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How Would Health Care Reform Impact California Senior Citizens?

by
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This issue brief analyzes how health care reform will impact senior citizens in California. The "Patient Protection and Affordable Care Act," which the Senate passed in 2009, as well as the "Health Care and Education Affordability Reconciliation Act of 2010" unveiled in the House on March 18, 2010, contain provisions that make changes to Medicare and other programs that affect seniors. These include changes to prescription drug costs—especially the Medicare Part D doughnut hole—as well as payment changes for primary care and preventive care, strategies to keep Medicare solvent, long-term care options, and changes that involve seniors eligible for Medicare and Medi-Cal.

Our analysis finds that the Senate health care reform bill and the reconciliation bill would lower out-of-pocket prescription drug costs for seniors in California, ensure greater access to primary care and preventive services, protect the solvency of Medicare, increase the options for long-term care, and protect the benefits of seniors eligible for both Medicare and Medi-Cal.

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Finding 1: Prescription Drugs Cost Less under Health Care Reform

Fixing the Medicare Part D "Doughnut Hole"

The Senate bill and the reconciliation bill include fixes to the Medicare Part D "doughnut hole" coverage gap. In 2009, over 1.6 million California senior citizens purchased prescription drugs through a standalone Medicare Part D plan, while 1.5 million used a Medicare Advantage Part D plan.[1] Spending by Part D enrollees in California, who make up 69% of the Medicare beneficiary population, can be estimated at $3.84 billion dollars.[2] Today, Medicare Part D stops paying for prescription drugs after the first $2,830 of spending.[3] The Senate bill would immediately increase the coverage limit by $500 (up to $3,330).[4] The reconciliation bill provides a $250 rebate for beneficiaries who reach the doughnut hole in 2010.[5] Increasing the coverage limit by $500 would help 519,000 California seniors enrolled in standalone Part D plans or Medicare Advantage Part D plans that do not provide doughnut hole coverage and potentially save seniors in California a total of $259.5 million.[6] The reconciliation bill provides a smaller subsidy and would save California Part D enrollees $129.75 million in 2010, but it would eliminate the doughnut hole entirely by 2020.

The reconciliation bill would improve upon the Senate bill and create a Medicare coverage gap discount program to help seniors before the "doughnut hole" is eliminated. This program creates a 50% discount for brand-name Part D drugs in the doughnut hole starting next year, while generic drugs and higher discounts will be phased in over time. By 2020, 75% of brand-name and generic drug costs will be covered by Part D and the "doughnut hole" will no longer exist.[7] Currently, no standalone Part D plans cover brand-name drugs when a beneficiary is in the doughnut hole, and only 11% of Medicare Advantage Part D plans cover brand-name drugs when a beneficiary is in the doughnut hole.[8]

Finding 2: Health Care Reform Would Provide Seniors With Improved Access to the Doctors of Their Choice

Better Access to Primary Care and Surgeons

The Senate bill creates incentives for primary care doctors and surgeons to join or remain in Medicare by increasing the reimbursement rate for primary care doctors and some surgeons. The bill provides a 10% bonus to doctors who provide primary care under Medicare

[1] "2009 Enrollment Information," Centers for Medicare and Medicaid Services. Last accessed March 16, 2010, http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/2009_Enrollment_Release.zip.
[2] "Medicare Part D: Spending, Beneficiary Cost Sharing, and Cost Containment Efforts for High-Cost Drugs Eligible for a Specialty Tier," United States Government Accountability Office, January 2010; "The Medicare Drug Benefit in California: Facts and Figures," California Healthcare Foundation, November 2008.
[3] This includes a $310 deductible, after which beneficiaries pay 25% in coinsurance until they reach the "doughnut hole" at $2,830.
[4] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 3315 (2009).
[5] Health Care and Education Affordability Reconciliation Act of 2010. H.R. 4872, 111th Cong. § 1101 (2010).
[6] "The Medicare Drug Benefit in California: Facts and Figures," California Healthcare Foundation, November 2008.
[7] Health Care and Education Affordability Reconciliation Act of 2010. H.R. 4872, 111th Cong. § 1101 (2010).
[8] "The Medicare Drug Benefit in California: Facts and Figures," California Healthcare Foundation, November 2008.

between January 1, 2011 and January 1, 2016. It would also pay a 10% Medicare bonus to surgeons who practice in areas with shortages of doctors.[9] In California, only sixteen counties have enough primary care physicians for their population. It is reasonable to assume that primary care providers would accept Medicare, so the incentives are likely to help seniors in forty-two counties.[10]

In addition, the bill would increase the number of new medical school graduates going into primary care by shifting unused medical residency training slots from specialty care to primary care.[11] These residency training programs are funded by Medicare through the Accreditation Council for Graduate Medical Education (ACGME).

Better Access to Preventive Care

The Senate bill would eliminate all out-of-pocket costs for a wide range of preventive care services under Medicare. Starting in 2011, the bill eliminates co-insurance payments and cost-sharing for preventive services, such as for prostate cancer screenings, mammograms, diabetes screening tests, and glaucoma screening tests.[12] This would affect all Medicare enrollees in California, whether they are in fee-for-service or Medicare Advantage.

Finding 3: Health Care Reform Will Strengthen Medicare

The Senate bill and the reconciliation bill would help stabilize the finances of Medicare. Current projections suggest that Medicare will run out of funds by 2017.[13] 4.47 million Californians are on Medicare.[14] Health care reform would guarantee that Medicare will be solvent for at least the next 16 years.[15]

Health care reform would also cover 438,000 uninsured Californians ages 55-64.[16] Covering the near-elderly uninsured strengthens Medicare. The previously uninsured have greater health care needs and cost the Medicare program more when they become eligible than do the previously insured, spending on average 20% more per year ($5,796 as opposed to $4,773).[17]

The Senate bill also creates the Independent Medicare Advisory Board in order to advise Congress on how to keep Medicare solvent. The proposals from this Board cannot include

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[9] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 5501 (2009).
[10] These counties are Alameda, Contra Costa, Humboldt, Inyo, Marin, Mendocino, Napa, Orange, Placer, Sacramento, San Francisco, San Mateo, Santa Clara, Solano, Sonoma, and Yolo. Kevin Grumbach, Arpita Chattopadhyay, and Andrew Bindman, "Fewer and More Specialized: A New Assessment of Physician Supply in California," California Healthcare Foundation, June 2009.
[11] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 5503 (2009).
[12] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 4104 (2009).
[13] "2009 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," Centers for Medicare and Medicaid Services, May 2009.
[14] "California: Total Number of Medicare Beneficiaries, 2008," The Henry Kaiser Family Foundation.
[15] Richard S. Foster, "Estimated Financial Effects of the Patient Protection and Affordable Care Act of 2009 as Proposed by the Senate Majority Leader on November 18, 2009," Centers for Medicare and Medicaid Services, December 2009.
[16] Shana Alex Lavarreda and E. Richard Brown, "National Health Care Reform Will Help Four Million Uninsured Adults and Children in California," UCLA Center for Health Policy Research, October 2009; Shana Alex Lavarreda, E. Richard Brown, Livier Cabezas and Dylan H. Roby, "Number of Uninsured Jumped to MoreThan Eight Million from 2007 to 2009," UCLA Center for Health Policy Research, March 2010.
[17] J. Michael McWilliams, Ellen Meara, Alan M. Zaslavsky, and John Z. Ayanian, "Medicare Spending for Previously Uninsured Adults," *Annals of Internal Medicine*, 151 (11) (2009): 757-767.

any recommendation to ration health care, increase beneficiary cost-sharing, or otherwise restrict benefits.[18]

Medicare Advantage Plans Will Receive Incentives Based on Improved Quality and Overpayments to Plans Will Decrease

Medicare Managed Care (Medicare Advantage) would continue under health care reform, but the potential for overpayments to managed care plans would be reduced. In 2009, it was estimated that Medicare paid more to managed care plans by $14 billion than if the same enrollees had received care through the existing fee-for-service system.[19] Approximately one sixth of that overpayment (16.7%) went to plan profits and administration.[20] The health care reform bills would reduce the average amount of spending on private health care plans through a competitive bidding process and revisions to the payment rates.[21] The Senate bill also prohibits Medicare Advantage plans from charging seniors more for certain benefits, such as some chemotherapy, renal dialysis and skilled nursing services, than what seniors would pay under the traditional fee-for-service Medicare program.[22]

Medicare Advantage plans come in several forms, including HMO plans, PPO plans, Prepaid Fee-for-Service plans (PFFS), and Special Needs Plans that serve low-income seniors and seniors with chronic conditions and specialized needs. The HMO plans operate relatively efficiently, but the PPO and PFFS plans cost the Medicare program significantly more than traditional fee-for-service.[23] Moreover, Medicare Advantage plans that operate in rural areas have greater overpayment rates than those operating in urban areas.[24]

The Senate and reconciliation bills would change the bidding process for Medicare Advantage plans, from a system that rewards low bids with no demonstrated efficiency to a system that would reward quality. Savings from lower bids would be used to pay for quality incentives. Currently, 75% of those savings are passed on to Medicare Advantage plans, effectively paying the plans a higher rate than what they bid.[25,26] The Senate bill and the reconciliation bill also offer incentives to Medicare Advantage plans to provide higher-quality care by using a five-star rating system for plans and paying bonuses to plans with high ratings for quality, improvements, and enrollee satisfaction.[27]

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[18] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 3403 (2009).
[19] "Report to the Congress: Medicare Payment Policy," Medicare Payment Advisory Commission, March 2010.
[20] Ibid.
[21] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 3201 (2009); Health Care and Education Affordability Reconciliation Act of 2010. H.R. 4872, 111th Cong. § 1102 (2010).
[22] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 3202 (2009).
[23] "Report to the Congress: Medicare Payment Policy," Medicare Payment Advisory Commission, March 2010.
[24] Douglas W. Elmendorf, "Letter to Honorable Mike Crapo, United States Senate," Congressional Budget Office, May 2009.
[25] Under existing law, plans can either bid above a benchmark rate (which is already more than the rate for traditional fee-for-service) and pass on the additional costs to their enrollees, or bid under the benchmark but get a payment increase above their bid amounting to 75% of the difference between their bid and the benchmark rate. This system rewards low bids but not quality.
[26] The reconciliation bill would change Medicare Advantage bidding processes, so that plans located in higher cost areas would bid based on a benchmark rate that is 5% lower than the overall FFS Medicare rate, while lower cost areas would bid based on a 15% higher benchmark rate. Health Care and Education Affordability Reconciliation Act of 2010. H.R. 4872, 111th Cong. § 1102 (2010).
[27] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 3201 (2009); Health Care and Education Affordability Reconciliation Act of 2010. H.R. 4872, 111th Cong. § 1102 (2010).

Eliminating over-spending on Medicare Advantage plans would lower the premiums that all seniors in traditional fee-for-service Medicare pay. Medicare enrollees have shouldered the cost of overpayments to private plans through their Part B premiums. Overpayments to Medicare Advantage plans have increased Part B premiums for all Medicare beneficiaries by $3.35 per month or $40 per year, including those in traditional fee-for-service who do not share in the extra benefits, services, or subsidies provided by the private plans.[28]

Reducing overpayments to private plans would extend the solvency of the Medicare Trust Fund.[29]

Finding 4: Health Care Reform Creates More Options for Long-Term Care

The Senate bill creates new, community-focused options for long-term care. It also contains the Elder Justice Act, which includes nursing home abuse prevention and relocation of residents when nursing homes close.[30]

More Funding for Home and Community-Based Services

The Senate bill provides an additional $10 million per year between 2010 and 2014 to increase funding for state aging and disability resource centers, which are "one stop" community-based centers that help seniors and persons with disabilities find and access services.[31] To date, very few centers exist. Examples are the Del Norte InfoCenter in Crescent City and the expanded Network of Care for San Diego County.[32]

The Senate bill would also allow California to add home and community-based services and attendant services for all Californians who are eligible for nursing facility services under Medi-Cal.[33] The bill provides incentives of up to $3 billion in total Medicaid funds to help transition individuals from nursing homes to home and community-based services.[34] Over 330,000 seniors in California are in nursing homes.[35] The ability to choose home and community-based care over nursing home care would further the interests of the 89% of Americans over 50—ten million of whom live in California—who want to remain in their own homes instead of a nursing facility.[36]

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[28] "Report to the Congress: Medicare Payment Policy," Medicare Payment Advisory Commission, March 2010.
[29] January Angeles, "Ending Medicare Advantage Overpayments Would Strengthen Medicare," Center on Budget and Policy Priorities, September 2009.
[30] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 2011 (2009).
[31] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 2405 (2009).
[32] California Department of Aging, "Federal Grants Administered by CDA." Last accessed March 14, 2010, http://www.aging.ca.gov/federal_grants/default.asp.
[33] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 2401 (2009).
[34] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 10202 (2009).
[35] "California Health Care Almanac: Long Term Care Facts and Figures," California HealthCare Foundation, November 2009.
[36] Candace Baldwin, and Susan Poor, "There's No Place Like Home: Models of Supportive Communities for Elders," California Healthcare Foundation, December 2009; Source: State Population Projections and Population Projections Program. Population Division: State of California, Department of Finance, Race / Ethnic Population Estimates with Age and Sex Detail, 2000–2007. Sacramento, CA, 2007.

Protection of Spousal Assets for Home and Community-Based Services

Under current law, spouses of nursing home residents whose care is paid for by Medi-Cal have the right to keep some income and assets. In 2009, California had a Community Spouse Resource Allowance, which is the amount of assets that the spouse of a nursing home resident is allowed to keep, of $109,560. California also allowed spouses to keep $2,739 per month in income.[37] The Senate bill extends these income and asset protections to include the spouses of seniors receiving home and community-based services between 2014 and 2019, as well as to the home and community-based attendant services state plan benefit.[38]

Creation of a National Long-Term Care Insurance Program Within the Community

The Senate bill would establish a new national voluntary long-term care insurance program to help senior citizens receive health services while remaining in their homes and communities. This program, known as the "CLASS Act" (Community Living Assistance Services and Supports), would cover individuals after a five year vesting period and pay an average of $50 per day for services such as housing modifications and personal assistance.[39]

Finding 5: Health Care Reform Includes Protections for Seniors Eligible for Medicare and Medi-Cal

The Senate bill creates a new office under the Center for Medicare & Medicaid Services in order to ensure proper coordination of benefits for senior citizens who are eligible for both Medicare and Medi-Cal. More than one million Californians are eligible for both Medicare and Medi-Cal.[40] The bill protects the full level of benefits for qualifying seniors. Furthermore, the bill would improve the coordination of benefits to eliminate regulatory conflicts, make access to services more efficient, and improve care continuity.[41]

Conclusion

The final health care reform bill will, by all indications, be based on the Senate bill as amended by the reconciliation bill. An analysis of both bills suggests that California seniors will benefit from the passage of the two bills due to the elimination of the Part D doughnut hole, savings from Medicare Advantage, and changes to Medicare financing that will keep Medicare solvent for longer than previously estimated.

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[37] See "Spousal Impoverishment," Centers for Medicare and Medicaid Services. Last accessed March 17, 2010, http://www.cms.hhs.gov/medicaideligibility/09_spousalimpoverishment.asp.
[38] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 2404 (2009).
[39] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 8002 (2009).
[40] "California: Dual Eligible Enrollment, 2005," The Henry Kaiser Family Foundation.
[41] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 2602 (2009).

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