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Aging Alert

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AGING CUTS COULD DOUBLE IN 2010

At the last minute, cuts to the Office of Services to the Aging (OSA) more than doubled in the Community Health budget bill now pending in the Michigan Legislature. The bill is now in the Senate pending a procedural vote, and then requires Governor Granholm's signature to go into effect. Granholm has the power to veto individual line-items.

More than \$5 million in cuts for OSA programs are included in House Bill 4436, the FY 2010 budget for the Department of Community Health. The cuts would hurt 6,000 seniors receiving meals, home care, care management and caregivers supports, and represent 13% of OSA's state funding. When the bill was introduced in the House of Representatives in February, it included \$2.2 million in cuts recommended by Governor Granholm, but the bill passed the House with those cuts restored. Next the bill went to the Senate, and the cuts were put back at \$2.3 million. The Senate-passed version of HB 4436 met the budget targets agreed to by legislative leaders. So aging advocates are wondering why OSA cuts more than doubled in the final days of budget negotiations. Here is a list of the amounts cut and their impact:

- Care management- \$1,063,999 cut affecting 465 vulnerable older adults
- In-home services- \$954,870 cut affecting 1,020 vulnerable older adults
- Access services- \$128,732 cut eliminating 8,000 units of service
- Congregate meals- \$179,400 cut eliminating 33,500 meals to 733 seniors
- Home-delivered meals- \$1,717,578 cut eliminating 406,600 meals to 2,574 seniors
- Respite care and adult day care- \$531,300 cut affecting 215 caregivers
- Retired Senior Volunteer Program (RSVP)- \$108,400 cut eliminating 108,400 hours of service provided by 542 volunteers
- Foster Grandparents- \$385,900 cut eliminating assistance to 700 at-risk children provided by 140 volunteers
- Senior Companions- \$277,400 cut eliminating assistance to 500 frail seniors provided by 100 volunteers
- Senior Olympics- \$100,000 cut.

There is some good news for home care programs in HB 4436. The bill funds the MI Choice Medicaid Waiver at \$176 million for 2010, a \$17 million increase over last year due to more people being transitioned from nursing homes. Also in the bill are wage increases for Home Help workers, raising the wages for most workers to \$8 an hour.



SPECIAL REPORT: HEALTH CARE REFORM

Talk of Medicare cuts, rationing, and even death panels have alarmed many older adults who support helping the uninsured, which includes their younger relatives and friends, but not at the expense of their own health care. Groups with a financial stake in the outcome are running television commercials presenting catchy sound bites with limited information or even outright falsehoods. Who can you believe? This Special Report is designed to separate fact from fiction in the health care debate.

DO WE REALLY NEED HEALTH CARE REFORM?

The U. S. is the only developed country with uninsured citizens (16% or 47 million), and 45,000 people die each year because they have no health insurance. The uninsured jeopardize the financial stability of hospitals and other providers, which are forced to provide uncompensated care, then raise rates on everyone else with insurance. Families USA (www.familiesusa.org) estimates that health insurance for a family cost an extra \$1,017 in 2008 because of the uninsured. There are over 1 million Michiganders with no insurance and some with insurance who are devastated by deductibles/copays when they experience a serious health problem.

Health care costs are rising faster than general inflation and personal income. Per capita, the U.S. spends more on health care than any other country. Year by year, health care takes a bigger chunk out of government budgets, company budgets and family budgets. For example, the Medicare Hospital Trust Fund will run out of money in 2017 and tax revenues will be insufficient to cover expenditures. Steeply rising premiums are squeezing employers who provide coverage, as well individuals and families who purchase their own policies. U.S. companies find it difficult to compete with companies in other countries that provide universal health care. Employers are scaling back or cancelling health benefits for employees and retirees. Health reform legislation would increase competition and make other changes to better control health care costs.

Another problem is the way insurers operate. Over a third of those who try to purchase individual policies are denied coverage because of pre-existing conditions; many of those because of cancer. Insurers also cancel policies or raise premiums when customers get sick, or place lifetime caps on what they provide, leaving sick customers with large debts. Over half of all bankruptcies are triggered by medical expenses. Reform legislation forbids all of these practices. It also limits companies in their ability to charge the elderly higher premiums.

There are also issues with the quality of health care. The Institute of Medicine (www.iom.edu) says that medical errors in hospitals cause more preventable deaths than auto accidents, cancer or AIDS. Another indication of quality problems – 20% of Medicare patients return to the hospital within 30 days of discharge, costing \$20 billion/year. Reform legislation would change financial incentives to reward high quality care, invest in patient safety, and require that hospital-acquired infection rates be reported to the public. Innovative models would be tested to better coordinate care, prevent medical complications and keep people healthier.

WHAT ARE THE DIFFERENT PROPOSALS FOR REFORM?

There are 3 different plans now being considered in the U.S. Congress. Three committees in the House developed one bill - H.R. 3200 - and two Senate committees have developed separate bills with the plan of merging them. Soon the House and Senate will be holding floor debates, considering amendments, and voting on their respective bills. For side-by-side comparisons of

the House and Senate bills, go to www.kff.org.

DO ANY PROPOSALS CREATE SOCIALIZED MEDICINE?

None of the three bills would create a health care system run by the government, such as in Canada, England or other countries. Nor do the bills cover everyone in the U.S.; there would still be some uninsured (6%). For example, illegal immigrants are not covered.

ISN'T THE "PUBLIC PLAN" THE SAME AS SOCIALIZED MEDICINE?

No. The public plan would be one of the options made available to people who are now uninsured, to increase their choices and lower their premiums. It would be one option like traditional Medicare is one option for people 65+. Like traditional Medicare, a government-run plan is expected to have lower costs than insurance company plans because of lower administrative costs and no profits.

WILL THE GOVERNMENT COME BETWEEN ME AND MY DOCTORS?

No. This is the same falsehood used by critics trying to block the passage of Medicare in 1965. Those same critics called the Medicare program "socialized medicine."

WHAT IS THE PRICE TAG FOR REFORM AND HOW WILL IT BE PAID?

Health reform would cost between \$830 billion and \$1 trillion a year. Half of that would come from new taxes and fees on wealthy families, individuals with no insurance, and/or insurance companies. Between \$400 and \$500 billion would come from savings in Medicare, Medicaid and other federal programs. Savings in Medicare could include: phasing out overpayments to insurance companies selling Medicare Advantage plans; changing the formulas used to calculate annual increases for providers taking into account productivity improvements; reducing payments for preventable hospital readmissions; allowing Medicare to negotiate directly with drug companies; making generic drugs more available by shortening patent protection; and stepping up waste, fraud and abuse efforts. None of the bills would cut the benefits or services provided to Medicare beneficiaries. The Senate Finance Committee bill creates more revenue than expenditures and will reduce the federal deficit.

WHY DO INSURERS GET OVERPAYMENTS FOR MEDICARE ADVANTAGE?

Higher reimbursements were offered in 2003 as an incentive to encourage companies to participate in Medicare Advantage. The incentive worked and many insurance companies signed up; there are 156 Advantage plans available in Michigan. Insurance companies get paid 14% more on average compared with costs under traditional Medicare.

HOW DO INSURANCE COMPANIES USE THESE OVERPAYMENTS?

Companies can use the money to provide extra benefits, lower premiums, pay for administrative expenses, or increase their profits. (The government does not tell companies how to use the overpayments, which will cost \$11 billion this year.) Examples of extra benefits available to beneficiaries in Michigan: fitness classes; one dental cleaning/year; one filling/year; one physical/year. The government only requires insurance companies to provide the same benefits as traditional Medicare. According to the National Committee to Preserve Social Security and Medicare (www.ncpssm.org), a significant portion of overpayments has gone into profits.

WHAT IS THE IMPACT OF OVERPAYMENTS ON THE FINANCIAL VIABILITY OF MEDICARE?

The overpayments are making the Medicare program go bankrupt faster. Actuaries now estimate

that the Medicare Hospital Insurance Trust Fund will run out of money in 2017 and tax revenues will be insufficient to cover expenditures. Health reform legislation would extend the life of the trust fund by 4 – 5 years.

Overpayments also inflate the Part B premium deducted from beneficiaries' Social Security checks. Higher reimbursements mean the \$96.40 monthly Part B premium is \$3.60 higher than it would be otherwise. In other words, all Medicare beneficiaries (even the 80% not enrolled in Medicare Advantage) are paying an extra \$43.20 per year because of the overpayments. The Center for Medicare Advocacy (www.medicareadvocacy.org) says the overpayments create a fundamental unfairness in the program, since they burden all Medicare beneficiaries with higher premiums, but benefit only the 20% who enroll in Medicare Advantage.

WOULD CUTS TO INSURANCE COMPANIES AFFECT SENIORS?

They could affect those enrolled in Medicare Advantage plans. Participation in Medicare Advantage is voluntary and companies can leave the program if they choose. In that case, the beneficiaries affected would have to pick another Advantage plan or return to traditional Medicare. There are provisions in the bills that would give insurance companies bonuses for providing high quality care, and cancel cuts if Advantage plans cost less than traditional Medicare, which occurs in certain parts of the U.S.

DO ANY REFORM BILLS INCLUDE RATIONING OR DEATH PANELS?

No.

I'VE READ THERE IS ALREADY A DOCTOR SHORTAGE. WOULD REFORM HURT MY ACCESS TO DOCTORS?

Adding millions of people to the health care system would add to the shortage problem. Massachusetts experienced this when it adopted universal health care several years ago. The U.S. needs more primary care physicians and the medical schools aren't producing enough. Why? Because financial incentives are driving new physicians to pursue specialty care rather than primary care. Reform addresses this issue by creating financial incentives for physicians to go into primary practice. The bills would also stop a scheduled 21% cut in physician payments scheduled to take effect January 1, 2010, and change payments to emphasize primary care and care coordination.

IS THERE ANYTHING IN REFORM LEGISLATION THAT IMPROVES MEDICARE BENEFITS?

Yes. The infamous prescription drug "donut hole" would be eliminated over time. In the meantime, brand name drugs would be available in the donut hole at a 50% discount. Legislation also increases the asset limit for Extra Help for prescription drugs, enabling more seniors to get drugs at little or no cost. It also eliminates copays for preventive services provided by Medicare, such as colonoscopies.

Next issue: Is there anything in health reform legislation that addresses long term care needs?