PROTECT THE MOST VULNERABLE, INCLUDING SENIORS AND PEOPLE WITH PREEXISTING CONDITIONS

As the prevalence of chronic conditions in the United States continue to rise, innovative solutions to improve care for vulnerable populations should be a top priority. Vulnerable populations encompass individuals who are not able to receive necessary care or preventive measures due to barriers and may include seniors and people with preexisting conditions. Eighty-one percent of Americans aged 65 years and older have multiple chronic conditions, but the government's Medicare program faces considerable challenges in meeting the future needs of seniors.

The United States Census Bureau expects the number of adults aged 65 years and older to increase from approximately 49 million in 2016 to nearly 95 million in 2060. Our Nation must be prepared to provide quality healthcare for all of our seniors by focusing on removing barriers to competition and promoting free-market solutions.

Unfortunately, our current system is not prepared to meet the challenges of today—or tomorrow. The Hospital Insurance Trust Fund, which pays hospitals and post-acute service providers under Medicare Part A, will become insolvent in 2028. When this occurs, revenues will be insufficient to cover program costs by a projected 10%, leading to a reduction in payments, which trustees warn could result in a rapid curtailing of access to healthcare.

Liberal lawmakers have nonetheless supported a fiscally unsustainable expansion of the Medicare program by proposing to add new benefits and lower the eligibility age from 65 to 60, further undermining the solvency of the existing program. Instead, we need to ensure seniors are protected. These policies would make Medicare's impending financial insolvency worse, which threatens access to care. Moreover, adding new dental, vision, and hearing benefits will likely put upward pressure on premiums. Seniors have access to these benefits now through supplemental plans or Medicare Advantage plans and should maintain the option to choose the additional coverage that best meets their needs.

Moreover, lowering the Medicare eligibility age would cost a projected $155 billion and provide new access to coverage for only approximately 400,000 people. In reality, much of the money would go toward shifting millions of those ages 60 to 64 years from private coverage into a taxpayer-financed, government-run system. For example, the Congressional Budget Office estimates the proposal could shift 3.2 million people with employer coverage and 2.0 million with non-group coverage into Medicare.

Liberal lawmakers have also proposed creating a new federal Medicaid program in states that did not undertake Obamacare expansion. A new federal program would undercut the long-standing state-federal partnership in Medicaid and could have unintended consequences for those the program intends to serve—those with disabilities and pregnant women, parents, and children from low-income families. This program was proposed despite evidence that previous Medicaid expansion in other states had higher enrollment and costs than projected, which impacted state budgets without a clear benefit for population health outcomes. States already spend 17.1 cents of every state- generated dollar on providing Medicaid coverage. And states that expanded Medicaid enrolled twice as many able-bodied adults as estimated, with per-person costs exceeding original estimates by 76%, leading to a combined cost

overrun of 157% on average.

A better way forward is to implement policies that target improving care for vulnerable populations, rather than broad expansions of government-run programs.

Increased access to telehealth services during the COVID-19 pandemic is an example of a targeted solution. During this public health emergency, millions of seniors gained access to telehealth services, and the technological revolution of healthcare delivery accelerated seemingly overnight. Regulatory flexibilities in Medicare, including waivers for originating site and geographic location restrictions, allowed seniors in any part of the country, rural and urban, to immediately gain access to available telehealth services from any location, including their homes.

A December 2021 Department of Health and Human Services (HHS) report found that the number of Medicare telehealth visits increased from approximately 840,000 in 2019 to 52.7 million in 2020, and 92% of beneficiaries received telehealth visits from their homes. While CMS permanently expanded the number of telehealth services through regulatory authority in December 2020, certain critical flexibilities in telehealth delivery would require Congress to remove existing Medicare statutory restrictions, specifically on originating site and geographic location restrictions.

Another free-market solution to benefit seniors is to provide more choices through Medicare Advantage, the private health insurance plans that comprise one-third of Medicare's total enrollment. This was a key focus of the October 2019 "Executive Order on "Protecting and Improving Medicare for Our Nation's Seniors." A systematic review found that Medicare Advantage outperformed traditional Medicare in several key metrics. The use of Medicare Advantage resulted in more preventive care services, fewer hospital admissions and emergency department visits, shorter hospital and skilled nursing facility lengths-of-stay, and lower healthcare spending.

Care for the most vulnerable can also be improved by providing new flexibilities to pay for necessary medical services. In 2019, federal agencies expanded the use of Health Savings Accounts (HSAs) to cover healthcare services for a range of Americans with chronic conditions enrolled in high deductible health plans (HDHPs). HDHPs are not required to have a deductible for preventive care, and patients with HSAs can now pay for preventive care of chronic conditions before meeting a minimum deductible. This gives individuals more options in managing their health, and the approach could be broadened to allow insurance companies to offer condition-specific health insurance plans for the most common chronic conditions.

THE FACTS

- ★ The Hospital Insurance Trust Fund, which pays hospitals and post-acute services providers under Medicare Part A, will become insolvent in 2028.
- ★ States that expanded Medicaid enrolled twice as many able-bodied adults as estimated, with per-person
- ★ costs exceeding original estimates by 76%, leading to a combined cost overrun of 157%.
- ★ Medicare Advantage outperforms traditional Medicare, including more preventive care services, fewer hospital admissions and emergency department visits, shorter hospital and skilled nursing facility lengths-of-stay, and lower healthcare spending.

THE AMERICA FIRST AGENDA

At the federal level, support policies that:

- ★ Permanently remove originating site and geographic location restrictions for telehealth services in Medicare if evidence continues to support benefits for patients and appropriate utilization.
- ★ Allow Medicare to auto-enroll new beneficiaries in Medicare Advantage instead of traditional Medicare, with clear information on both options for all new enrollees.
- ★ Permanently expand the list of preventive care benefits for a range of chronic conditions that may be provided by a high deductible health plan.
- ★ Allow insurance companies to offer condition-specific health insurance plans for the most common chronic conditions.
- ★ Allow states to implement work requirements for Medicaid to align with other social safety net programs and create opportunities for tiered

support as job wages increase.

At the state level, support policies that:

★ Authorize states to apply for a Medicaid waiver to implement flexibility to the maximum extent of federal law. Develop a plan to submit federal waivers in coordination with their state Medicaid directors.

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