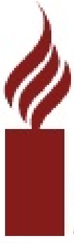

Rekindling Reform:
A Vision of Quality Health Care for All

c/o Community Studies of New York 155 W. 72nd St., Suite 402 New York, NY 10023 email@rekindlingreform.org www.rekindlingreform.org

May 30, 2007 rev.

Reclaim and Strengthen Medicare

Undo the Damage to Health Care for All

The traditional Medicare program, enacted in 1965, remains, despite its limitations, a fine example of *social insurance*, a system that is publicly instituted and publicly controlled. It is distinctly different from *private* insurance. As the National Academy of Social Insurance notes:

> Certain risks we have agreed to confront as a society, rather than as individuals. Citizens have decided, through the political system, that we need financial protection against some of life's difficulties that are hard to face as individuals. These include old age, ill health, unemployment, disability that makes it impossible to work, injury on the job, and the death of a family breadwinner. For all these conditions, we rely on help from social insurance programs, which are financed by workers and employers.

A war against Medicare had been developing for years, with the goals of replacing it totally with private insurance and discrediting the social insurance concept. Enactment of the Medicare Modernization Act of 2003 (MMA) was a victory for privatizers in the first major battle of that war. It virtually embodies a master plan for the war. The MMA undermines the health insurance program that senior citizens and people with long-term disabilities have relied on for many years. It strips away protections that people with Medicare continue to need. Moreover, as described below, if MMA's provisions are allowed to remain in force, they will continue to erode traditional Medicare.

Of most immediate note, one provision of the MMA is generating an artificial crisis. In the guise of a Medicare cost control measure, the MMA launches a brazen attack on the revenue underpinning of social insurance: it frames the issue of cost containment in Medicare mainly as a matter of limiting Medicare's access to the income tax revenues it has depended on since Medicare Part B was created. It sets an alarm designed to pressure Congress to act: either to limit Medicare spending or to start drawing much more heavily on beneficiary premiums and the dedicated payroll tax. That alarm was triggered when the Medicare Trustees issued their annual report April 23.

Initially, however, Congress has focused on the Medicare drug benefit.

Starting on Repairs

The next battle over the MMA has begun, in the new 110th Congress. The first objective of Congress's new leaders in the early months of this Congress has been to direct the federal government to bargain for lower drug prices. One of the most shameful provisions of the MMA is that it denies the Medicare program authority to negotiate prices with drug companies. This costs American taxpayers and Medicare beneficiaries tens of billions of dollars for windfall profits to the drug industry, deprives millions of seniors and disabled people of affordable access to the prescriptions they need, and undermines the sustainability of the entire Medicare program. It has accelerated the onset of a manufactured crisis for Medicare funding, as the next section makes clear. If the Medicare program were allowed to negotiate on behalf of its huge pool of beneficiaries, it could achieve far lower prices than the insurance companies buying separately can get.

Also under way is a concerted move to open up the importation of prescription drugs provided that they are produced in FDA-approved facilities and are packaged and shipped with counterfeit-resistant technologies.

Most immediately meaningful to millions of Medicare beneficiaries in the poorest health would be elimination of the "doughnut hole" gap in coverage that is proving to be a major hardship and leaving many unable to afford critically needed, life-sustaining medications. The more successfully pharmaceutical prices are reined in, the fewer beneficiaries will actually reach this coverage gap and the less Medicare will need to spend to eliminate the gap.

We support these reform objectives, but to stop there, for whatever reason, will fail to fix the most profound damage the MMA has inflicted, including provisions that, if left to work their masked purposes, will destroy the social insurance bases of Medicare. Leadership is needed urgently to alert the nation to these provisions that the MMA has put into law. Alerted and mobilized, the nation will rise up to preserve Medicare as it rose up to preserve Social Security. Failure to act will leave intact not only corrosive provisions already in force but also devastating statutory time bombs whose existence is not widely known.

As a cost-effective social insurance program, Medicare could be a foundation for extension of health care to all. However, first we need decisive action to safeguard Medicare's integrity, including its fiscal integrity.

Eliminate Threats to the Survival of Medicare

Using a much sought-after drug benefit as a lure enabled privatizers in Congress to enact the MMA's less well-known but more harmful provisions. Those provisions were a major step in a decade-long stealth effort to undermine and kill Medicare by starving it of funds.

Although the drug benefit reflects only Title I of the MMA's twelve titles, the public remains largely unaware of the numerous poison pills embedded in the rest of the law. Medicare's defenders need to bring the law's history to light and press for legislative actions to stem, and reverse, the damage wrought by the MMA:

> **Attention of responsive legislators has begun to concentrate on Medicare's overpayments to private health plans. These overpayments must end.** This scandalous subsidy is a bribe to draw the private plans into offering Medicare coverage to a cherry-picked, healthier-than-average beneficiary pool, leaving traditional Medicare with a sicker and ever more costly constituency. This rip-off of Medicare's precious reserves, according to the Medicare Payment

Advisory Commission, now amounts to paying 12 percent more per beneficiary (for beneficiaries who are healthier than average!) than under Medicare's traditional (indemnity) coverage option. In the case of private fee-for-service plans, average overpayments reach 19 percent. These overpayments drain the Medicare Trust Fund.

One phase of the attack on Medicare made news in late April 2007, when the Medicare Trustees issued their annual report on the state of Medicare's trust funds. The MMA directs the Medicare Trustees to monitor the general (non-dedicated) federal revenue projected to go to Medicare annually, and to sound an alarm when, two years in a row, looking seven years ahead, they foresee that stream exceeding 45 percent of Medicare's overall annual inflows. The stated aim is to trigger action to keep the general revenue contribution below an entirely arbitrary 45 percent level.

> By law, Medicare's main funding sources have been the Hospital Insurance Trust Fund ("Part A"), derived from a dedicated payroll tax; beneficiary premium payments for Parts B (Supplementary Medical Insurance) and D (Prescription Drug Benefit); and major supplementation (75%) for Parts B and D from general tax revenues.

Thanks to the MMA's overpayments to private health plans and its windfall to drug manufacturers, the 2007 report confirmed, for the second year in a row, that the 45 percent ceiling would be hit by 2012. Consequently, as noted above, Congress will soon be pressed to curtail Medicare's future access to income tax revenues.

Pursuant to **Sections 801-804 of the MMA**, when the President sends Congress his budget message next January (2008), he will need to propose a way to implement the 45 percent cap. He has already indicated in this year's budget message that he will ask Congress to program a series of automatic reimbursement cuts to all providers, to be imposed starting in 2012 and thereafter in any succeeding year for which the 45 percent cap is otherwise projected to be exceeded. The MMA requires Congress to consider the President's recommendation. Although it does not require Congress to act upon the recommendation, it forces consideration under highly restrictive, fast track rules, and some observers believe Congress will feel considerable pressure to act. An effort should be made to **repeal Sections 801-804**, but if that fails, **Congress should simply reject the cut the president recommends. In any case, Congress should initiate a study of Medicare's long-term financing,** to assure fiscal integrity while continuing to ensure beneficiaries' health and financial security **.** The study should look at overall health system cost factors and consider how best to control growth in Medicare costs.

A comprehensive **prescription drug option is needed that is entirely within Medicare** rather than involving private insurers. As a key move toward leveling the playing field by offering a choice between the public and private options, this will potentially enable a clearer demonstration of which model offers the greater effectiveness and efficiency. Given Medicare's low administrative costs, the premium charged to beneficiaries should be lower than premiums charged by private insurance companies.

Means testing of premiums for Medicare Part B, enacted in the MMA, with premium differentials now being phased in, should cease. By 2009, premiums for beneficiaries with the highest incomes are slated to be more than triple the regular premiums. But higher income beneficiaries were already paying more before the MMA – in payroll tax contributions and income taxes. By providing an incentive for upper income beneficiaries to leave Medicare, means-tested premiums undermine the universality of the Medicare program and weaken its base of political support. If the government's aim is to make individuals with higher incomes pay

more, that should be done via income tax reforms, not by tampering with access to the benefit.

The MMA's provision for an "experiment" with a defined contribution plan, euphemistically called **"premium support,"** must be eliminated. Its radical objective, masquerading as choice, is to fundamentally transform Medicare's character. Under this provision, effective in 2010 *all* Medicare beneficiaries in six metropolitan areas are to start getting vouchers. A "defined contribution" voucher, to help buy unreliable private insurance in an uncertain market, would replace what, since Medicare's beginning, has always been an entitlement to care – a "defined benefit." Great numbers of voucher recipients would find themselves squeezed to come up with additional cash to buy their accustomed level of coverage. Few if any Americans want this kind of "choice," which may force them to decide between their spouse's medical treatment and paying the rent. Traditional Medicare already affords the choice beneficiaries really want, choice of health care providers without fear of financial risk.

Health Savings Accounts (HSAs) should be repealed. They are part of privatizers' broad strategy to build popular support for individual private insurance. Their attraction is that either the policyholders or their employers can contribute pre-tax dollars to the accounts, and distributions from the accounts to pay medical expenses are tax-free. But only individuals with high deductible health coverage are permitted to have HSAs, and the lower cost of providing high deductible coverage can be an attractive alternative for employers who have been providing conventional health coverage. Lacking better coverage, if people open HSAs to conserve sparse financial resources, they risk finding themselves forced to go without necessary care. To the extent that higher income individuals end up relying on HSAs, the political support base for Medicare is likely to shrink. Meanwhile, the extraordinary tax write-offs that HSAs give to these same people deprive the government of money sorely needed to fund Medicare, thus putting at greater risk all who continue to rely on Medicare.

Take Further Steps to Strengthen Medicare

Next, **to make the drug benefit more helpful** to beneficiaries while containing the government's costs, further actions will be needed:

Under the MMA, employers with retiree plans currently receive subsidies that are based on combined employer *and* retiree expenditures. This incentive for employers to shift rising drug costs onto retirees should be eliminated.

Enrollment in the Low Income Supplement program should be made automatic, based on people's federal income tax filings. The assets test that now excludes many low-income beneficiaries from helpful additional subsidies should be eliminated.

The foregoing sections have focused on protecting Medicare and moving to restore its fiscal integrity. If, beyond this, Congress were to reduce Medicare's financial barriers for beneficiaries and make its benefits truly comprehensive, this would not only enable it to serve current beneficiaries more adequately but would also make it a more widely acceptable base for extension of coverage to the whole population.

Beneficiaries' annual out-of-pocket costs for Parts A and B should be capped, at a level below their current combined average.

People with disabilities must not be compelled to wait 29 months for Medicare coverage. There

is a precedent for change: those with ALS now need to wait only five months.

Federal legislation on mental health parity in private health insurance plans that include mental health coverage has been in effect for more than a decade, but that law has loopholes. A new bill to close the loopholes has strong congressional support and is moving ahead favorably, but that measure does not yet extend to Medicare. Parity is guaranteed to enrollees in the Federal Employee Health Benefits Program. It should prevail in Medicare as well.

Medicare benefits should be broadened to include comprehensive vision, dental, hearing, and long-term care.

The standard Medicare benefit should be broadened to eliminate the need for supplementary "Medigap" coverage.

Coordination of services for people with chronic conditions, especially those with multiple chronic conditions, must be improved.

As the struggle to expand the scope of Medicare benefits unfolds, the need for the nation to address inefficiency and waste arising from the ways medical goods and services are organized, paid for and delivered will become more and more compelling. Safe, trustworthy ways to contain costs need to be identified. Failure to do so would be a disservice to the nation as it strives to meet other vital needs of its people. Many of those other needs, on close scrutiny, turn out to be critically important for the nation's health even though this is often not apparent at first glance.

In Conclusion

Protecting and reclaiming Medicare can succeed only as a broad coalition effort. Existing coalitions need to be broadened and strengthened and, where they don't exist, need to be joined by new coalitions, so that the urgently needed changes recommended above can be achieved. The privatization camp, preferring to let the destructive MMA scenario play out, is powerful and has vast resources that it is using to influence Congress. However, the one essential element those forces lack is the power of a determined electorate demanding that Medicare be restored, protected, and strengthened. The demand must go out to the nation's present elected representatives as well as to all those who will be running for public office in 2008.

The fight begins now and the chances for success will be increased if all members of Congress hear from their constituents on the need to enact these changes.

Appendix

Four Cases that Exemplify the Failures of Medicare Private Health Plans*

Mr. L.

Mr. L. is a Latino man who lives in New York City. In the spring of 2007, Mr. L. began to experience bleeding and his doctor told him that his bladder and prostate cancer ~~he~~ had returned after 20 years. Mr. L.'s doctor ordered several diagnostic tests, but Mr. L. soon learned that the diagnostic testing center was not in his Medicare private health plan's network. Mr. L. had already stopped seeing his cardiologist because this specialist was not in the plan's network. Mr. L. requested disenrollment from his private health plan, Healthfirst.

Ms. A.

Ms. A. lives in Miami, Florida. She had been enrolled in the Medicare HMO Preferred Care Partners for a few years when in the spring of 2007, she learned that her private health plan had dropped South Baptist Health Care Systems from its network. South Baptist Health Care Systems consists of five hospitals and multiple diagnostic and treatment centers in Dade County. Ms. A. had been receiving specialized medical care from one of these facilities but now, because the facility was no longer in her HMO's network, she would have to pay the full cost of her treatment.

Ms. A. wanted to disenroll from Preferred Care Partners so that she could continue her treatment at the facility she had been using. Preferred Care Partners had not informed Ms. A. of the change in the plan's network until after March 31st -- the deadline to enroll or disenroll from a Medicare private health plan. Ms. A. contacted government agencies and advocacy groups in the hope that she could still disenroll from her plan. She was told that she could not disenroll from Preferred Care Partners until the next enrollment period, beginning November 15th with coverage effective in the New Year. Ms. A. will have to find a different facility which accepts Preferred Care Partners, where she can continue her treatment.

Mr. and Mrs. R.

Mr. R. of Memphis, Tennessee suffered a heart attack and was hospitalized for nine days in November 2006. After he was discharged, Mrs. R. went to the pharmacy to fill his prescriptions but found they could not be filled through his Medicare prescription drug plan. The pharmacist informed Mrs. R. that Mr. R. was enrolled in Health Spring, a Medicare HMO, which had disenrolled him from his Medicare prescription drug plan because no one is permitted to be in a private Medicare health plan and have a stand- alone drug plan.

---

* Case profiles generously provided by the Medicare Rights Center (MRC)

Mr. and Mrs. R. also received bills that totaled more than $87,000 from the hospital where Mr. R. had been treated. Original Medicare had rejected these claims because Mr. R. was now required to receive his medical care through Health Spring.

Mrs. R. contacted Health Spring and learned that a Health Spring sales representative had come to their home the previous spring and enrolled Mr. R., who is 80-years old and has Alzheimer's, into their health plan. A Health Spring representative also told Mrs. M. that Health Spring will not cover Mr. M.'s hospital bills because Health Spring had not approved Mr. R.'s hospital stay before he was admitted.

Mr. and Mrs. R are appealing to make Health Spring cover Mr. R.'s hospital stay but, in the meantime, the hospital has threatened to send them to a collections agency.

Ms. M.

Ms. M. is a Latina woman who has diverticulosis, a condition in which pouches form along the digestive tract. In the spring of 2007, Ms. M.'s pouches had become infected and her doctor scheduled surgery to treat them at Columbia Presbyterian Hospital. Ms. M., who was enrolled in Original Medicare at the time, was advised to join a Medicare prescription drug plan to cover the medications she would need after the surgery. Ms. M. decided to enroll in HIP's prescription drug plan but the HIP sales representative she spoke with enrolled her in their Medicare private health plan.

Just before Ms. M.'s surgery, she learned that HIP's private health plan would not cover care at Columbia Presbyterian Hospital. Ms. M. called the Medicare Rights Center the day before her surgery. A MRC counselor began to assist her and learned that it would be dangerous for Ms. M. to delay the surgery. Fortunately, the MRC counselor, after extensive work, was able to expedite Ms. M.'s disenrollment from HIP's private health plan and enroll her in EPIC, New York state's drug assistance program. Ms. M. was able to have surgery as scheduled.

Sponsors of Rekindling Reform

AARP -- New York State
Ackerman Institute for the Family
Adelphi University School of Social Work
American Medical Student Association Region II
Associated Medical Schools of New York
Avery Institute for Social Change
Brooklyn College Department of Health and Nutrition Sciences
Brooklyn Society for Ethical Culture, Ethical Action Committee
Citizen Action of New York
Columbia University Graduate School of Social Work
Columbia University Mailman School of Public Health
Columbia University School of Nursing
Committee of Interns and Residents, SEIU
Communications Workers of America Local 1180
Community Studies of New York/Infoshare
Council of Churches of the City of New York,
Interfaith Committee of Religious Leaders
Council of Municipal Retiree Organizations of New York City
District Council 37, AFSCME, Retirees Association
Ethical Culture Society of Queens
Five Borough Institute
Fordham University Graduate School of Social Service
Gray Panthers of Suffolk County
Green Party of New York State
Health Care NOW
Hunger Action Network of New York State
Hunter-Bellevue School of Nursing
Hunter College School of Social Work
Interfaith Alliance of Long Island
International Longevity Center - USA
League of Women Voters of the City of New York
League of Women Voters of New York State
Local 1199, SEIU
Long Island Coalition for a National Health Plan
Long Island Council of Churches
Long Island Health Access Monitoring Project
Medicare Rights Center
Metro New York Health Care for All Campaign
Mental Health for All New Yorkers
National Association of Social Workers, New York City Chapter
National Association of Social Workers, New York State Chapter
National Coalition of Mental Health Professionals and Consumers
National Medical Association, Manhattan Central Medical Society
New School University Robert J. Milano School of Management
and Urban Policy
New York Academy of Family Physicians
New York Academy of Medicine
New York Citizens Committee on Aging
New York Citizens Committee on Health Care Decisions
New York City Committee on Occupational Health and Safety
New York Medical College School of Public Health
New York State Association of Deans of Social Work Schools
New York State Nurses Association
New York State Professional Nurses Union
New York State Psychological Association, Social Issues Comm.
New York State Public Health Association, Long Island Region
New York University Ehrenkranz School of Social Work,
New York Univ. School of Medicine Center for Global Health
New York University Wagner School of Public Service
NORC Supportive Services Center
Nurse Practitioners of New York
Physicians for a National Health Program, Metro NY Chapter
Professional Staff Congress, CUNY
Professional Staff Congress, CUNY, Retirees Chapter
Public Health Association of New York City
Queens College Department of Urban Studies
Retired School Supervisors and Administrators
Sara Lawrence College, Health Advocacy Program
SUNY College at Old Westbury, Program in Health and Society
SUNY (Stony Brook) Health Sciences Center
SUNY (Stony Brook) School of Social Welfare
Women's City Club
Working Families Party
Yeshiva University Wurzweiler School of Social Work