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Issue Brief

How Health Reform Legislation Will Affect Medicare Beneficiaries

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ABSTRACT: Despite criticism that health reform legislation will result in cuts to Medicare, the bills passed by the House of Representatives and the Senate, as well as President Obama's proposal, contain provisions that would strengthen the program by reducing costs for prescription drugs, expanding coverage for preventive care, providing more help for low-income beneficiaries, and supporting accessible, coordinated, and comprehensive care that effectively responds to patients' needs. The legislation also would help to extend the program's fiscal solvency—for nine years, under the Senate bill. This issue brief examines the provisions in the pending legislation and how each one would work to improve benefits, extend the fiscal solvency of the Medicare Hospital Insurance Trust Fund, reduce pressure on the federal budget, and contribute to moving the health care system toward better access to care, improved quality, and greater efficiency.

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OVERVIEW

The pending health reform legislation (i.e., the bills passed by the House of Representatives and the Senate, as well as President Obama's proposal, which builds on those bills) contains several provisions that would strengthen the Medicare program for beneficiaries. These provisions would help reduce costs for prescription drugs, expand coverage for preventive care, provide more help for low-income beneficiaries, and support accessible, coordinated, and comprehensive care that effectively responds to patients' needs.

Some critics have characterized these changes as cuts to the Medicare program, arguing that they represent a reduction in benefits. In fact, all beneficiaries would continue to be guaranteed all of Medicare's basic benefits, and those benefits would be improved with the expansion of coverage for preventive care and reduction in costs for prescription drugs.

The way hospitals and other health care providers are paid would be changed to focus more on the quality and effectiveness of care that patients receive. New initiatives aimed at improving the organization and delivery of care

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promise to improve care coordination and effectiveness and slow cost growth. The Medicare savings that would come from improved productivity would help sustain the fiscal solvency of the Medicare Hospital Insurance Trust Fund while reducing beneficiary premiums and the program's draw on tax revenues, relative to current projections.

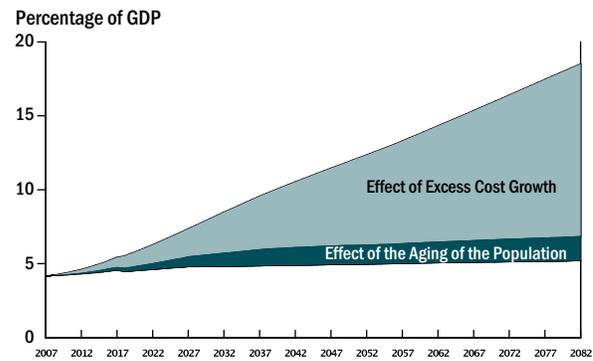
Health reform legislation therefore would improve benefits for most Medicare beneficiaries, extend the fiscal solvency of the program, and begin to move the health care system toward better access to care, improved quality, and greater efficiency.¹

Medicare and the Health Care System

As the largest payer for health care—accounting for 20 percent of U.S. national health expenditures in 2008 for its almost 45 million beneficiaries—Medicare plays a central role in the health system.² Like the rest of the system, it is plagued by rapidly rising costs. The Hospital Insurance (Part A) Trust Fund, which pays for hospital and other facility-based services used by Medicare beneficiaries and is financed by an earmarked payroll tax, is projected to become insolvent by 2017 under current law.³ Both Supplementary Medical Insurance (Part B), which pays for physician and other ambulatory care and medical supplies, and Prescription Drug Coverage (Part D) are financed by beneficiaries' monthly premiums and open-ended draws on general revenues, so they are fully-financed by definition, but they represent a progressively greater burden on both beneficiaries' resources and the federal government's budget. The total Part A Trust Fund deficit, plus the draw on general revenues to cover Part B and Part D costs in excess of beneficiary premiums under current law, has a present value (i.e., the amount in today's dollars that would be necessary to cover those costs) of \$88.9 trillion—or 6.8 percent of gross domestic product (GDP)—if nothing is done.⁴

The increasing number of retirees from the baby boom generation is often cited as a threat to Medicare's future. However, it is primarily the systemwide growth in health care spending per person that drives the projected growth in Medicare spending (Exhibit 1).

Exhibit 1. Sources of Growth in Projected Federal Spending on Medicare and Medicaid, 2007 to 2082



Source: Congressional Budget Office, *The Long-Term Outlook for Health Care Spending* (Washington, D.C.: CBO, 2007), as presented by P. Orzag at the New America Foundation, Nov. 2007, accessible at: <http://www.newamerica.net/files/Orzag%20PPT%20111307.pdf>.

Medicare is therefore both an important part of the problem that health reform is intended to address and a victim of those problems. Medicare's problems cannot be solved without addressing the causes of those problems, which reside throughout the health system. As such, Medicare can and should be both a key vehicle for developing approaches to slowing health spending growth and a major beneficiary of them.

Medicare Provisions in the Health Reform Legislation

The health reform legislation contains several provisions that would affect Medicare and its beneficiaries (Exhibit 2).⁵ President Obama's proposals are based largely on the Senate bill, with any differences indicated explicitly below:

- **Prescription Drugs**

Both the Senate and House bills would address the costs that beneficiaries face for prescription drugs and require more transparency to promote increased competition.

The Senate bill would require a 50 percent discount on brand-name drugs in the coverage gap (commonly known as the "doughnut hole") for beneficiaries with annual incomes below \$85,000 or couples with incomes below \$170,000. It reduces the coverage gap by \$500 in 2010, but not any further in succeeding years. The Senate bill also would require pharmaceutical benefit managers to

Exhibit 2. Medicare Provisions in the Health Reform Legislation

- **Prescription drugs.** Reduce the cost of prescription drugs, narrow the coverage gap, and require more transparency.
 - **Preventive services.** Expand coverage, eliminate cost-sharing.
 - **Assistance for low-income beneficiaries.** Eliminate prescription drug copayments for dual-eligibles.
 - **Primary care.** Increase payments for primary care providers.
 - **Care coordination.** Encourage development of more coordinated models of health care delivery.
 - **Provider payments.** Adjust payments for expected productivity improvements, reward reduction of hospital-acquired infections and avoidable hospital admissions.
 - **Medicare Advantage.** Reduce overpayment of private Medicare Advantage plans.
 - **Medicare solvency.** Extend solvency of Hospital Insurance Trust Fund.
 - **Innovation.** Create Center for Medicare and Medicaid Innovation, providing platform for new approaches to payment and health care delivery.
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disclose discounts negotiated with drugmakers and pass on savings to consumers.

The House bill would require a 50 percent discount on brand-name drugs in the coverage gap for all beneficiaries, while counting the full price of those drugs in determining the threshold for catastrophic coverage, which would help reduce expenses for beneficiaries with high prescription drug costs. It also would phase out the coverage gap within 10 years. The House bill would require the Secretary of Health and Human Services to negotiate directly with pharmaceutical manufacturers to lower drug prices for Medicare stand-alone prescription drug plans and Medicare Advantage plans, and it would require drug manufacturers to provide rebates for dual-eligibles (i.e., individuals eligible for both Medicare and Medicaid) who are enrolled in Medicare drug plans. The House bill also would require disclosure of financial relationships among health entities (e.g., between physicians and drug companies), and it would lift the current 36-month limit on coverage of drugs to prevent rejection of a kidney transplant.

The president's proposal, which is based largely on the Senate bill, would add a provision similar to that in the House bill that would close the coverage gap within 10 years.

- **Preventive Services**

Both the Senate and House bills would improve the coverage of preventive services by covering proven preventive services under Medicare and Medicaid and eliminating any cost-sharing for preventive services in Medicare.

The Senate bill also would expand the number of covered preventive services, including an annual wellness visit under Medicare.

- **Assistance for Low-Income Beneficiaries**

The Senate and House bills contain provisions that would increase assistance for low-income beneficiaries.

The Senate bill would eliminate prescription drug copayments for certain dually eligible (Medicare and Medicaid) beneficiaries receiving home- or community-based long-term care. It also would

extend the spousal impoverishment protections available to spouses of persons in institutional care (i.e., provisions intended to protect some of the assets of spouses of people who “spend down” their assets to become eligible for Medicaid nursing home benefits) to spouses receiving home- and community-based care.

The House bill would eliminate prescription drug copayments for certain dually eligible (Medicare and Medicaid) beneficiaries receiving home- or community-based long-term care. It also would expand eligibility for the low-income subsidy that helps to pay drug premiums and copayments under Medicare’s Part D prescription drug benefit. In addition, it would expand eligibility for the Medicare Savings Programs that help low-income beneficiaries pay Medicare premiums, deductibles, and coinsurance under Parts A and B, by more than doubling the amount of allowable savings and other financial assets beneficiaries can have. It also extends the Qualified Individual program, which helps low-income beneficiaries pay for their Part B premium. It also pays some Medicare coinsurance and deductibles for disabled beneficiaries who have incomes below 150 percent of the federal poverty level and limited assets.

- **Primary Care**

Both the Senate and House bills would enhance Medicare beneficiary access to primary care by increasing primary care provider payment rates. Patients with greater access to coordinated primary care report better care and better outcomes than patients who do not have such access.⁶

The Senate bill seeks to strengthen primary care by providing 10 percent bonus payments to primary care providers (and general surgeons) that would be in effect for five years. In addition, the Senate bill strengthens chronic care management by providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition.⁷

The House bill includes a permanent 5 percent payment bonus for evaluation and management services (i.e., office visits) and other services associated with ensuring accessible, continuous, coordinated, and comprehensive care when provided by a physician or other practitioner who specializes in family medicine, general internal medicine, general pediatrics, or geriatrics and for whom primary care represents a majority of his or her practice income. It provides an additional 5 percent allowance for practice in areas where there is a shortage of health professionals. Medicaid fees for primary care services, under both fee-for-service payment and managed care plans, would be raised to Medicare levels over a three-year period.

- **Care Coordination**

Both the House and Senate bills establish initiatives that would encourage development of more coordinated models of health care delivery, including incentives for providers to form accountable care organizations that take joint responsibility for the quality and outcomes of their patients’ care while eliminating duplicative and wasteful care. They also establish initiatives that would provide extra payments and incentives for patient-centered medical homes, which improve access to primary care services and encourage coordination of patient care.

- **Provider Payments**

Both the House and Senate bills would reduce the growth in payment rates for services provided by hospitals and other facilities, to extend the solvency of the Medicare program. They also would reward reduction of hospital-acquired infection rates and avoidable hospital readmissions. A recent study found that 20 percent of Medicare beneficiaries who are discharged from the hospital are readmitted within 30 days—an occurrence that often represents poor care, hardship for the patient, and avoidable costs.⁸

The Senate bill also establishes an Independent Payment Advisory Board with a mandate to reduce

provider payment rates to meet Medicare spending targets, preserve the program's viability over time, and recommend other policy changes to reduce overall health spending growth.

- **Medicare Advantage**

Both the House and Senate bills would reduce the current overpayment of private Medicare Advantage plans, which drained an estimated \$11 billion from the Medicare program in 2009.⁹ With those extra payments, Medicare Advantage plans can offer some additional benefits to the minority (25 percent) of beneficiaries who are enrolled in private plans. However, these additional benefits are not available to the 75 percent of Medicare beneficiaries in traditional Medicare, despite the fact that they are paid for out of program funds contributed by all workers and taxpayers and exacerbate the looming threat to the program's solvency—as well as increasing the Part B premiums paid by all beneficiaries.

The Senate bill would set payments for Medicare Advantage plans based on bids submitted by each plan relative to the bids submitted by all plans in the area, providing bonus payments to plans that meet broadly defined quality or care coordination criteria. The Senate bill also would prohibit plans from charging enrollees more than traditional Medicare for certain medical services and would require plans to use bonus payments to reduce cost-sharing for medical services. It also would establish a single annual enrollment period during which private plan changes can be made.

The House bill would set payments for Medicare Advantage plans based on projected costs per beneficiary in traditional Medicare in each county, providing bonus payments to plans that provide high-quality care based on specific performance standards. The House bill also would prohibit plans from charging enrollees more than traditional Medicare for any medical services and limit plan profits and administrative expenses to 15 percent

of Medicare payments and enrollee premiums. It also would establish a single annual enrollment period during which private plan changes can be made.

The president's proposal would contain the provisions in the Senate bill, except that payments for private plans would be set differently: they would be determined on a sliding scale depending on traditional Medicare costs in each area, with plans in low-cost areas receiving higher rates relative to the costs they face. High-performing plans (as measured by quality and patient experience criteria) would receive extra payments relative to other plans in the same area.

- **Medicare Solvency**

The net impact of the House bill would extend the solvency of the Part A Trust Fund by five years, to 2022.

The Senate bill would raise drug plan premiums for individuals with incomes over \$85,000 or couples with incomes over \$170,000, and would increase the Medicare Part A payroll tax by 0.9 percentage points for individuals with incomes over \$200,000 or couples with incomes over \$250,000. The net impact of the Senate bill would extend the solvency of the Part A Trust Fund by nine years, to 2026.

- **Innovation**

Perhaps the most important provision in the health reform legislation, which appears in similar forms in the two bills, is the creation of a Center for Medicare and Medicaid Innovation, which provides a platform for developing new approaches to paying for health care to encourage greater quality and efficiency. As described previously, the primary source of the financial pressure faced by the Medicare program is the excessive growth of health care costs throughout the health system. This growth is fueled by the current fee-for-service payment system, which rewards the provision of

Exhibit 3. Estimated Reductions from Currently Projected Medicare Spending, 2010–2019, from Provisions in House and Senate Bills (dollars in billions)

	CBO estimate of House Bill	CBO estimate of Senate Bill
Total Medicare Savings from Payment and System Reforms	–\$469	–\$387
Productivity improvement/provider payment updates	–177	–151
Medicare Advantage reform	–170	–136
Primary care, geographic adjustment	–9	2
Increased coverage of preventive services	3	4
Payment innovations	–2	–8
Hospital readmissions	–9	–7
Disproportionate share hospital adjustment	–10	–24
Prescription drugs	–50	6
Home health	–55	–39
Independent board	—	–28
Savings and low-income subsidy program	12	—
Other improvements and interactions	–2	–6

Source: Authors' estimates based on Congressional Budget Office analysis of H.R. 3962, The Affordable Health Care for America Act, Nov. 20, 2009, <http://www.cbo.gov/doc.cfm?index=10741>; and Congressional Budget Office analysis of the Patient Protection and Affordable Care Act, incorporating the Manager's Amendment, Dec. 19, 2009, <http://www.cbo.gov/doc.cfm?index=10868>.

more services, more complicated procedures, and more expensive care.¹⁰ The long-run viability of Medicare—and the health care system in general—depends on moving toward a different way of paying for and providing care, one that is affordable for those who need it while providing value for the resources spent.

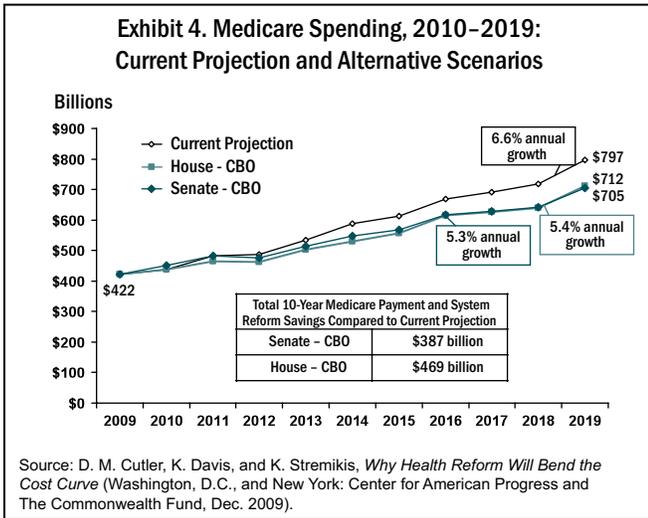
Reductions in Cost Growth, Not Cuts

Some critics have characterized the improvements to the Medicare program as Medicare cuts, making beneficiaries concerned that their benefits are being cut. In fact, all beneficiaries would continue to be guaranteed all of Medicare's basic benefits. Those benefits would be improved—changes to the way hospitals and other health care providers are paid would enhance, not undermine, the quality of care.

At the same time, Medicare savings that result from improved productivity and reduced overpayments would help sustain the fiscal solvency of the Medicare

Hospital Insurance Trust Fund. The Congressional Budget Office estimates that changes to Medicare in the House and Senate bills would yield savings of \$469 billion and \$387 billion, respectively, over the 10-year period, 2010–2019 (Exhibit 3). The largest contributions would come from changes to provider payments that would reflect increases in productivity, a decrease in the need to offset losses from treating the uninsured, and gradual elimination of overpayments to Medicare managed care plans that benefit insurance companies and a minority of beneficiaries at the expense of all Medicare beneficiaries.

Even with the reduced spending growth under the House and Senate bills, the Medicare program would still grow over the next decade. Taken in the context of projected Medicare spending of more than \$6 trillion over the next 10 years, the savings figures cited above are—while certainly meaningful—hardly earth-shaking. The 67 percent growth over the next decade under the House bill (5.3 percent per year)



and the 69 percent growth under the Senate bill (5.4 percent per year) would be substantial reductions from the current projection of 89 percent (6.6 percent per year) (Exhibit 4). However, even those reduced growth rates are greater than projected growth in the rest of the U.S. economy: the U.S. GDP is projected to increase by 63 percent between 2009 and 2019 (5.0 percent per year).¹¹

CONCLUSIONS

Health reform is essential to avoid the deteriorating access, mushrooming costs, and disappointing performance that the U.S. health system faces. It is also critical to ensuring Medicare’s continued ability to provide elderly and disabled beneficiaries with access to needed care. Health reform legislation would improve benefits for Medicare beneficiaries, extend the fiscal solvency of the Medicare Hospital Insurance Trust Fund, reduce pressure on the federal budget, and contribute to moving the health care system toward better access to care, improved quality, and greater efficiency. We need reform to put the U.S. health system on the path to high performance and move away from the fragmented, inefficient, and poor-quality system that now undermines the health and health care of far too many Americans. Medicare beneficiaries, who depend particularly on access to high-quality health care, stand to benefit substantially from such changes.

NOTES

- ¹ Affordable Health Care for America Act, available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3962eh.txt.pdf; Patient Protection and Affordable Care Act, available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590eas.txt.pdf; and The White House, “The President’s Proposal,” (Washington, D.C.: The White House, Feb. 22, 2010).
- ² M. Hartman, A. Martin, O. Nuccio et al. “Health Care Spending Growth at a Historic Low in 2008,” *Health Affairs*, Jan. 2010 29(1):147–55.
- ³ The Boards of Trustees, *2009 Annual Report* (Wash., D.C.: Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds, May 12, 2009).
- ⁴ Ibid.
- ⁵ K. Davis, S. Guterman, S. R. Collins, K. Stremikis, S. Rustgi, and R. Nuzum, *Starting on the Path to a High Performance Health System: Analysis of Health System Reform Provisions of Reform Bills in the House of Representatives and Senate* (New York: The Commonwealth Fund, updated Jan. 2010); Medicare Rights Center, *Side-by-Side Comparison of Health Reform Bills’ Impact on Medicare* (New York: Medicare Rights Center, Jan. 2010), available at <http://www.medicarerights.org/pdf/Side-by-Side-Comparison-of-Health-Reform-Bills-Impact-on-Medicare-Jan2010.pdf>; The Henry J. Kaiser Family Foundation, *Summary of Key Medicare Provisions in House and Senate Health Reform Bills* (Menlo Park, Calif.: Kaiser Family Foundation, updated Mar. 15, 2010), available at http://www.kff.org/healthreform/upload/7948_HR3962_HR3590_Summary.pdf.
- ⁶ A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).
- ⁷ Davis, Guterman, Collins et al., *Starting on the Path*, 2010.
- ⁸ S. F. Jencks, M. V. Williams, and E. A. Coleman, “Rehospitalizations Among Patients in the Medicare Fee-for-Service Program,” *New England Journal of Medicine*, Apr. 2, 2009 360(14):1418–28.
- ⁹ B. Biles, J. Pozen, and S. Guterman, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to \$11.4 Billion in 2009* (New York: The Commonwealth Fund, May 2009).
- ¹⁰ S. Guterman and S. C. Schoenbaum. “Getting From Here to There in Payment Reform: Necessary Practices and Policies,” *Journal of Ambulatory Care Management* Jan.–March 2010 33(1):52–57.
- ¹¹ Centers for Medicare and Medicaid Services, *National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2004–2019* (Washington, D.C.: Centers for Medicare and Medicaid Services, Office of the Actuary, 2009), Table 1, available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2009.pdf>.

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