



HEALTH CARE REFORM AND MEDICARE

They all clapped. Okay, maybe not everybody, but most members of Congress, Democrats and Republicans, applauded last night when President Obama pledged to safeguard Medicare, calling it a "sacred trust" with older Americans.

What the President didn't say, and what too many people forget, or try to, is that Medicare is a public health insurance program. It was created and is broadly implemented by the federal government; claims are administered by private insurance companies. For everyone who applauds Medicare – and most people do: support a public option so we can pass the promise of health care security on to younger generations.

Center for Medicare Advocacy Executive Director Judith A. Stein,
commenting on President Obama's speech on health care reform at,
www.cmahealthpolicy.com. (September, 2009)

The Center for Medicare Advocacy has written numerous times in recent months about the importance of a public plan option for health insurance under health reform proposals. We have pointed to Medicare as a solid example of a sound, popular public program on which the new public option could be modeled. We have pointed out, as Judith Stein notes above, that Medicare was designed as a public and private partnership, with the federal government designing the program, beneficiaries and taxpayers sharing its costs, private insurance companies administering claims processing, and private providers delivering care.

We have, however, written little about why health reform should matter to Medicare beneficiaries who, unlike more than 45 million other Americans, already have good access to comprehensive health care. A recent poll reported by the Kaiser Family Foundation¹ indicates that 34% of people over age 65 believe they and their families will be worse off under health reform; 37% believe that Medicare will be worse off.

Why does the Center for Medicare Advocacy, whose mission is to advocate for Medicare beneficiaries, support health care reform? The answer is that health reform is a matter of fundamental fairness; it will strengthen the country's overall economy, improve the solvency of Medicare itself, and provide many specific improvements to the program for beneficiaries.

HEALTH CARE REFORM IS A MATTER OF FUNDAMENTAL FAIRNESS

Medicare itself is based on the notion of shared undertaking, of pooling resources for the common good; in its case, the common good of older people and people with disabilities and their families. That same notion should apply to all our citizens. As long as we have more than 45 million Americans uninsured² and another 25 million underinsured,³ including millions of people declaring bankruptcy each year due to health care costs, we are not living up to our American ideal of fairness.

The Constitution calls upon Congress to establish laws to "provide for the general welfare."⁴ Health care reform meets this mandate and provides people who are not yet 65 with the kind of security Medicare beneficiaries have – fair access to necessary health care.

Health care reform proposals include:

- Private insurance market reforms such as elimination of pre-existing condition exclusions, elimination of life-time caps on benefits and prohibition on policy cancellation due to use of benefits,
- Establishment of an "insurance exchange" through which people needing insurance can compare and purchase policies, and
- Subsidies for premiums and other cost-sharing to help make insurance affordable for those with lower incomes.

These changes make health care a reality for more people.

REFORM IS NECESSARY TO IMPROVE THE HEALTH OF THE NATION'S ECONOMY AS WELL AS OF ITS CITIZENS

Medicare beneficiaries and their families live and work in the same economy as other Americans. Much has been written about how costs of health care in the United States undermine our ability to participate in the global economy.⁵ For example, the American automobile industry, currently on life-support, is in such dire straits in part due to its inability to compete with manufacturers in countries where access to health care is universal and costs of health care are well below those in our country.⁶ Productivity is affected by illness of workers who have insufficient insurance or no insurance and so cannot receive ongoing attention for chronic conditions.⁷ When health care is tied to employment, workers may be locked into jobs for fear of losing health care for themselves and their families. They may not advance to new jobs or start new businesses because health insurance purchased on the private market is unavailable or unaffordable.

Access to affordable insurance, through the provisions described above, will have a positive effect on the United States' competitiveness in the world economy and on the health of its citizenry. Sometimes it is as simple as remembering that people without health insurance often go without care.

HEALTH CARE REFORM IS NEEDED TO REIN IN HEALTH CARE COSTS - HIGH MEDICARE SPENDING IS RELATED TO HIGH COSTS THROUGHOUT THE SYSTEM

Health economists generally agree that high Medicare spending is reflective of health care spending in all sectors throughout the United States;⁸ high costs are not intrinsic, or limited, to the design or management of the Medicare program itself. Health reform that begins to address costs system-wide will have positive effects on the fiscal health of Medicare. One of the reasons the Center supports a strong public option is our belief that a public plan will promote competition among private plans and provide a vehicle for testing delivery system reforms that promote high quality and cost efficient care.

SPECIFIC PROVISIONS RELATING TO MEDICARE IN HEALTH REFORM LEGISLATION WILL IMPROVE THE PROGRAM FOR BENEFICIARIES

Reducing Overpayments to Medicare's Private Plans

Some older people have expressed concern that Medicare will be cut in order to pay for health insurance for others. Actually, the cuts proposed for Medicare will strengthen Medicare itself. The proposed cuts primarily target the wasteful subsidies to private Medicare plans which cost, on average, 14% more than the traditional program. Eliminating these subsidies will end cost-shifting from private plans to the larger Medicare program and will put the traditional program back on a "level playing field" with the private plans. It should also help reduce the increases in Part B premiums that have been required to help pay for these unnecessary subsidies to private companies.

The overpayments to private plans, legislated in 2003, create a fundamental unfairness in the program, since they burden all Medicare beneficiaries with higher premiums, but benefit only the smaller portion of beneficiaries who enroll in private plans. If private plan "extra" benefits are in fact valuable, they should be available to all Medicare beneficiaries. If they are not valuable, then paying for them is sheer waste and abuse. By the same token, overpayments to private plans cost taxpayers extra money, since portions of Medicare are financed from general revenues, and, as described by the Medicare Payment Advisory Commission, these wasteful private plan overpayments "contribute to worsening the long range financial sustainability of the Medicare program."⁹

Eliminating Scheduled Reductions in Payments to Physicians and Other Health Care Providers and Re-Focusing Payment on Care Coordination

Under a payment formula in current law, cuts of 21% to physician payments are scheduled to take effect January 1, 2010. Provisions in health reform legislation change the payment formula so that (1) these cuts do not take effect and (2), going forward, Medicare's payments emphasize primary care and care coordination.

The emphasis on care coordination in Medicare is a critical improvement to the program for which the Center for Medicare Advocacy has advocated for years.¹⁰ Better care coordination

will improve the health of beneficiaries and provide an important step in reducing costs in the health care system by addressing the issue of unnecessary, duplicative services and by providing care that is more responsive to individuals' needs.

Eliminating Out of Pocket Costs for Preventive Services

Medicare now covers a number of screening services, including pap smears, mammograms, prostate cancer screening, colorectal and glaucoma screening. Moreover, since January 1, 2009, the Secretary of the Department of Health and Human Services has had authority to add coverage for preventive services that are recommended by the U.S. Preventive Services Tasks Force. Some health reform legislation proposes that, beginning January 1, 2011, no deductibles or co-insurance will be charged for such services. Also, under some proposals, beginning January 1, 2010, Medicare will cover all federally-recommended vaccines.

Improving Access to Medicare for Beneficiaries with Low Incomes

Some pending health care reform legislation will make subsidies to pay for Part A and B services and for prescription drugs available to more individuals by increasing the level of assets people can retain while qualifying for subsidies. Research shows that many people with low incomes have modest assets that are, nonetheless, above the level allowed under current law for the subsidy.

Current bills also eliminate Part D cost-sharing for those beneficiaries dually eligible for Medicare and Medicaid who live in the community and need long-term care services. The elimination of cost-sharing corrects an institutional bias in existing law under which cost-sharing is eliminated *only* for beneficiaries living in institutions. Other Part D improvements for low-income beneficiaries include authorizing Medicare to assign beneficiaries to the plan best suited to their individual needs and changing the designation of which plans are available at no premium cost to beneficiaries, thereby reducing the number of people who have to choose a new plan each year.

Other Provisions

Some proposals include reducing the cost of brand name drugs in the Part D gap in coverage, or "Donut Hole," and the gradual phasing out of the donut hole in its entirety. While the phase out is projected over a long period, some protections would begin sooner under health care reform.

To protect nursing home residents, proposals include requirements for greater transparency in nursing home reporting of ownership and staffing data. Such information will promote greater accountability by nursing facilities which, under current law, are able to shield such information from public scrutiny.

Conclusion

Medicare, enacted in 1965, provided older people with health insurance they had previously been unable to afford. Medicare provided families with peace of mind that allowed them to focus on

other financial needs, rather than worrying about having enough money to pay for their older family members' health care. Now, health care reform could provide older people with the peace of mind that their children and grandchildren will not lose access to health care if they lose their job, or choose to start their own business, or develop a health condition under current conditions would disqualify them from purchasing private health insurance, or result in astronomical premiums.

Health reform is good for Medicare beneficiaries and good for their families. It is a matter of fundamental fairness that will strengthen the country's overall economy, improve the solvency of Medicare itself, and provide many specific improvements to the program for beneficiaries.

¹ <http://slides.kff.org/chart.aspx?ch=1131> (site visited September 5, 2009)

² Health Insurance Coverage: 2007, U.S. Census Bureau (July 1, 2007), <http://www.census.gov/hhes/www/hlthins/hlthin07/fig06.pdf>.

³ How Many Are Underinsured? Trends Amongst U.S. Adults, 2003 and 2007, The Commonwealth Fund (June 10, 2008), <http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2008/Jun/How-Many-Are-Underinsured--Trends-Among-U-S--Adults--2003-and-2007.aspx>.

⁴ Article I; Section 8.

⁵ The Impact of Rising Health Costs on the Economy: EFFECTS ON BUSINESS OPERATIONS, National Coalition on Health Care (October 31, 2008), <http://www.nchc.org/documents/Costs-Businesses-2009.pdf>

⁶ Id.

⁷ The Impact of Rising Health Costs on the Economy: EFFECTS ON WORKERS AND FAMILIES, National Coalition on Health Care (November 16, 2008), <http://www.nchc.org/documents/Costs-Workers-2009.pdf>.

⁸ Medicare: Medicare Spending and Financing Fact Sheet, Kaiser Family Foundation (May 2009), <http://www.kff.org/medicare/upload/7305-04-2.pdf>.

⁹ Medicare Payment Advisory Commission "Report to Congress: Medicare Payment Policy" March 2009, available at http://www.medpac.gov/documents/Mar09_EntireReport.pdf (site visited Sept. 8, 2009)

¹⁰ See, e.g., Center for Medicare Advocacy, "One Third at Risk: Creating a Blueprint for a Coordinated Care Benefit" and "Services in the Traditional Medicare Program: Recommendations for a Medicare Coordinate Care Benefit." March 22, 2002 available at http://www.medicareadvocacy.org/Archives/ArchivedPages/Reform_CoordinatedCare.htm (site visited September 8, 2009)