



Press Release

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Medicare Beneficiaries May Lose In Congressional Health Care Reform

Denver, CO. Under the Congressional health care reform bill, much of the cost savings is being realized through changes in the Medicare. Although the administration is not asking for any specific cuts in benefits, proposals to change and reduce reimbursements for hospital services, skilled nursing, rehabilitation, durable medical equipment, hospice and home care are part of the project savings.

Congress is planning to save \$538.5 billion of which 37% would come from provider payments and 32% from payments to Medicare Advantage plans. At the same time, Congress is also considering new spending reforms for \$320.4 billion, of which 72% would result in changes to physician reimbursement.

According to the Kaiser Family Foundation, hospitals are giving up \$155 billion in Medicare funds, but they believe they will gain \$170 billion by having to treat fewer uninsured patients. Medicare beneficiaries may be particularly vulnerable with this compromise because with less money, individuals may face earlier discharges as hospitals receive less money.

Under the current system, hospitals are reimbursed an agreed on amount for an admission diagnoses and although the hospital is to treat the patient for that amount of money and there are penalties for early discharge, many times patients are discharged before they feel safe. An unintended outcome of this practice is a 20% re-admission rate of Medicare beneficiaries to the hospital within 30 days of the original discharge which has concerned both state and national policy makers. The re-admission rate is a priority for Medicare expenditures in the proposed bill.

Nursing homes that provide skilled services and rehabilitation are similarly bracing for a 5% cut of about \$45 billion according to the same source. Nursing homes, according to the Colorado Health Care Association, which are usually understaffed, expect these cuts to result in the loss of an additional 500 jobs in Colorado alone. The economic impact is a projected reduction in business activity of more than \$35,000,000. Revenue from Medicare is often used to offset the lower reimbursement for Medicaid clients.

On the positive side, nursing homes would be required to implement quality improvement plans that should result in better delivery of care. Congress would also provide for improvements to the nursing home care website which is designed to

provide consumer information for selecting high quality facilities. Information from surveys and other oversight information would be more current.

The compromises with the pharmaceutical companies appear to be more beneficial to seniors. The companies are agreeing to pay about \$80 billion to finance expansion of health care coverage. According to the Kaiser Family Foundation, the drug industry will pay for half of the cost of prescription drugs when individuals reach the coverage gap (or the doughnut hole) eventually closing the doughnut hole by 2023. The amount paid by the manufacturer would be counted in the TrOOP (or the individual's out of pocket expenses)

In addition, the industry will pay higher payments to states to offset the cost of prescription drugs used by the Medicare/Medicaid population. At the same time, the government would negotiate prices such as rebates, discounts, and other price concessions on behalf of the Part D plan sponsors starting in 2011; thus allowing the plan sponsors to obtain discounts and price reductions below the government negotiated rates.

Under the proposal, low income individuals would be eligible for extra help and Medicare Savings Program if their assets are less than \$17,000 for individuals and \$34,000 for couples effective January 1, 2012. Individuals on home and community based services (including assisted living) would not be required to pay co-payments starting January 1, 2011.

Individuals who lose eligibility for extra help because the prescription drug plan does not meet the federal benchmark would be reassigned based on "intelligent assignment" to other companies, rather than randomly, making it easier for the individual to get more prescriptions covered by the plan, thus reducing out of pocket costs.

By cutting \$34.2 billion from home care according to the Kaiser Family Foundation, Congress hopes to more accurately reimburse home care agencies for the average number and types of home health visits in an episode. Similar to nursing homes, many Medicare beneficiaries receive fewer home care visits than desired to feel safe. In addition, prior to being able to order home care, physicians will have to have face-to-face or a telemedicine encounter with the patient within the past six months.

Medicare Advantage plans are targeted for some reductions in HMOs, and PPOs; while the Private Fee for Services plans are being targeted for significant reductions. The Kaiser Family Foundation notes that because much of the debate is focused on health insurance reform, the insurance industry has elected not to focus on these cuts, making Medicare Beneficiaries more vulnerable to higher out-of-pocket costs and fewer benefits.

The goal of Medicare is to reduce the payments to Medicare Advantage plans to be the same as Medicare fee-for-services reimbursements. Facing these cuts, Medicare Advantage programs which have used excess funding to fund such things as dental and vision benefits, will most likely increase out-of-pocket co-payments for these and other services, as well as face reductions in their networks of physicians and other providers due to reduced reimbursement.

Congress is expected to increase spending by \$228.5 billion for physician reimbursement for evaluation and management services and the provision of preventive services, according to the Kaiser Family Foundation. Selected physicians are expected to get additional bonuses starting January 1, 2011 for providing comprehensive, coordinated care if they specialize in internal medicine, family medicine and/or geriatrics.

Congress would also allow physicians to be reimbursed for advanced care planning starting January 1, 2011. The goal of this counseling is to determine if patients want to receive all available treatments at the end of life or if they want other less invasive measures to be taken. Medical Orders for Treatment would be standardized to allow patients the opportunity to expect certain levels of treatment regardless of where they live or receive services within the United States.

Although this has been publicized as a “death plan” for older adults, many individuals already talk with their physician about their values and wishes for care and formalize that wish with the completion of medical powers of attorney, as well as “do not resuscitate orders” giving families and health professionals directions on how to proceed with end-of-life care.

The health care reform bill is projected increase benefits especially for low income beneficiaries who need assistance with paying their co-payments for physician visits and prescriptions as well as more coordinated care with an emphasis on reimbursing geriatricians to provide quality care.

At the same time, the reduction in reimbursement to health care providers to realize savings to cover the proposed health care for the uninsured may leave many seniors without adequate coverage. The danger in cutting reimbursement to health care providers is an increase in waiting times due to fewer providers, earlier discharges, and increased out-of-pocket expenses.

For more information about how the proposed changes will affect you, contact your local Congressional representative or Senator.

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