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# Seniors' Stake in Health Reform

## What it Means for Medicare Beneficiaries

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Marilyn Moon   November 2009



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# Introduction and summary

America's seniors, not surprisingly, are asking what health care reform means for them. Seniors, of course, receive the bulk of their health care services through Medicare, as do Americans under the age of 65 with disabilities. And even if there were no issues specific to this important government program in today's health reform debate—which there are—Medicare beneficiaries have the same stake as all of us do in an affordable health care system that works for everyone. All Americans will benefit from improved quality and efficiency in health care delivery, as well as the economic advantages of reducing the spiraling growth of health care costs and assuring that all Americans have affordable, comprehensive health coverage.

That's why it's important to clarify what really is at stake for seniors and disabled Medicare beneficiaries in Medicare. This paper reviews the two most discussed legislative proposals—The House of Representatives' Affordable Health Care for America Act (H.R. 3962) passed by the House on November 7, 2009, based on the America's Affordable Health Choices Act (H.R. 3200), which the three House authorizing committees passed this summer, and the Senate's America's Healthy Future Act, which passed the Senate Finance Committee earlier this month.<sup>1</sup> We examine provisions in the two pieces of legislation that both improve Medicare benefits and slow the rate of growth in Medicare payments to doctors, hospitals and other providers.

Specifically, we will demonstrate that the House bill is the more generous of the two for Medicare beneficiaries, although it is also the more expensive—in part because of these additional Medicare benefits. On balance, though, most of the reforms contained in the two bills would make Medicare a stronger program. Key benefit improvements, particularly associated with the House bill, include:

- Better protection against the costs of prescription drugs.
- Better access to primary care physicians through payment reform.
- Better coverage of preventive care and other health care services.
- New long-term care coverage.
- Expanded protections for those with low incomes.

Key reductions in Medicare spending include:

- Payment reform for Medicare Advantage plans offered by private insurance companies.
- Reductions in annual payment growth for hospitals and other non-physician providers.
- Some changes to Medicare premiums paid by Medicare beneficiaries.

If enacted, these reforms will improve our nation's health care system, but the impact of health reform's proposed changes for Medicare must be evaluated in a broader context. Just as health reform can substantially improve our health care system, even if it falls short of everyone's "ideal," so too can changes in Medicare improve its effectiveness—even if the legislation doesn't achieve all we'd like to see. Further, regardless of whether health care reform legislation is passed, pressures for holding down costs will continue—both for Medicare and for private insurance as taxpayers, employers and employees alike find that the rate of growth of spending to be an increasingly untenable burden.

The following analysis recognizes these broader issues while examining the specific issues of concern to America's seniors and disabled who rely on Medicare for their health care needs. Changes being proposed for the Medicare program include a combination of expansions and reductions in payments and modest improvements in coverage that, on the whole, will improve the program and achieve the goals of health care reform by:

- Encouraging better primary care and preventive care.
- Making physicians, hospitals and other health care providers conscious of finding ways to increase the productivity of care delivered.
- Rebalancing Medicare payment levels where they are either too high or too low.

The improvements are modest, but in line with the fiscal limits that Congress has prescribed for overall health care reforms. For Medicare beneficiaries, the House bill offers a number of advantages over the Senate version of the legislation. Specifically, the House bill would do more to improve coverage and provide protections to beneficiaries and would not increase income-related beneficiary premiums nor create a commission that would single out Medicare for arbitrary growth limits.

All Americans, however, recognize that while it is tempting to ask who wins or loses directly, we all have a stake in an improved health care system that meets the needs of all Americans. We can save costs and ensure appropriate emergency room services, for example, only by ensuring patients who could be treated better elsewhere have health insurance coverage, thereby reducing the burden on overcrowded emergency rooms. Similarly, new preventative services for those Americans who have poor access to health care will result in a healthier population, bolstering our ability to afford care and lowering the long-range costs of Medicare.<sup>2</sup>

The changes being proposed for Medicare are examined in detail in the pages that follow. This expansion of benefits clearly represents helpful improvements, but even the spending reduction proposals are reasonable within the context of system-wide goals. Our health care system will change over time, of course, but the goal is to make those changes apply fairly and reasonably for all Americans. The legislation now before Congress can achieve those two important goals.

# Better Medicare benefits

The expansion of benefits being considered for Medicare patients in the legislation now before Congress address some of the well-known gaps in benefits and assure that access to care will be improved over time. These are important first steps toward a more comprehensive benefit package for this group of the population. These include:

- Closing the so called “donut hole.”
- Payment reform and greater access to physicians.
- Better coverage for preventative health services.
- Long-term health care reforms.
- Expanded protection for low-income Medicare beneficiaries.

Consider each of these critical reforms in turn.

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## Closing the “donut hole” and other gaps in Medicare Part D drug coverage

Topping the list of coverage improvements are proposals to eliminate or mitigate the “donut hole” in Medicare’s drug benefit program by filling in insurance coverage for the period in which beneficiaries with annual expenses of more than \$2,700 (in 2009) have no insurance protection until they have spent \$3,454 out of pocket. After that, in the current program, catastrophic protection goes into place. This gap in coverage arose because President George W. Bush and Congress in 2003 limited subsidies to a predetermined amount that had to be stretched to cover both catastrophic expenses and enough basic coverage to encourage relatively healthy people to sign up for the benefit. That created today’s “donut hole.”

Evidence shows that enrollees in Medicare Part D plans who have chronic conditions and take multiple medications each day are likely to fall into the donut hole at some time during the year. About 3.4 million enrollees in Part D—about 14 percent of all enrollees—enter the coverage gap in any given year.<sup>3</sup> And a number of these beneficiaries stop taking at least some of their drugs during this period because of the costs. Private insurers could offer coverage for these expenses in the gap; they get no government subsidy so very few now do so, though some private plans cover inexpensive, generic drugs.

The House legislation would gradually eliminate the donut hole, raising the level of initial coverage by \$500 in 2011, with reductions thereafter until the donut hole is fully eliminated by 2019. This slow phase in is similar to changes in other parts of the legislation that also take place over time. For Medicare beneficiaries, this will mean modest increases in premiums—since they pay about 25 percent of the costs of the premiums while the federal government covers the remaining 75 percent. But out-of-pocket costs would fall for many enrollees. To fully eliminate the donut hole immediately would require spending of about \$134 billion over the next 10 years.<sup>4</sup>

In addition, the House bill requires drug manufacturers to offer discounts of 50 percent on the costs of brand-name drugs when patients are in the donut hole—and hence responsible for the full costs of their drugs—until the gap is fully eliminated. This requirement for discounts is also contained in the Senate bill.

The House bill would also require drug manufacturers to pay rebates for prescription drugs purchased by Part D enrollees who are dually eligible for Medicare and Medicaid. The Congressional Budget Office estimates the combined rebates and discounts in the House bill will not only cover the cost of closing the donut hole but also result in net savings of \$42 billion over 10 years.<sup>5</sup>

The House and Senate bills would also provide some important consumer protections. The House bill, for instance, would allow Medicare enrollees to change mid-year if their plan reduces coverage or increases cost sharing for drugs they take. This should help all beneficiaries who sign up for a plan only to find its coverage is not as helpful after changes are made and are currently locked in for a full year. Both bills include some additional restrictions and protections for those who sign up.

While these changes would not fully resolve the problems of inadequate drug benefits facing Medicare beneficiaries, the House bill does represent a substantial improvement over time.

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## Payment reform and better access to physicians

If not changed by law, Medicare payments to physicians will be cut by as much as 21 percent in 2010 because of a flaw in the government's payment update formula. These changes need to be made to the Medicare program regardless of health reform; for a number of years only temporary annual fixes have been offered because of the high costs of doing so. At this point, it is unclear whether Congress will handle this issue in the context of health reform legislation. The previous House proposal updated physician payment rates and addressed concerns with primary care payments. The new bill does not contain these provisions. Similarly, the Senate recently defeated a procedural motion on a proposal to fix the update formula, raising the possibility that only a short-term patch may be possible for now.

Regardless of the overall update fix, however, the bills recognize that we need to encourage a stronger primary care system for Medicare patients and include a number of other changes to both encourage growth in the numbers of primary care physicians and to compensate them for providing better and more comprehensive services. The concept of a medical home—comprehensive primary care practices that manage high-need individuals—is one of the ideas that shows promise to both improve the quality of care while holding down costs that arise from redundant or unnecessary tests, poor coordination of medications and excessive reliance on specialists.

A number of elements in the House bill address these issues. For example, beginning in 2011, a 5 percent bonus payment would be allowed for Evaluation and Management, or E&M, and other services for primary care physicians who offer coordinated, comprehensive, and accessible care to their patients and adds an additional 5 percent for those who practice in shortage areas. Funds would also be allocated to encourage more training of primary care physicians. The goal is to raise the status of primary care practice and to encourage such physicians to take a greater role in the care of their patients. Another 5 percent add-on payment would be offered to counties in the lowest fifth of Medicare spending. These changes are also intended to ensure continued strong participation by physicians in the Medicare program.

There are also a range of other changes in the House bill aimed at altering the payment levels for certain types of physicians—by increasing psychiatric service payment, for example, and by decreasing payment for advanced diagnostic imaging—to better reflect appropriate payment levels.

Separately, the House SGR reform bill will allow for a higher rate of growth for E&M and preventive services.

The Senate bill also recognizes the importance of improving payments for office visits by increasing these payments by 10 percent for primary care doctors who receive most of their revenues from these E&M services. This increase—alongside one for physicians in health shortage areas—would be paid for by taking the costs out of payments for other physician services.

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## Better coverage for preventive care and other services

Another set of changes proposed in both the House and Senate bills would expand access to preventive care services under Medicare. Currently, beneficiaries are required to pay Medicare Part B insurance deductibles and coinsurance on preventive services, potentially discouraging individuals from using these services. Both bills would eliminate these charges, which would reduce what beneficiaries must pay. And for beneficiaries with supplemental insurance, the premiums for such coverage should also fall over time.



The House bill also includes all federally recommended vaccines in this expanded coverage. These steps should help to improve access to preventive services for all Medicare beneficiaries. In the House bill, Medicare would also be required to cover immunosuppressive drugs indefinitely for kidney transplant recipients. Currently such coverage is only available for three years. The Senate bill also adds an additional service not found in the House bill—an annual physical or wellness visit for all beneficiaries. Under current law this is only available for those who are just coming onto the program.

Another covered service found in the House bill is for consultations for advanced care planning. This is the source of the infamous claims about a “death panel” requirement in the House legislation. Health care analysts and researchers have argued for a number of years that health care professionals do not do a very good job of helping patients sort out their options when they are facing challenges such as a terminal illness. These supportive services, helping patients who wish to discuss such issues, are not mandatory in this new covered benefit.<sup>6</sup> This provision is actually an expansion of services that were added in 2003 legislation without controversy. The Senate legislation explicitly eliminated a similar provision after this proved controversial.

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## Long-term services and supports

Although attention is heavily focused on the impact of health reform on coverage for medical services, millions of people face problems getting and paying for long-term services and supports along with their medical needs. Impairments in the ability to perform basic daily tasks such as bathing, dressing, eating or simply getting out of bed create the need for such personal assistance. An estimated 10 million people of all ages face this need, due to chronic conditions, disease, injury or developmental disabilities. Although just over 4 in 10 people needing long-term services are under the age of 65, the likelihood of needing service increases with age.

Medicare beneficiaries are painfully aware that Medicare does not cover long-term care support. Instead, Medicare coverage of home care and nursing home care is closely tied to episodes of acute illness and covers relatively short-term care, associated with “rehabilitation.” Medicaid, the nation’s long-term care safety net provided by the federal government and state governments together, provides coverage only when people are or have become impoverished and tends to emphasize support for nursing home care over care at home or in the community. Eligibility and coverage for non-institutional services also vary enormously across states.

Health care reform includes several provisions likely to significantly enhance support for people needing long-term supports. The most extensive provision, included in the House legislation, is the establishment of a new national, voluntary insurance program that would provide daily cash benefits to people with significant impairments. The benefits would be financed by employees’ voluntary payroll deductions. After contributing for five

years, individuals would be eligible for benefits, should they become disabled. Benefits are focused on the purchase of services for people at home. This new program is commonly referred to as the Community Living Assistance Services and Supports, or CLASS Act.

These provisions are all contained in the House bill, but were not included in the bill reported out of the Senate Finance Committee. The Senate Health Education and Labor Committee proposal, however, includes the full CLASS Act. This could be included in the full Senate's proposal.

People who need long-term care are often people with multiple chronic conditions. They are therefore also likely to benefit considerably from the payment reform efforts described above, which are aimed at enhancing primary care and creating medical homes and other organizational arrangements aimed at coordinating care. The most vulnerable Medicare beneficiaries needing long-term care who are also receiving Medicaid (so-called Medicare-Medicaid “dual eligibles”) will also benefit from health reform aimed at better integrating services across the two programs. Provisions to this effect are included in both House and Senate bills. The Senate Finance legislation includes a provision creating a new office charged with better integrating care for dual eligibles.

In addition, the Senate Finance Committee bill includes a number of provisions improving home and community-based services for low-income people with impairments. These include enhanced federal financing for states that offer community-based attendant supports—called Community First Choice—extending investment in home and community-based services and nursing home diversion programs, and establishing medical homes for chronically ill Medicaid beneficiaries.

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## Expanded protection for low-income Medicare beneficiaries

Another important area often identified for improving Medicare is more protection for low-income beneficiaries. Such protection is currently very limited. The proposed legislation by the House makes some important improvements.

The largest and most important change is to raise the asset limit used to determine eligibility for the Medicare Savings Programs and the Medicare Part D low-income subsidy benefits. Current law set these limits as low as \$4,000 for an individual. The new limits would be \$17,000 for individuals and \$34,000 for couples beginning in 2012. These changes would help Medicare beneficiaries whose incomes are very low but who have some minimal assets that currently make them ineligible for help.

In addition, low-income subsidy benefits are allowed to be retroactive to when the individual qualified if there is a delay in applying or processing this eligibility. This could be particularly important since outreach programs for these benefits have found that many beneficiaries

struggling to afford drug coverage do not know about them. The House bill also would simplify the enrollment process to encourage greater participation in the subsidy program. One of the Medicare Savings programs also would be extended in the bill to retain eligibility for those Americans with incomes up to 135 percent above the poverty level.

Both the House and Senate bills would waive coinsurance and deductibles under Medicare Part D for noninstitutionalized individuals eligible for both Medicare and Medicaid, or dual eligibles. This would lower their costs for prescription drug coverage—costs that for many dual eligibles were originally lower when the program was covered by Medicaid rather than Medicare Part D.

While it would be desirable to expand further the protection offered to Medicare beneficiaries to a level comparable to that for protections for younger families, the House bill nonetheless represents a step in the right direction.

# Medicare savings proposals

Proposed changes to Medicare payments as a primary means of financing health reform's benefits for the under-65 population has dominated news coverage of the effects of health reform on Medicare. Critics characterize these proposals as “starving” the program and threatening care. In reality, proposals to reduce spending are significantly offset by new investments contained in the House bill, as detailed above. The Senate bill, however, has less in the way of new investments. In both bills, though, the reductions address overpayments evident in the current Medicare program.

Furthermore, those reductions in payments are lower than reductions that have been made in the program several times in the past. And—in contrast to past payment reductions—the reductions included in the House and Senate bills will be offset by higher revenues flowing to health care providers from expanded coverage for younger Americans who currently do not have private health insurance.

When considering the payment reductions or savings described below, Medicare beneficiaries should recognize that of the total projected 10-year savings of \$550 billion in the House bill, a considerable amount goes to fund the changes described above to improve the Medicare program. Moreover, since a substantial amount of these reforms entail Medicare Part A (hospital insurance), they will extend the life of the Medicare Part A trust fund by five years—a key concern for beneficiaries as well as many policy makers.

Most of the savings described below will not have a direct impact on Medicare beneficiaries. In the House bill, the only area in which benefits would affect beneficiaries is for those in the Medicare Advantage program. The Senate bill would also make such changes and increase the income-related premium in Medicare Part B and add a new income-related premium to Part D. These latter changes would affect only a small portion of high-income beneficiaries. Most Medicare beneficiaries would not see any changes in the benefits they receive.

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## Payment reform for Medicare Advantage

Health care legislation enacted in 2003 established what are now regarded to be “excess” payments to the Medicare Advantage program.<sup>7</sup> The goal of the law was to encourage private health insurance companies to offer private plan options to Medicare beneficiaries by

enticing the private insurers with government-provided incentive payments. Presumably, this excess would have gone away once the new private plans began competing, resulting in lower payments over time.

In 2009, however, these payments still average 14 percent above what it would cost to provide Medicare coverage in the traditional fee-for-service portion of the government-run program. Despite a bidding process, Medicare Advantage plans still cost the Medicare program more and indirectly raise premiums for those not in private plans. As a consequence, this creates serious inequities between those in private plans and those remaining in traditional Medicare.

Private plans receiving overpayments often offer additional services to their enrollees, in the form of lower cost prescription drug plans or extra services. If, as proposed in the House legislation, payments to Medicare Advantage plans are reduced, then some of these extra services will likely be reduced or eliminated, or premiums to enroll in the private plans will rise. Many private plans have complained that this will hurt their enrollees.

How should such changes be viewed? In some ways, the House proposal is analogous to closing a tax loophole where people who previously benefited now must pay taxes comparable to those just like them but who did not have access to—or for other reasons chose not to use—the loophole. The loss of these windfall gains will undoubtedly be painful for some beneficiaries, but will not affect the bulk of Medicare recipients.

In 2009, more than 75 percent of Medicare beneficiaries were in the traditional part of Medicare and hence did not have access to any windfall benefits offered at government expense by private insurers. While many Medicare beneficiaries live in areas where such private plans exist, they choose not to enroll, often because they have multiple doctors upon whom they rely and who do not participate in the private plans. Others may live in areas where Medicare Advantage plans have not offered many extra benefits and will see little change.

And, even for those in Medicare Advantage, not all receive extra benefits. Private fee-for-service plans, which do not establish provider networks or otherwise coordinate care, provide few extra benefits. And because some of these plans offer different combinations of cost sharing, beneficiaries may pay even more out-of-pocket. About 23 percent of all those in Medicare Advantage are in private fee-for-service plans in 2009.<sup>8</sup>

Moreover, neither of the two bills is punitive toward existing Medicare Advantage beneficiaries. The House bill requires that the payments to private insurance companies be reduced (over a period of three years) to levels comparable to what it costs the Medicare program to provide benefits to those in the traditional fee-for-service portion of the program. If private managed care plans can in fact be more efficient than Medicare, as they claim but have so far failed to demonstrate, then payment levels should be sufficient to

continue offering some expanded services. And even once the payments return to the same level as the traditional Medicare payments, the legislation calls for bonus payments for high quality plans. On grounds of fairness, there is broad consensus that these changes need to be made. Altogether, these changes are expected to save about \$170 billion over ten years.

The Senate bill takes a different approach. It reduces the Medicare Advantage payments by a smaller amount and takes longer to phase in. Only modest changes would be made in 2011 and the full change would not be complete until 2015—as compared to 2013 in the House plan. The Senate plan also allows some of the payments to be “grandfathered” in certain areas of the country. Total savings in the Senate bill have been estimated at \$117 billion over 10 years.<sup>9</sup>

Finally, the House and Senate bills offer new consumer protection reforms that will improve assurances that when beneficiaries do enroll in Medicare Advantage, the plan will be one that meets the promises it makes. Marketing reforms and greater oversight on issues such as cost-sharing requirements and so called medical-loss ratios (to ensure that plans are paying out a substantial share of their premiums in benefits) should improve the care that individuals receive under these plans. The House and Senate differ in their approaches, but both would place more controls on the operation of private plan options.

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## Other savings provisions from reducing Medicare payment growth

In addition to the Medicare Advantage reform, changes affecting payments for many Medicare services will be reduced over their current projected levels in both of the bills. This generally means that the rate of growth of payments would be lower than the law currently dictates and in line with similar changes made over the past several decades.

Critical to evaluating these payment changes is whether they are consistent with the ability of health care providers to improve efficiency in service delivery or whether the changes will threaten access to care or the quality of care, especially relative to non-Medicare patients. But just as critical is whether these changes will likely be made over time anyway. Specifically:

- Are they necessary for the health of the Medicare program, which continues to be under financial pressure?
- Are they out of line with similar changes that have been made over time and have not resulted in declines in access or quality?
- Will they be consistent with how the rest of the health care system pays providers?
- What about other areas of reform?

The largest changes that result in savings are adjustments to the so-called market baskets that are used each year to determine how much payment rates will increase over the preceding year. These changes would have an across-the-board effect on services provided

by all types of health care institutions, including hospitals, skilled nursing facilities, and hospice care. These adjustments are intended to account for productivity increases that allow facilities to provide care without having to receive a full market basket update.

In the House bill, these savings are estimated to be about \$100 billion—less than 4 percent of the total payments that were projected to go to these services under Medicare Part A over the next 10 years.<sup>10</sup> In addition, payments will be frozen for a year for skilled nursing facilities and inpatient rehabilitation facility payments, largely because of analyses indicating that these payments are sufficient to retain access to care. Under the Senate bill, these productivity changes for Medicare Part A services would generate savings of \$116 billion.

Changes to Medicare Part B services other than physician payments are also proposed in both bills. Similar changes in annual updates to account for productivity improvements will be made for outpatient facilities, laboratory services, and some durable medical equipment. These reforms would add another \$40 billion in savings on the Part B side of Medicare under both the House and Senate bills. The Senate bill also includes a number of other reforms to the payment systems now in place. In particular, savings would be obtained from reforms to home health care services and a reduction in Medicare disproportionate share payments to hospitals that serve a high proportion of uninsured patients.

Will these changes harm access to care or the quality of care for Medicare patients? These same types of adjustments have been used extensively in the past, particularly in the 1980s and early 1990s. And health care providers responded rapidly to those Medicare changes. In response to payment changes in the early 1980s, for example, hospitals reduced their lengths of stay enormously.

More recently, the Balanced Budget Act of 1997 constrained growth rates in hospital payments by reducing the annual payment increases for hospitals. Prices were frozen in 1998 and then constrained in growth for the next four years. These savings were expected to slow hospital spending by about \$33 billion or about 8 percent of expected spending over five years. But the savings turned out to be even larger. Within three years, the expected insolvency date for the Medicare Part A trust fund, which covers inpatient hospital care, was extended from four to 25 years. While some later adjustments were made to soften the impact, hospitals nevertheless were able to achieve enough productivity increases that Medicare has remained a reasonable payer of bills.

For the past six years, Medicare has applied no such constraints, leaving open the opportunity for to pursue savings now. Hospitals may challenge reductions in payment updates with claims that they lose money from Medicare. Medicare payment rates are indeed below those of private payers, but for about two-thirds of all hospitals, Medicare's payments exceed the cost of care. Moreover, the Medicare Payment Advisory Commission, which advises Congress, has found that the hospitals that lost money on Medicare are in

areas where private insurers aren't pressuring them to reduce costs. Medicare payments exceed costs where hospitals are pressured to be more efficient. Efficient hospitals can be role models for the rest.<sup>11</sup>

Similarly, skilled nursing facilities and other specialty facilities have considerable room for efficiencies and show no signs of cutting access to Medicare patients. In the past, these institutions have done an excellent job of lobbying for adjustments when necessary, and MedPAC and others monitor care to determine if quality or access issues arise.

Reform legislation also would achieve savings by changing current incentives to providers in ways that improve the quality of care. The Congressional Budget Office, for example, estimates that over \$9 billion can be saved by reducing payments to hospitals that have high readmissions in care situations that were preventable. The goal is to get hospitals to take extra precautions to assure that patients do not have to return to the hospital unnecessarily. Savings from this source should be viewed as an improvement in care for beneficiaries as well.

Along with concerns about access and quality, assessing proposed savings must take into account the near-universal agreement that something must be done to rein in the costs of health care spending over time—not just for Medicare but for the entire health care system. Historically, the private sector has followed Medicare's lead in instituting payment reforms—an impact that becomes even more likely if health reform includes a public health insurance option that alongside Medicare seeks greater efficiency throughout the entire health care system. Generating financial pressures on hospitals and other providers to seek further ways to raise productivity is consistent with the long-run stability of Medicare and our overall health care system.

Both the House and Senate legislation address efficiency and productivity. Both bills, for example, provide funding for research on comparative effectiveness, which would encourage study about how well various alternative drugs or treatments work compared to each other. Such analyses are important since very little scientific evidence of what actually works well in practice exists. Many health care analysts believe this is critical to ensure reasonable costs in the future.

While there has been some concern expressed over such work leading to denial of care, the legislation is quite restrictive in terms of how comparative effectiveness research could be used. Nonetheless, better analysis and information on what works is an important tool in a world in which we must be conscious of the costs of care.

Both bills also propose the creation of a center for innovation in Medicare to explore issues beyond comparative effectiveness. In combination with requirements for demonstrations on the efficacy of the medical home model and other activities, the push for new ideas and approaches to health care—and the resources to support those innovations—could also generate positive outcomes for everyone.



Less clear is the benefit to be gained from a provision in the Senate bill that would create a 15-member Medicare Commission, which would operate independently to guarantee that Medicare would not grow excessively over time. While to some degree this is an extension of the changes above and has been cited by supporters as a way to assure continued savings over time, it could prove to be overly punitive on just one part of the health care system. The reason: Setting absolute growth targets fails to offer the flexibility that might be needed over time.

Consider this example. Because the allowed growth rate would be tied to GDP, what would happen in case of another severe recession such as we have been experiencing? The need for health care does not fall just because of a financial crisis.

Further, why establish such constraints on Medicare when it is the full health care system that needs to be examined seriously in terms of cost growth? It is important to assure that Medicare continues to be in the mainstream of health care delivery for our seniors and disabled Americans eligible for the program and not be inordinately singled out for change. If Medicare were to be penalized excessively, then savings could come at the expense of beneficiaries' access to care. And since other strong measures contained in the Senate bill will help to hold down costs over the next decade, a commission that would be unduly restrictive does not make sense at this point in time. It would seem to violate the strictures discussed above for evaluating whether the savings sought from Medicare would be harmful to beneficiaries.

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### Income-related beneficiary premiums

The Senate bill does propose to increase the income-related premium for Medicare Part B services and adds a new income-related premium to Part D that effectively reduces the subsidy now offered under the Medicare Part D drug benefit. For Part B, the proposal would freeze the adjustment that normally raises the threshold at which beneficiaries begin to pay the premium from 2011 to 2019. Thus, those who have incomes above \$85,000 for singles and \$170,000 for couples would continue to be subject to the tax for a number of years, rather than seeing these thresholds rise as the cost of living goes up. It would mean that more and more beneficiaries would be subject to the higher premium each year.

A new Part D income-related premium would operate in much the same way as that for Part B, effectively increasing the burden on those whose incomes are above the threshold. While the number of beneficiaries affected by this option would be small, it would raise the costs of Medicare for these individuals considerably over time, and expand the number of individuals subject to this higher premium.

# Endnotes

- 1 See *America's Healthy Future Act of 2009*, S. 1796, 111th Cong. 1 sess. (Government Printing Office, 2009) and *America's Affordable Health Choices Act of 2009*, H.R. 3200, 111th Cong. 1 sess. (Government Printing Office, 2009). In addition, a good comparison can also be found from Kaiser Family Foundation, "Side by Side Comparison of Key Medicare Provisions in 2009 Health Reform Legislation: H.R. 3200 and Senate Finance Committee Chairman's Mark" (2009) available at <http://kff.org/healthreform/upload/7948-3.pdf>.
- 2 See for example, J. Michael McWilliams, Ellen Meara, Alan Zaslavsky, and John Ayanian. "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine* 357 (2) (2007): 143-153.
- 3 Jack Hoadley and others, "The Medicare Part D Coverage Gap: Costs and Consequences in 2007" (Washington: Kaiser Family Foundation, 2008).
- 4 Congressional Budget Office.
- 5 Letter from the Congressional Budget Office to Chairman Chuck Rangel, October 29, 2009, available at: <http://cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf>.
- 6 Another claim that is now being made to give credence to death panels is the unrelated "reward" that will be given to physicians who do an effective job of coordinating care for patients. Physicians should be compensated for taking a larger role in helping patients navigate a complicated system; this is the intent of the medical home model and has no direct relationship to the counseling sessions described elsewhere in the bill.
- 7 See, for example, Medicare Payment Advisory Commission, "Report to Congress: Medicare Payment Policy" (2009).
- 8 Kaiser Family Foundation, "Tracking Medicare Health and Prescription Drug Plans" (2009).
- 9 Letter from the Congressional Budget Office to Senator Max Baucus, October 7, 2009.
- 10 Congressional Budget Office, "Medicare Baseline Projections" (2009).
- 11 Medicare Payment Advisory Commission, "Report to Congress: Medicare Payment Policy."

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