should establish standards for ensuring continued competency and should consider granting deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care delivery institutions, when the private programs meet board-established standards. To assure providers' continued competence, state licensing boards should go beyond mandatory continuing education requirements to require demonstrations of continued competence that include periodic assessment of knowledge, skills, and clinical performance, along with development, execution, and documentation of an improvement plan based on the assessment.
Complementary and alternative medicine (CAM)	FEDERAL	Ongoing support is needed for clinician education on CAM and traditional medicine. Additionally clinicians should communicate with their patients about CAM usage. (For AARP's position on research funding for CAM, see this chapter's section Medical Research.)

Licensing	STATE	States should set strong licensing standards for all health care providers. States should ensure that licensing boards have adequate funding and authority to carry out their responsibilities, including vigorous investigation and disciplining of substandard providers. In conducting their licensing functions, states should discipline incompetent health care professionals and providers and eliminate substandard care by revoking or suspending licenses to practice and/or imposing other sanctions, as appropriate. States should review and revise licensing laws for health facilities as necessary to improve the administration and operation of their provider and physician oversight responsibilities. Reforms should increase the range of sanctions that can be taken against poorly performing providers and practitioners. States should have the proper professional licensure body oversee the type of health care professional and should not have duplicative and redundant licensing bodies for a single profession.
Information sharing and public disclosure	STATE	States should mandate public disclosure of disciplinary actions taken by health regulatory boards, and make this information easily accessible by consumers. States should encourage licensing bodies to promote patient safety performance standards for health care professionals by implementing periodic reexaminations and relicensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practices. Professional societies should make a visible commitment to patient safety by establishing a permanent committee dedicated to safety improvement. The committee should develop a curriculum on patient safety and encourage its adoption into training and certification requirements; disseminate patient safety information to its members; recognize patient safety considerations in developing practice guidelines and standards on the introduction and diffusion of new technologies, therapies, and drugs; work with the Center for Patient Safety to develop community-based, collaborative initiatives for error reporting and analysis; and collaborate with other professional societies and disciplines in a national summit on the professional's role in patient safety. Licensing boards should be required to share appropriate case information with peer review organizations and query the National Practitioner Data Bank before giving a clinician the right to practice.
National Practitioner Data Bank (NPDB)	FEDERAL	The federal government should permit public access to NPDB to assist consumers in choosing practitioners and providers.
Scope of practice	FEDERAL STATE	Current federal regulators and policies should be interpreted to allow advance practice registered nurses (APRNs) and physician assistants (PAs) to fully and independently practice as defined by their education and certification. The Centers for Medicare & Medicaid Services (CMS) regulations and policies should be updated as appropriate to include APRNs and PAs in the interpretation of the terms "physician" and "physician

		services" as providers of services that are within the scope of practice of the APRNs and PAs and would be covered if furnished by a physician. Medicare legislation and regulations should authorize PAs and APRNs such as nurse practitioners and clinical nurse specialists to certify patients for home health services and for admission to hospice, and clarify that they are authorized to certify admission to a skilled nursing facility, and to perform the initial admitting assessment. Medicare hospital conditions of participation should be amended or clarified to facilitate APRNs eligibility for clinical privileges and membership on medical staffs. Federally mandated physician supervision of APRNs in Medicare payment policy (that is more restrictive than state law requirements) should be eliminated to allow these licensed professionals to practice to the full extent of their licensure in hospitals, critical access hospitals, ambulatory surgery centers, skilled nursing facilities, centers of excellence, and other health care facilities regulated by CMS.
Scope of practice (cont'd.)	FEDERAL STATE	States should allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills where evidence indicates services can be provided safely and effectively. States should allow and expect different professions to share overlapping scopes of practice. States should amend current scope of practice laws and regulations to allow nurses, APRNs and allied health professionals such as dental hygienists to perform duties for which they have been educated and certified—These professionals should be monitored by the appropriate state licensing board and disciplined when they deliver inferior care or attempt to provide care that exceeds their capabilities. Current state nurse practice acts and accompanying rules should be interpreted and/or amended where necessary to allow APRNs to fully and independently practice as defined by their education and certification. States should require training and demonstrated competency (in both speaking and writing) in English as a second language, as appropriate. (For background and policy on state licensing and competency requirements, see this chapter's section Quality and Safety.)