A First Look at the Impact on Medicare || CMA

Last week, President Obama unveiled his recommendations to Congress's Joint Select Committee on Deficit Reduction ("Super Committee").[1] The President's Plan for Economic Growth and Deficit Reduction seeks to pay for the President's jobs bill and produce net savings of more than $3 trillion over the next decade.[2] The proposal includes $320 billion in savings from changes to federal spending on Medicare and Medicaid (including $248 billion in Medicare savings). In addition, the President has threatened to veto any bill that takes away Medicare benefits without an increase in contributions from "the wealthiest Americans and biggest corporations."[3]

This *Alert* looks at specific aspects of the President's plan that would affect future Medicare beneficiaries. While we applaud a focus on increasing revenue to address our nation's debt and deficit concerns, we are troubled by proposals that shift costs to Medicare beneficiaries who already pay significant out-of-pocket expenses for their health care.

Promising Proposals

One strength of the President's plan is that it seeks new revenues as part of any discussion about overall debt and deficit reduction. We are glad to see the following included (or not included) in the President's Plan:

- **Rebates from drug manufacturers for prescription drugs provided to dually eligible beneficiaries and those receiving the Part D Low-Income Subsidy (LIS):** While not the full negotiation of drug prices that could save Medicare billions or dollars, this proposal would allow Medicare to benefit from the same rebates that Medicaid receives for brand name and generic drugs provided to individuals who receive the LIS. By restoring the law as it applied to dual eligibles prior to the creation of Part D in 2006, and extending the rebate to all LIS enrollees, Medicare would save an estimated $135 billion over 10 years.
- **NO increase in eligibility age:** This Plan from the President does not call for raising the age of Medicare eligibility from 65 to 67, which experts have reported would increase and shift costs onto employers, individuals, and states.[4] We are pleased that the President has eliminated this change in his proposal.

Proposals of Concern

However, we are concerned about certain aspects of the President's plan that, if implemented, would shift significant cost-sharing to beneficiaries who already pay considerable costs for their medical care.[5] For example, the Medicare Payment Advisory Commission (MedPAC) reports that premiums and cost-sharing for Parts B and D alone absorbed 30 percent of the average Social Security benefit in 2010.[6]

Many provisions of the President's Plan aim to achieve Medicare savings by creating "financial incentives for newly eligible beneficiaries to seek high-value health care services."[7] Starting in 2017, higher costs would be imposed on beneficiaries under the misguided assumption that greater out-of-pocket expenses will lead to more reasonable decisions about obtaining various types of medical care. On the contrary, these proposals would fail to steer people toward high-value services, and, at worst, simply charge people more for accessing needed health care, or deter people from seeking care altogether.[8]

The following provisions are troubling because they would directly shift costs to Medicare beneficiaries:

- **Implementing a Co-Payment for Home-Health Care:** Starting in 2017, this proposal would create a home health copayment of $100 per home health 60-day episode, applicable for episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay. Imposing such co-pays would have a staggering impact on individuals with long-term and chronic conditions, who would essentially incur $600 in new out-of-pocket costs annually. Additionally, it could lead to higher hospitalizations (and thus, higher costs) as a result of beneficiaries forgoing needed care when they cannot afford the co-payments. Moreover, eliminating the co-pay requirement to situations where there has been a hospital or nursing home stay creates a perverse incentive toward hospitalization or nursing home care.
- **Increasing Part B deductible for new beneficiaries:** The President's plan would increase the Part B deductible *only for new beneficiaries* by $25 dollars in 2017, 2019 and 2021 (for a total $75 increase). This proposal would have a significant impact on Medicare beneficiaries, nearly half of whom have annual incomes below $22,000.[9] Only about 14% of Medicare beneficiaries – those with

incomes of about $11,000 or less - get financial help to pay their Medicare cost-sharing. The proposal shifts costs to beneficiaries and could result in increased costs when needed care is postponed until an illness is more complicated and more costly to treat. Further, this proposal draws an arbitrary line between current beneficiaries and near retirees who would be unaffected and those who will join Medicare in the future and will permanently pay more.

- **Further income-basing Medicare Part B and D premiums**: Medicare is already a means-tested program, with higher-income beneficiaries paying more for Part B and Part D premiums. The current requirements affect only about 5% of beneficiaries – those with incomes at or above $85,000 a year. The President's proposal would not only raise the income-related premium by 15%, it would also freeze the income level for higher payments at $85,000, not adjusting for inflation, cost of living, or any other such factors, until 25% of beneficiaries were paying the higher premiums. Using today's dollars, this means that beneficiaries with current incomes of $43,500 belong in the top 25% of Medicare beneficiaries based on income. In the future, Medicare beneficiaries in the top 25% who are far from wealthy would find themselves paying disproportionately for their healthcare costs.[10] Not only would this proposal shift more costs to people who have incomes well below the highest levels, it might lead to more people choosing not to participate in Medicare. Fewer participants in parts B and D would result in increased costs for the remaining participants.
- **Increasing the cost of certain Medigap policies**: In another effort to discourage utilization of health care, the Plan proposes a surcharge on Part B premiums for people who purchase Medigap policies with low cost-sharing. This surcharge would be equivalent to about 15% of the average Medigap premium (or roughly 30% of the Part B premium). Eliminating or discouraging first-dollar coverage in Medigap only shifts those costs to beneficiaries, who may go without necessary medical care prescribed by their doctors. In fact, since Medigap policies only cover care that Medicare deems "medically necessary," such changes should not be needed to deter unnecessary utilization and would instead inhibit use of necessary care.[11] This proposal would penalize future beneficiaries who rationally seek to fill in Medicare's gaps in coverage for care they need.

Other Options Are Available to Save Money

Other steps could be taken to lower costs and save money that would not reduce the care for, or increase cost-sharing for, current or future beneficiaries. In addition to the drug rebate for low-income enrollees which is included in the President's Plan, the Center has written about other ways to improve care while saving money for Medicare. Our proposals include requiring the Secretary of Health and Human Services to negotiate drug prices with pharmaceutical companies and allowing traditional Medicare to offer a prescription drug option, rather than relying solely on private, commercial plans to do so.[12]

Conclusion

The President's plan contains broad proposals, well beyond the health care arena, that seek to both raise revenues and achieve further reductions in federal spending. With respect to Medicare, we believe there are some strong proposals that could achieve significant savings – in particular, we support the proposed drug rebate for low-income beneficiaries. However, we are concerned about the many provisions of the plan that discourage the use of medically necessary services by increasing out-of-pocket costs for beneficiaries. These provisions are more likely to lead lower- and middle-income people to forego necessary and preventive care than to limit all beneficiaries' use of unnecessary care.

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[1] For a discussion of the Super Committee and the potential impact on Medicare, see, e.g., the Center's Weekly Alert "What Does the Debt Ceiling Mean for Medicare?" (August 4, 2011) at: http://www.medicareadvocacy.org/2011/08/what-does-the-debt-ceiling-agreement-mean-for-medicare/.
[2] White House Press Release: "Fact Sheet: Living Within Our Means and Investing in the Future – The President's Plan for Economic Growth and Deficit Reduction" (September 19, 2011), available at: http://www.whitehouse.gov/the-press-office/2011/09/19/fact-sheet-living-within-our-means-and-investing-future-president-s-plan . For the full text of the President's proposal, see http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf.
[3] Id.
[4] See, e.g., Kaiser Family Foundation, "Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform (July 2011), available at: http://kff.org/medicare/upload/8169.pdf; also see Center for Budget and Policy Priorities, "Raising Medicare's Eligibility Age Would Increase Overall Health Spending and Shift Costs to Seniors, States and Employers" (August 2011), available at: http://www.cbpp.org/files/8-23-11health.pdf.
[5] See, e.g., Kaiser Family Foundation's Data Spotlights Examining the Financial Burden of Health Care Costs on Medicare Beneficiaries (June 2011), available at: http://www.kff.org/medicare/medicare-spending-

briefs.cfm.
[6] MedPAC Public Meeting Presentation: "Context for Medicare Payment Policy" (September 15, 2011), at: http://www.medpac.gov/transcripts/Context%202012.pdf.
[7] The President's Plan for Economic Growth and Deficit Reduction (September 2011), page 35, available at: http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf.
[8] Trivedi, Amal, Rakowski, William & Ayanian, John Z (2008) "Effect of Cost Sharing on Screening Mammography in Medicare health Plans," *The New England Journal of Medicine, 358*, 375-383.
[9] See, e.g., Kaiser Family Foundation's Data Spotlights Examining the Financial Burden of Health Care Costs on Medicare Beneficiaries (June 2011), available at: http://www.kff.org/medicare/medicare-spending-briefs.cfm.
[10] MEDPAC Data book, June 2011, http://www.medpac.gov/document_TOC.cfm?id=617.
[11] See, e.g., National Association of Insurance Commissioners, Letter to the Joint Committee on Deficit Reduction (September 21, 2011), available at: http://www.naic.org/documents/committees_ex_grlc_110921_letter_murray_hensarling_medigap_first_dollar.pdf.
[12] See, e.g., the Center's Weekly Alerts, including: "Real Solutions For Medicare Solvency" (June 9, 2011), available at http://www.medicareadvocacy.org/hidden/so-what-would-you-do-real-solutions-for-medicare-solvency-and-reducing-the-deficit/; "Real Solutions to Save Medicare Dollars in Skilled Nursing Facilities" (June 30, 2011), available at: http://www.medicareadvocacy.org/2011/06/real-solutions-to-save-medicare-dollars-in-skilled-nursing-facilities/; and "Debunking Medicare Myths: Drug Rebates for Dual Eligibles" (July 21, 2011), available at: http://www.medicareadvocacy.org/2011/07/debunking-medicare-myths-drug-rebates-for-dual-eligibles/.