List of Inaccuracies and Omissions in the CMS Brochure Entitled "Medicare and the New Health Care Law – What it Means for You"

Page 1:

Claim: *"These are needed improvements that will keep Medicare strong and solvent."*

This statement ignores conclusions by the Chief Actuary for Medicare within the Department of Health and Human Services in an April 22, 2010 memorandum (Chief Actuary's Memorandum) that plainly states that the reduced spending resulting from the significant Medicare cuts in the health reform bill, "cannot be simultaneously used to finance other Federal outlays (such as coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."

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More Affordable Prescription Drugs

Claim: *"Over the next ten years, you will receive additional savings until the coverage gap is closed in 2020."*

According to the latest data from the Medicare Payment Advisory Commission (MedPAC) , about 3 million beneficiaries -- out of 17 million non-LIS eligible Part D enrollees -- were actually exposed to 100 percent cost-sharing in the Part D coverage gap or "donut hole." The Congressional Budget Office (CBO) has concluded that some of the changes enacted in the health reform law will likely raise Part D premiums almost 10 percent. Despite these facts, the brochure fails to disclose that 17 million seniors enrolled in Part D are likely to see significantly higher premiums for their drug coverage without seeing any benefit from the new law.

Improvements to Medicare Advantage

Claim: *"The new law levels the playing field by gradually eliminating Medicare Advantage overpayments to insurance companies."*

This statement in the brochure ignores statutory requirements that Medicare Advantage funds, termed in the brochure as "overpayments to insurance companies," must be used for lower cost-sharing or extra benefits for seniors. The Medicare statute clearly states that 75 percent of the difference between the plan's bid and the benchmark payment amount must go directly to seniors in the form of lower cost-sharing and extra benefits, while 25 percent is returned to the federal government. In fact, these funds, again referred to in the brochure as "overpayments," help millions of low-income seniors – who can't afford to pay $175 per month for supplemental coverage in a Medigap plan – fill in the holes of traditional Medicare. As a result, these low-income beneficiaries will be the most significantly impacted from these cuts in Medicare Advantage funding despite the brochure's claim that this is an "improvement in Medicare."

Claim: *"If you are in a Medicare Advantage plan, you will still receive guaranteed Medicare benefits."*

The brochure fails to disclose that a significant number of seniors will lose access to Medicare Advantage benefits due to the health reform law." According to CBO, Medicare Advantage enrollment 10 years from now will be almost 2 million less than it is today. Enrollment was projected to increase by 4.8 million before the health reform law passed. This decrease is the result of plans cutting benefits and dropping out of the program entirely. So it is important to note that Medicare Advantage may no longer be an option for millions of seniors as a result of the new law.

Also, the brochure consistently uses the phrase "guaranteed Medicare benefits" to hide the fact that the changes to Medicare Advantage will cut extra benefits – like lower cost-sharing, disease management and dental and vision services – by approximately 50 percent. Seniors who rely on these benefits don't care if they are guaranteed or not. They just want to know they'll continue to have to health benefits they have come to rely on.

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<u>Better Access to Care</u>

Claim: "*Your choice of doctor will be preserved."*

This statement in the brochure ignores a number of conclusions by experts in direct contradiction of this claim. First, the Chief Actuary's Memorandum concluded that cuts in Medicare due to productivity adjustments "are unlikely to be sustainable on a permanent annual basis" because of their impact on the program. In fact, the Chief Actuary's conclusion is that 15 percent of Medicare Part A providers could be unable to sustain their operations in the next ten years as a result of the drastic Medicare cuts in the new health reform law and would therefore be unable to continue offering health care services to beneficiaries. According to the Chief Actuary, absent legislation to intervene and correct the problem, these cuts could cause some providers to "end their participation in the program" with the effect of "possibly jeopardizing access for beneficiaries." Claims in the brochure that "choice of doctor will be preserved" are not support by the conclusions of the Department's own Chief Actuary and are, at best, blatantly erroneous. Jeopardizing access to health care services will make access to care worse and not better.

Second, the Patient Protection and Affordable Care Act (PPACA) failed to address the Sustainable Growth Rate (SGR) problem so without additional legislation, it is unlikely that a beneficiary's "choice of doctor will be preserved". This is a significant fact that is omitted from the brochure and a clear example of the brochure failing to disclose all the facts.

Claim: *"The law increases the number of primary care doctors, nurses, and physician assistants to provide better access to care through expanded training opportunities, student loan forgiveness, and bonus payments."*

These statements make broad assumptions that certain PPACA provisions (GME, student loans, and primary care bonus payments) will, in fact, increase the number of primary care physicians and health care professionals. There is no guarantee that the new health reform law will actually result in an increased number of primary care physicians and other health professionals. In fact, many primary care physicians continue to express concern about their shrinking numbers.

Better Chronic Care

Claim: *"Community health teams will provide patient-centered care so you won't have to see multiple doctors who don't work together."*

This claim is overbroad and overstates the impact of PPACA. Section 3502 (Establishing Community Health Teams to Support the Patient-Centered Medical Home) of PPACA establishes a program to provide grants to eligible entities to establish community-based health teams. It requires state entities to apply for grants or enter into contracts with eligible entities to establish community based health teams to support primary care. There is a lengthy list of requirements to be a "health team" and eligible entities for grants must submit a plan for achieving long-term financial sustainability within 3 years and meet other specific requirements.

The broad statement in the brochure that "Community health teams will provide patient-centered care so you won't have to see multiple doctors who don't work together" implies that community health teams will be available to provide patient-centered care to all Medicare beneficiaries. This statement is misleading because it fails to include any caveats regarding the eligible entities or the extensive list of requirements for health teams and primary care providers that would convey the limited applicability of this program and make the statement accurate.

Claim: *"If you're hospitalized, the new law also helps you return home successfully—and avoid going back—by helping to coordinate your care and connecting you to services and supports in your community."*

This claim is overbroad and overstates the impact of PPACA. Sec. 3026 (Community-Based Care Transitions Program) of PPACA establishes a program that provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries. To qualify for the program, a beneficiary would have to be hospitalized in a hospital identified as having a high readmission rate and receive services from an appropriate community-based organization that provides specific care transition services detailed in the section. To qualify, an individual would also have to be a "high-risk" beneficiary based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission that includes at least one of the specified risk factors, such as cognitive impairment or depression.

As noted in the previous paragraph, the broad statement that if you're hospitalized, you will get help returning home and avoiding readmissions is not accurate since it paints a misleading picture by implying that this program would be available to all Medicare beneficiaries when in fact the program will only be available to certain hospitals and high-risk beneficiaries.

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<u>Keeps Medicare Strong and Solvent</u>

Claim: *"Over the next 20 years, Medicare spending will continue to grow, but at a slightly slower rate as a result of reductions in waste, fraud, and abuse. This will extend the life of the Medicare Trust Fund by 12 years and provide cost savings to those on Medicare."*

This claim that Medicare is strengthened is directly contradicted by the facts. First, reductions in growth are not the result of reductions in fraud, waste and abuse as claimed in the brochure. The reductions in growth are the result of drastic cuts in Medicare by the permanent productivity cuts and the cuts recommended by the Medicare Advisory Board (IPAB). The Chief Actuary estimated in the Chief Actuary's Memorandum that the permanent productivity cuts, which the Chief Actuary warns are "unlikely to be sustainable" would reduce overall Medicare cost growth by 0.6 to 0.7 percent per years and the IPAB process would reduce Medicare cost growth by 0.3 percent per year. It is therefore misleading to claim that fraud, waste and abuse provisions are responsible for extending the life of the Federal Hospital Insurance Trust Fund by 12 years.

Also, the statement ignores conclusions in the Chief Actuary's Memorandum that the reduced spending resulting from the significant Medicare cuts in the health reform bill, "cannot be simultaneously used to finance other Federal outlays (such as coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."

According to the Chief Actuary's Memorandum, "the estimated savings…for one category of Medicare provisions [permanent annual productivity adjustments] may be unrealistic."

OACT also noted that "[a]verage Medicare costs per beneficiary usually increase over time" based on medical price-growth, higher utilization of services and greater complexity of the services and that actual Medicare cost growth per beneficiary was below the target level in only 4 of the last 25 years. Three of the four years were immediately after the Balanced Budget Act of 1997, and Congress passed two subsequent laws to mitigate its effects.

Also, during the last 25 years, the average increase in the target growth rate has been -.33 percent/year below the average Gross Domestic Product increase, approximately the same target level as the SGR system. Congress has overridden the SGR reductions for each of the last seven years and twice this year for the first five months of 2010. Another SGR override is expected for the rest of 2010 and possibly several years beyond.