Congressional discussions about health care reform legislation are entering their final stages. The Affordable Health Care for America Act, H.R. 3962, was introduced in the House of Representatives on Thursday, October 30, 2009, and is expected to be voted upon in early November. The Senate is in the process of merging bills that were passed by the Senate Finance Committee and the Senate Health Education Labor and Pensions (HELP) Committee.

Medicare plays an important role in these discussions. Congress hopes to use Medicare to develop innovative delivery system reforms that will improve quality of care and slow the growth of health care costs. Congress also would like to address issues pertaining to the solvency of the Medicare Part A trust fund as part of reform efforts.

This brief outlines some of the reforms that may be addressed by HR 3962 and similar legislation that will be introduced in the Senate.

**Ensuring access to doctors**

Opponents of health care reform have threatened Medicare beneficiaries that they would not be able to see their doctors if health care reform legislation is enacted. The opposite is true: reforms are needed to ensure that physicians will continue to be reimbursed adequately enough to accept Medicare beneficiaries as patients. Under current rules, physicians are scheduled to see a 21% reduction in the amount by which they will be reimbursed by Medicare starting in January 2010.

Unfortunately, for political reasons, a “doc fix” designed to reform the physician payment system is not included in H.R. 3962 or its Senate counterpart. A separate bill to redesign doctor payment was introduced in the House of Representatives on the same day as HR 3962; the Senate is considering a modification that is more short-termed. H.R. 3962 does, however, include other payment reforms that create incentives for primary care physicians and other practitioners to serve Medicare beneficiaries.
Reducing overpayments to Medicare Advantage plans

Both the House and the Senate address the 14% overpayment to Medicare Advantage (MA) plans. The House bill would adopt the MedPAC recommendation to create a “level playing field” with traditional Medicare. It also eliminates the fund set-aside for regional MA plans, and extends permanently the authority of the Secretary to adjust payments when MA plans claim their beneficiaries have higher health care needs than claims data establish.

The Senate bill would create a competitive bidding process for MA plans that would not achieve as much in savings and that would still result in MA plans in some areas being paid more than traditional Medicare. Both bills include bonus payments for quality. The Senate bill may include a provision to “grandfather” in extra benefits for plans in areas such as Miami that would see the most dramatic change in their compensation.

Closing the Part D donut hole and other reductions in drug costs

Under H.R. 3962, the phase down of the donut hole would begin in 2010. The bill would increase the initial coverage limit, the point at which people enter the Part D coverage gap, by $500 for next year. The phase-down of the donut hole would be completed by 2019. Beneficiaries would be charged only 50% of the cost of certain drugs in the coverage gap. Additionally, drug manufacturers must agree to Medicaid drug rebates for persons dually eligible for Medicare and Medicaid in order for their drugs to be covered by Part D in 2010 and beyond. The House also provides for negotiation of drug prices by the Secretary of Health and Human Services, with Part D plan sponsors still having the opportunity to try to negotiate greater drug price savings for their plans.

The bill that passed the Senate Finance Committee only included a provision to reduce the cost of brand name drugs in the coverage gap. It did not close the donut hole, require pricing rebates, or provided for negotiation of drug prices by the Secretary. The final bill introduced in the Senate may do more to close the donut hole.

Preventive services

Much of the focus on health care reform is on prevention of health conditions. The House bill eliminates co-payments and deductibles for preventive services that are covered by Medicare. It is expected that the Senate bill will do the same. The House bill also provides that all Medicare-covered vaccines will be covered under Medicare Part B. This ensures access to vaccines for all beneficiaries and should make them available without any cost-sharing.

Provisions to assist beneficiaries with limited incomes and resources

Neither the House bill nor the bill passed by the Senate Finance Committee includes all of the improvements that beneficiaries would have liked to see included in health care reform legislation. The Senate bill so far includes only minor adjustments.
H.R. 3962 increases the resource limit to $17,000/individual, $34,000/couple and provides for self-verification of income and resources. It establishes a process for reimbursement to beneficiaries who are found retroactively eligible for the Part D low-income subsidy. It eliminates Part D cost-sharing for dual eligible individuals who are in a Medicaid waiver program and who require skilled care. It also extends the Qualified Individual (QI) program for two years.

### Coordination of care

H.R. 3962 provides for a variety of demonstrations and pilot projects to move Medicare toward reimbursement for coordination of care for beneficiaries with chronic conditions. These programs include:

- **Transitional care services**: follow-up services designed to prevent avoidable hospital re-admissions, including pre-and post-discharge planning services, care coordination, medication orders, and translator/interpreter services;
- **Accountable care organizations (ACOs)**: An ACO is a group of physicians and other providers who use patient-centered processes and other best practices to coordinate care and avoid duplication of services. Payment incentives are based on improved quality and reduced expenditures. ACOs must agree not to deny, limit, condition coverage or the provision of care based on the health status of an eligible beneficiary.
- **Medical home**: A medical home directs or provides access to primary care and all health care needs, taking responsibility for arranging for care and ensuring access.
- **Independence at home**: home-based primary care teams provide coordinated care to high need populations at home to reduce hospital admissions and re-admissions, to reduce duplicative testing, and to improve outcomes.

### Medicare Commission:

The House, the Senate, and President Obama all expressed interest in having some independent entity review Medicare payment mechanism. H.R. 3962 authorizes two studies by the Institute of Medicine (IOM). One looks at geographic adjustment factors under Medicare, including issues concerning workforce recruitment and retention. The other looks at geographic variation in health care spending and promoting high value health care, including variations in prices, health status, practice patterns, access and supply, and socio-economic factors.

The Senate Finance bill included a provision to establish a Medicare Commission with authority to review Medicare payment structures and make recommendations to effectuate cost-savings. The recommendations would become effective if Congress did not act within specified, and very fast, time periods. The provision also included targeted caps on Medicare spending. Although the provision said that the Commission could not make recommendations about beneficiary premiums and cost-sharing, a last-minute
amendment would allow the Commission to make recommendations concerning Part D premiums.

Other beneficiary provisions

H.R. 3962 incorporates some additional consumer protections. The Senate bill is also likely to include provisions designed to provide additional protection to beneficiaries. The following are examples of some of these protections:

- Change the time frame for enrollment in Medicare Advantage and Part D plans;
- Limit cost-sharing in Medicare Advantage plans;
- Require MA plans to make available to beneficiaries information on their administrative costs (Medical Loss Ration);
- Allow payments by ADAP and Indian Health Service programs to count towards the Part D; out-of-pocket limit;
- Calculate the Part D benchmark premium amount before application of MA plan subsidies;
- Extend the exception process for the Part B therapy caps;
- Demonstration for reimbursement for culturally and linguistically appropriate services.

Combating misinformation about health care reform and older people

The Center for Medicare Advocacy wants to ensure that older people and people with disabilities have accurate information on how any health care reform bill would affect Medicare and their access to health care. Please check our web site, www.medicareadvocacy.org, and our blog, http://cmahealthpolicy.com, for updates.

The Center is also a member of Seniors to Seniors, a coalition of groups dedicated to educating older people about health care reform. Their web site, http://seniorstoseniors.org, provides information directed to Medicare beneficiaries and their families.