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Obamacare: Impact on Seniors

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According to surveys, no group of Americans is more skeptical of Obamacare than senior citizens[1]—and with good reason.

While bits and pieces of the massive law are designed to appeal to seniors—more taxpayer subsidies for the Medicare drug benefit, for example—much of the financing over the initial 10 years is siphoned off from an estimated $575 billion in projected savings to the Medicare program. Unless Medicare savings are captured and plowed right back into the Medicare program, however, the solvency of the Medicare program will continue to weaken. The law does not provide for that. Medicare is already burdened by an unfunded liability of $38 trillion.

Medicare Advantage plans,[2] which currently attract almost one in four seniors, will see enrollment cut roughly in half over the next 10 years. Senior citizens will thus be more dependent on traditional Medicare than they are today and will have fewer health care choices.

Initial Provisions. Under the Medicare Modernization Act of 2003, Congress deliberately created a gap in Medicare drug coverage (the so-called "donut hole") in which seniors would be required to pay 100 percent of drug costs up to a specified amount. Obamacare provides a $250 rebate for seniors who fall into the "donut hole" and requires drug companies to provide a 50 percent discount on brand name prescriptions filled in the hole.

In 2011, Obamacare will also impose a new tax (a "fee") on the sale of these brand name drugs in Medicare and other government health programs, ranging from $2.5 billion in 2011 to $4.1 billion in 2018. Meanwhile, the law will freeze payments to Medicare Advantage plans and restrict physicians from referring seniors in Medicare to specialty hospitals where physicians have an ownership interest. In 2013, the law eliminates the tax deductibility of the generous federal subsidy for employers who provide drug coverage for retirees. This could further undercut provision of employment-based prescription drug coverage for seniors.

Fewer Plan Choices. With the freezing of Medicare Advantage payments in 2011, Congress has set the stage for a progressive reduction in seniors' access to, and choice of, the popular Medicare Advantage health plans.

In 2012, the law will begin reducing the federal benchmark payment for these plans. In 2014, these health plans must maintain a medical loss ratio of 85 percent, and the Secretary of Health and Human Services is to suspend and even terminate enrollment in plans that miss this target.

Enrollment in Medicare Advantage by 2017 is estimated to be cut roughly in half, from a projected 14.8 million (under current law) to 7.4 million.[3] Since there are serious gaps in Medicare coverage, including the absence of catastrophic protection,

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roughly nine out of 10 seniors on traditional Medicare already need to purchase supplemental insurance, such as Medigap. Without Medicare Advantage, millions more seniors will have to go through the cumbersome process of paying two separate premiums for two health plans.

Less Access to Physicians. In 2011, the new law provides a 10 percent Medicare bonus payment for primary care physicians and general surgeons in "shortage" areas. This is a tepid response to a growing problem.

With the retirement of 77 million baby boomers beginning in 2011, the Medicare program will have to absorb an unprecedented demand for medical services. For the next generation of senior citizens, finding a doctor will be more difficult and waiting times for doctor appointments are likely to be longer. The American Association of Medical Colleges projects a shortage of 124,000 doctors by 2025.[4]

Obamacare has not ameliorated the growing problem of projected physician shortages and has surely made it worse. Under the new law, physicians will be even more dependent on flawed government payment systems for their reimbursement. Moreover, the congressionally designed Medicare physician payment update formula, the Sustainable Growth Rate (SGR), initiates cuts that are so draconian that Congress goes through annual parliamentary gyrations to make sure its own handiwork does not go into effect.[5]

The new law also dramatically expands Medicaid, a poorly performing welfare program with low physician reimbursement rates, and this expansion will account for roughly half of the 34 million newly insured Americans.[6] Furthermore, the law creates an Independent Payment Advisory Board, which will recommend measures to reduce Medicare spending. Formally, the board is forbidden to make recommendations that ration care, increase revenues, or change Medicare beneficiaries' benefits, cost-sharing, eligibility, or subsidies. For the board, reimbursement for doctors and other medical professionals seems the only target left. But payment cuts can effectively ration care.

More Medicare Payment Cuts. According to the Centers for Medicare and Medicaid Services (CMS):

> Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers cost of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries).[7]

Indeed, creating a real problem for seniors, the CMS Actuary estimates that roughly 15 percent of Medicare Part A providers—the part of the Medicare program that pays hospital costs—would become unprofitable within 10 years.[8]

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1. For example, according to an April 2010 Kaiser Family Foundation survey, 47 percent of seniors expect that they will be worse off under the new law. (*www.kff.org*).
2. For a description of the Medicare Advantage program, see Robert E. Moffit, "The Success of Medicare Advantage: What Seniors Should Know," Heritage Foundation *Backgrounder* No. 2142, December 5, 2006, at *http://www.heritage.org/research/healthcare/bg2142.cfm.*
3. Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," U.S. Department of Health and Human Services, April 22, 2010, p. 11.
4. American Association of Medical Colleges, "AAMC Workforce Conference Examines Reform's Effect on Physician Supply," *News Alert*, May 10, 2010, at *http://www.aamc.org/newsroom/pressrel/2010/100510f.htm* (May 17, 2010).
5. For a description of the Medicare payment and the SGR formula, see John O'Shea, M.D., "The Urgent Need to Reform Medicare's Physician Payment System," Heritage Foundation *Backgrounder* No. 1986, December 5, 2006, at *http://www.heritage.org/Research/Reports/2006/12/The-Urgent-Need-to-Reform-Medicares-Physician-Payment-System.*
6. Foster, "Estimates of Financial Effects," p. 6.
7. *Ibid.*, p. 10.
8. *Ibid.*

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Higher Taxes. Under the new law, seniors are going to pay higher taxes. The higher taxes on drugs (effective in 2011) and medical devices (effective in 2013) will affect seniors especially, as they are more heavily dependent on those very products. Older people, of course, have higher health costs than younger people. But the existing tax deduction for medical expenses will be raised from 7.5 to 10 percent of adjusted gross income in 2013. The reduced tax deductibility of medical expenses is waived for seniors only from 2013 to 2016. Likewise, older people have larger investments than younger people, and thus high income older persons will be more heavily impacted by the new 3.8 percent Medicare tax imposed on unearned or investment income (effective 2013).

New federal health insurance taxes—both the premium taxes and the excise taxes—will also impact older workers and retirees. The federal premium tax (effective 2014) will be applicable to Medicare Advantage plans and health plans offered to federal retirees in the Federal Employees Health Benefit Program (FEHBP). Likewise, starting in 2018, there is a new 40 percent federal excise tax on "Cadillac" health plans (defined as $10,220 for individual coverage and $27,500 for family coverage). This will also apply to FEHBP plans, which enroll federal retirees.

A Better Policy. Forcing doctors and hospitals to comply with new rules and shaving reimbursement for treating senior citizens is not real reform. If Congress is going to reduce Medicare and impose a hard cap on Medicare payment to restrain per capita cost growth, at the very least it ought to channel those savings right back into the program to enhance Medicare's solvency and lay the fiscal foundation for real reform. Seniors deserve better than what Obamacare gives them.

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