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# HOUSE HEALTH REFORM BILL WOULD STRENGTHEN MEDICARE

By Edwin Park

## Summary

The comprehensive health reform bill (H.R. 3962)<sup>1</sup> unveiled by House Democratic leaders on October 29 includes a number of significant changes to the Medicare program that would enhance benefits and improve the quality of care, as well as shore up the program's finances.<sup>2</sup> Much of the discussion of Medicare in the health reform debate has focused, however, on various proposals to secure savings in that program, and some seniors appear to believe that Medicare "cuts" made in health reform would make them worse off — or at a minimum, that as Medicare beneficiaries, they would be no better off.<sup>3</sup>

Yet this is not the case. The Medicare provisions in the House health reform legislation would both strengthen Medicare's financial footing and benefit most of the more-than-40 million seniors and people with disabilities whom Medicare covers. For example, the bill would do the following:

- **Eliminate the "doughnut hole" in the Medicare drug benefit over time.** Currently, Medicare beneficiaries are required to pay for 100 percent of the cost of their medications once they exceed an initial coverage limit. This gap in coverage discourages the use of needed drugs and likely produces poorer health outcomes. By closing the doughnut hole, the bill would, on average, lower beneficiaries' out-of-pocket drug spending by providing greater financial protection against high drug costs.
- **Expand access to preventive care services for Medicare beneficiaries.** Many of the preventive care services that Medicare covers, such as some screening tests for cancer, require

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<sup>1</sup> For an overall analysis of the House health reform bill, see Edwin Park, Judith Solomon, Paul Van de Water, Sarah Lueck and January Angeles, "House Health Reform Bill Expands Coverage and Lowers Health Cost Growth, While Reducing Deficits," Center on Budget and Policy Priorities, October 31, 2009.

<sup>2</sup> The bill merges the three bills approved this summer by the House Ways and Means, Energy and Commerce, and Education and Labor Committees.

<sup>3</sup> See, for example, Kaiser Family Foundation, "Health Tracking Poll," conducted October 8-15, 2009.

deductibles and/or co-insurance that can discourage their use by beneficiaries. The House health reform legislation would waive Medicare deductibles and co-insurance for all preventive care services.

- **Expand eligibility and increase participation in programs that assist low-income Medicare beneficiaries with their premiums and cost-sharing.** While the “Medicare Savings Programs” and the “Low-Income Subsidy” within the Medicare drug benefit provide substantial benefits (by covering the cost of the Medicare Part B premium or the premiums, deductibles, and co-insurance for prescription drug coverage), eligibility is limited and participation is relatively low. The House bill would both increase the number of beneficiaries eligible for these programs and make it easier for beneficiaries to enroll and stay enrolled.
- **Create incentives for health care providers to improve the quality of care they furnish to Medicare beneficiaries.** The House bill would change how Medicare pays a variety of health care providers like hospitals, physicians, and nursing homes in order to encourage greater coordination of care that could produce better health outcomes for patients at lower cost.
- **Make Medicare more efficient by modifying payment rates in order to lower costs while maintaining beneficiary access to the providers that care for them.** One key provision in the House bill would eliminate the overpayments that private insurers receive through the Medicare Advantage program. Currently, it costs 14 percent more to cover the same beneficiaries through private plans than it does through the traditional Medicare program. This and other payment changes produce significant savings to help pay for the cost of Medicare improvements and the overall health reform legislation. These measures also extend the solvency of the Medicare program by five years.

What follows is a more detailed discussion of these Medicare improvements in the House health reform bill.

## **1. Closing the “Doughnut Hole” in the Medicare Drug Benefit and Lowering Out-of-Pocket Drug Costs for Most Beneficiaries**

Under current law, Medicare beneficiaries who participate in Medicare’s Part D prescription drug benefit face a gap in coverage once their drug costs in a year exceed a coverage limit, such as \$2,700. Beneficiaries must then pay 100 percent of their drug costs until their total out-of-pocket drug costs (excluding the premiums) exceed a threshold set several thousand dollars higher. The result is that beneficiaries must pay as much as \$3,450 in drug costs within this “doughnut hole.”<sup>4</sup>

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<sup>4</sup> The standard Part D benefit in 2009 has an initial deductible of \$295, with the plan covering 75 percent of a beneficiary’s total drug costs up to \$2,700, and the beneficiary paying the remaining 25 percent of those costs. The beneficiary then faces a coverage gap and must pay all drug costs up to \$6,154 — i.e., the beneficiary must pay the next \$3,454 in drug costs (although some plans cover generic drugs to a limited degree within the “doughnut hole”). After that point, the plan covers 95 percent of any additional drug costs. It should be noted that most Part D plans do not actually provide the standard benefit but instead offer coverage that is actuarially equivalent to it. Low-income beneficiaries participating in the Low-Income Subsidy do not face a coverage gap. See Kaiser Family Foundation, “Medicare: The Medicare Prescription Drug Benefit,” March 2009.

Research conducted for the Kaiser Family Foundation found that in 2007, approximately 3.4 million Medicare beneficiaries had to pay the full cost of their drugs within the doughnut hole. More than 20 percent of beneficiaries in the doughnut hole who used certain classes of drugs stopped taking their medications, switched drugs, or reduced their use of medications once they reached the coverage gap. For example, among beneficiaries using drugs to treat diabetes, 10 percent stopped taking their diabetes medications altogether, and 5 percent reduced their use of those drugs, which could result in poorer health outcomes.<sup>5</sup>

The House health reform bill would address problems resulting from this coverage gap by eliminating it over time. Starting in 2010, the bill would both increase the dollar level at which the doughnut hole starts and lower the level at which it ends each year until the doughnut hole is fully closed in 2019. In addition, the House bill would require that while the doughnut hole is being closed, drug manufacturers must provide discounts of 50 percent on brand-name drugs used by beneficiaries within the doughnut hole.

By making the Medicare drug benefit more generous, the House bill would cause average Part D premiums paid by beneficiaries to rise somewhat. But beneficiaries' out-of-pocket prescription drug costs would decrease, on average, because closing the doughnut hole would provide substantially greater protection against high prescription drug costs. The Congressional Budget Office has previously reported that overall, this reduction in out-of-pocket drug costs would outweigh the increase in premiums.<sup>6</sup>

## **2. Increasing Access to Preventive Services by Waiving Deductibles and Cost-Sharing**

Greater availability of preventive care services can improve health and be cost-effective (that is, the clinical value of these services can outweigh the cost of providing them).<sup>7</sup> Last year, Congress provided the Secretary of Health and Human Services with the authority to add additional preventive services and tests to the Medicare benefits package, which generally has covered such services to a much lesser extent than private health insurance and Medicaid.

The House bill would ensure greater use of preventive services by Medicare beneficiaries by waiving deductibles and the usual 20 percent co-insurance for all preventive services, starting in 2011.<sup>8</sup> Deductible and/or co-payment charges thus would be eliminated for services such as glaucoma screening, colonoscopies, bone mass measurements for those at risk of osteoporosis, and other preventive services added by the Secretary. The House bill also would ensure that Medicare covers all vaccinations recommended by the federal government.

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<sup>5</sup> Jack Hoadley, Elizabeth Hargrave, Juliette Cubanski, and Tricia Neuman, "The Medicare Part D Coverage Gap: Costs and Consequences in 2007," Kaiser Family Foundation, August 2008.

<sup>6</sup> Congressional Budget Office, "Letter to the Honorable Dave Camp," August 28, 2009.

<sup>7</sup> Congressional Budget Office, "Letter to the Honorable Nathan Deal," August 7, 2009. CBO notes, however, that while preventive services are cost-effective (and can reveal early on a condition that could be treated for a fraction of the cost of treating the condition after it has progressed), they may not actually produce net savings overall because the cost of making preventive services widely available can outweigh the savings gleaned from detecting treatable conditions among the share of individuals who actually have those conditions.

<sup>8</sup> Some preventive services like diabetes tests and prostate cancer screening are already exempt from both deductibles and co-insurance.

### 3. Expanding Eligibility and Improving Participation in Programs That Help Low-Income Medicare Beneficiaries Pay Their Premiums and Cost-Sharing

Under the Medicare Savings Programs (MSPs), state Medicaid programs pay either the Medicare Part B premiums, or both the premiums and Medicare cost-sharing charges, for certain low-income Medicare beneficiaries.<sup>9</sup> Within the Medicare Part D prescription drug benefit, the Low-Income Subsidy (LIS) serves a similar role, subsidizing drug premiums, deductibles, and cost-sharing for low-income Medicare beneficiaries.

These programs make health care more affordable for low-income Medicare beneficiaries. For example, they pay the Part B premium of about \$1,158 in 2009. In addition, Social Security Administration data show that LIS beneficiaries receive an average of \$3,900 a year in assistance with their drug costs, including highly subsidized coverage for these beneficiaries within the doughnut hole. One study also found that enrollees below the poverty line who receive help with both premiums and cost-sharing were only half as likely as poor beneficiaries *not* enrolled in the MSPs to forgo seeing a physician because of cost concerns. They also were less likely to avoid going to the hospital or refilling a prescription.<sup>10</sup>

Unfortunately, most individuals eligible for the Medicare Savings Programs do not participate in them despite the very significant benefits they provide.<sup>11</sup> The Low-Income Subsidy program under Part D also suffers from relatively low participation among those eligible Medicare beneficiaries who are not enrolled in it *automatically*. (Medicare beneficiaries who also are enrolled in *Medicaid* are automatically enrolled in the LIS; other eligible low-income Medicare beneficiaries must apply to receive the subsidy.<sup>12</sup>)

According to the Medicare Payment Advisory Commission (MedPAC), Congress' expert nonpartisan advisory body on Medicare payment policy, the main reasons for low participation in these programs are a lack of awareness of the programs among low-income Medicare beneficiaries and the complexity of the eligibility rules and the application and retention procedures.<sup>13</sup> Medicare

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<sup>9</sup> Medicare beneficiaries with incomes below the poverty line receive assistance with premiums, deductibles, and cost-sharing through the Qualified Medicare Beneficiary (QMB) program. Low-income beneficiaries with incomes between 100 percent and 135 percent of the poverty line receive help with their Medicare premiums (but not deductibles and cost-sharing), through the Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI-1) programs. For a more detailed description of the MSPs, see Edwin Park and Danilo Trisi, "Improving the Medicare Savings Programs Would Help Low-Income Seniors Cope with Higher Medical Expenses," Center on Budget and Policy Priorities, May 20, 2008.

<sup>10</sup> Alex Federman, Bruce Vladeck, and Albert Siu, "Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program," *Health Affairs*, January/February 2005. See also Jack Ebeler, Paul Van de Water, and Cyanne Demchak, "Improving the Medicare Savings Programs," National Academy of Social Insurance, June 2006.

<sup>11</sup> Congressional Budget Office, "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit," July 2004.

<sup>12</sup> Kaiser Family Foundation, "Medicare: Low Income Assistance under the Medicare Drug Benefit," February 2008. See also Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2008.

<sup>13</sup> Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009.

legislation enacted last year included improvements to the MSPs and the LIS to expand eligibility somewhat and to try to make it less difficult for eligible beneficiaries to enroll and stay enrolled.<sup>14</sup>

The House health reform bill would take additional steps in this area. It would expand eligibility by substantially raising the maximum amount of assets that Medicare beneficiaries can have and be eligible for the LIS and MSPs from a maximum of \$6,600 for individuals and \$9,910 for couples to \$17,000 for individuals and \$34,000 for couples, starting in 2012.<sup>15</sup> It would also make it easier for low-income Medicare beneficiaries to document their income and assets when applying for the LIS. Currently, many state Medicaid and CHIP programs allow families to self-certify their eligibility information without burdensome paperwork, with the state subsequently verifying that information administratively through the use of public wage databases and other sources. This has proved to be successful in increasing participation among eligible children and families. The House bill would apply this approach to the LIS program, as well.

#### **4. Encouraging Health Care Providers to Furnish Higher Quality Care to Medicare Beneficiaries**

One area of discussion in health reform has been how to improve the delivery of medical care by providing incentives for hospitals, physicians, and other providers to furnish higher quality care at lower cost to patients in both private health insurance and public health insurance programs. For example, MedPAC has found that nearly 18 percent of hospital admissions among Medicare beneficiaries in 2005 occurred within 30 days of being discharged from the hospital. MedPAC also found that some of these readmissions could have been prevented if hospitals had provided better care during the initial hospital stay, ensured more accurate prescribing of necessary medications upon discharge, and improved post-discharge communication and coordination between patients and the doctors providing follow-up care.

Preventable readmissions result not only in poorer health outcomes for patients but also in higher costs; according to MedPAC, they increased Medicare expenditures by \$12 billion in 2005, with an average cost of \$7,200 per readmitted patient.<sup>16</sup> The current Medicare reimbursement system for hospitals fails to address this problem. Hospitals are paid separately for each hospital stay, even if a stay follows a very recent admission and discharge. As a result, hospitals are rewarded, rather than being subject to disincentives, when they provide inadequate care that leads to readmission.

The House bill attempts to address this problem by reducing Medicare payments to hospitals with high readmission rates to encourage them to do a better job in preventing avoidable readmissions.

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<sup>14</sup> See Families USA, "Congress Delivers Help to People with Medicare: An Overview of the Medicare Improvements for Patients and Providers Act of 2008," October 2008.

<sup>15</sup> Under current law, in 2009, the MSP asset limit is only \$4,000 for individuals and \$6,000 for couples. (Some states have raised those limits.) The LIS limit in 2009 for the most generous level of subsidy equals \$6,600 for individuals and \$9,910 for couples. Under Medicare legislation enacted last year, starting on January 1, 2010, the asset limit for the MSPs will be increased to the LIS asset limit and like the LIS asset limit, it will then be increased annually by inflation. The House bill would further increase the asset limit in 2012 to \$17,000 for individuals and \$34,000 for couples for both the MSPs and the LIS, with these limits being indexed by inflation in subsequent years.

<sup>16</sup> Medicare Payment Advisory Commission, "Report to Congress: Promoting Greater Efficiency in Medicare," June 2007.

The bill also establishes new pilot projects to test other changes in how Medicare reimburses health care providers. For example, the bill would experiment with “accountable care organizations” in which groups of physicians would be paid fixed payments and/or bonuses to provide coordinated and integrated primary and specialty care services to Medicare beneficiaries. The intent is to encourage physicians caring for the same patient to better coordinate their care, rather than providing episodic, fragmented health services.<sup>17</sup>

The House bill would also establish a “medical home” pilot project under which Medicare would pay a physician or similar provider to coordinate a beneficiary’s care and oversee the patient’s various treatments and providers. In addition, it would require the Secretary of Health and Human Services to develop a plan under which hospitals and post-acute care providers like nursing homes and rehabilitation facilities would receive so-called “bundled payments.” By receiving a single Medicare payment for all hospital and post-acute services, rather than being reimbursed separately as is the case today, hospitals and post-acute care providers would have greater incentives to coordinate care and provide more cost-effective care both during the hospital stay and after the patient is discharged.

Under the House bill, the Secretary would be required to expand the geographic scope of these various pilot projects if they prove successful in reducing costs and improving health care quality.

## **5. Instituting Efficiencies in the Medicare Program and Extending its Solvency**

There has been much misleading criticism leveled at the House health reform bill for cutting benefits for Medicare beneficiaries. But the bill makes no explicit reductions in Medicare benefits or cost-sharing increases. Moreover, the bill includes extensive savings from changes in payment rates to providers and private plans and other efficiencies related to providers, and these savings help beneficiaries both by holding down beneficiary premiums and by extending Medicare solvency.

Each year, MedPAC makes numerous recommendations to Congress on how to modify provider payment rates and encourage efficiency while ensuring that payments are adequate so that beneficiaries continue to have access to the hospitals, physicians, nursing homes, and other providers that care for them. One key MedPAC recommendation is related to payments to private insurance companies in the Medicare Advantage program. Medicare Advantage provides health care coverage to Medicare beneficiaries through private health plans as an alternative to the traditional Medicare fee-for-service program. But even though private plans were brought into Medicare to introduce competition and reduce costs, MedPAC estimates that in 2009, Medicare will pay the private plans, on average, *14 percent more* per beneficiary than it would cost to cover these beneficiaries in traditional Medicare.<sup>18</sup> (A Commonwealth Fund study estimates that these overpayments exceed \$1,100, on average, for each beneficiary enrolled in a private Medicare Advantage plan.<sup>19</sup>) MedPAC has recommended for a number of years that Congress rein in the

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<sup>17</sup> Congressional Budget Office, “Budget Options Volume 1: Health Care,” December 2008.

<sup>18</sup> Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” March 2009.

<sup>19</sup> Brian Biles, Jonah Pozen, and Stuart Guterman, “The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to \$1.4 Billion in 2009,” The Commonwealth Fund, May 4, 2009.

excessive payments to private insurance companies so that Medicare pays the private plans no more than it would cost to treat the beneficiaries under the traditional Medicare program.<sup>20</sup>

By increasing Medicare costs, these overpayments drive up the premiums that beneficiaries in traditional Medicare must pay. The chief actuary at the Centers for Medicare and Medicaid Services (CMS) has reported that in 2009, the overpayments are raising premiums by \$3.60 per person per month, or \$86 a year for a couple.<sup>21</sup> These overpayments also weaken Medicare's long-term finances; they advance by 17 months the date when the Medicare Hospital Insurance Trust Fund will become insolvent.<sup>22</sup>

The House health reform bill would adopt the MedPAC recommendation in this area and phase out the overpayments over three years. CBO estimates this would save \$154 billion over ten years.<sup>23</sup> These and other Medicare Advantage savings measures account for roughly one-third of the savings in the House bill that result from instituting greater efficiencies in Medicare.<sup>24</sup>

MedPAC also makes specific recommendations on how much payment rates for providers in the traditional Medicare program should increase from year to year. The House bill adopts many of these recommendations and other MedPAC payment recommendations as well.

Altogether, these provisions produce the overwhelming bulk of the Medicare savings in the House bill. Some of these savings are then reinvested into the Medicare program to finance the improvements for Medicare beneficiaries noted above.

In addition, these provisions have the effect of strengthening Medicare's financing. Under current law, the Medicare Hospital Insurance Trust Fund is estimated to become insolvent in 2017. According to the Office of the Actuary at the Centers for Medicare and Medicaid Services, the similar Medicare savings included in an earlier version of the House bill (after taking into account the increased Medicare spending for the bill's beneficiary improvements) would push back by five years the date when the Medicare Hospital Insurance Trust Fund goes insolvent.<sup>25</sup>

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<sup>20</sup> For a further discussion of why the overpayments to Medicare Advantage plans should be curbed, see January Angeles, "Ending Medicare Advantage Overpayments Would Strengthen Medicare," Center on Budget and Policy Priorities, September 15, 2009.

<sup>21</sup> Rick Foster, "Letter to Pete Stark on Medicare Advantage and the Hospital Insurance Trust Fund Solvency," Centers for Medicare and Medicaid Services, Office of the Actuary, June 25, 2009.

<sup>22</sup> See Foster, *op. cit.*

<sup>23</sup> Congressional Budget Office, "Preliminary Analysis of America's Affordable Health Choices Act of 2009," July 17, 2009.

<sup>24</sup> Under the House bill, an additional \$15.5 billion in Medicare Advantage savings over ten years would come from addressing the complex problem of "upcoding," which undercuts the ability of Medicare to accurately adjust payments to private insurance companies selling policies through the Medicare Advantage program if the private plans' enrollees are healthier — and, thus, lower cost — than the beneficiaries enrolled in traditional Medicare. See January Angeles and Edwin Park, "Upcoding Problem Exacerbates Overpayments to Medicare Advantage Plans," Center on Budget and Policy Priorities, revised September 14, 2009.

<sup>25</sup> See, for example, U.S. Department of Health and Human Services, "America's Seniors and Health Insurance Reform: Protecting Coverage and Strengthening Medicare," August 2009.