

Report on Senate health bill: Medicare cuts jeopardize access to care

Kate Randall
14 December 2009

Cuts to Medicare in the health legislation being debated in the US Senate pose a threat that many institutions serving large numbers of Medicare patients might drop the government program, “possibly jeopardizing access to care for beneficiaries,” according to a report issued Friday.

The analysis by Rick Foster, chief actuary for the Centers for Medicare and Medicaid Services (CMS), questioned the sustainability of the more than \$400 billion in cuts to the government-run health care program for the elderly and disabled proposed in the Senate bill. The CMS analysis also suggests that 20 percent of institutional medical providers could become unprofitable within a decade.

The Senate is continuing debate on the “Patient Protection and Affordable Care Act,” which if passed must then be reconciled with legislation passed by the House in early November. Senate Majority Leader Harry Reid, Democrat of Nevada, needs the votes of all 58 Democrats and the 2 Senate independents to ensure passage of the Senate bill. The Congressional Budget Office (CBO) has placed the cost of the legislation at \$848 billion over 10 years, not including the proposed cuts.

Barack Obama is vigorously promoting the Senate bill, and is pushing for some version of health care legislation to be on his desk to sign before he delivers his State of the Union address in late January. He is insisting that any costs of the bill be defrayed by deep cuts to services, to maintain legislation that is “deficit neutral.” In an interview Sunday on CBS’s “60 Minutes” program, Obama said he expected the Senate bill to be passed before Christmas, December 25.

The legislation is deeply regressive, defending the profits of the insurance industry and pharmaceuticals while threatening cuts in care for millions of ordinary

Americans. In addition to the massive cuts to Medicare, it would leave an estimated 25 million people without any insurance coverage. Individuals and families would be mandated to obtain coverage or pay a penalty, funneling billions of dollars in premium payments to the private insurers.

The CMS report also predicts that new demand for care as a result of the bill could prove “difficult to meet initially,” as doctors and hospitals would charge higher fees as a result of the increased demand. White House spokesman Reid Cherlin disputed the report’s findings, stating, “Congress has implemented even larger savings in Medicare in the past, and no access problems materialized.”

The report also questions the sustainability of the Senate bill’s creation of a long-term-care insurance program that would provide a daily subsidy for people with disabilities and illnesses requiring home-based care. Because individuals requiring such care would be more likely to use this insurance, there is a danger of “adverse selection,” the analysis suggests, posing a risk that insurance payments might exceed premium revenues.

The CMS analysis also warns that people with preexisting conditions could face problems under the Senate plan. While the bill prohibits insurers from denying coverage for preexisting conditions, this ban would not take effect until 2014. A provision in the bill provides a measure to provide relief for this “high-risk pool.”

According to the CMS analysis, however, this intermediary program could run out of money as early as 2011. CMS’s Foster writes, “By 2011 and 2012 the initial \$5 billion in Federal funding for this program would be exhausted, resulting in substantial premium increases to sustain the program; we anticipate such

increases would limit further participation.”

It also emerged over the weekend that a loophole in the Senate bill would allow insurance companies to place annual dollar limits on people suffering from costly illnesses, such as cancer. As it is currently written, the bill would permit insurance companies to limit annual monetary payouts for medical care, as long as those limits are not “unreasonable.” There is no explanation of what level of limits would be allowable, consigning this task to administration officials.

The language capping costs is conveniently included in a clause of the bill titled, “No lifetime or annual limits.” Stephen Finan, a policy expert with the American Cancer Society Cancer Action Network, denounced the loophole in comments to AP. “The primary purpose of insurance is to protect people against catastrophic loss,” he said. “If you put a limit on benefits, by definition it’s going to affect people who are dealing with catastrophic loss.”

Cancer treatment costs can exceed \$100,000 a year. Under conditions where these costs could be deemed “unreasonable,” patients could exhaust their insurance benefits. Finan added, “If you are a cancer patient you could be faced with a situation where you either have to terminate your care, or face a financial catastrophe. We see this kind of situation with some regularity.”

As debate continued in the Senate on final form of the health care legislation, it appears all but certain that a government-run “public option” will not be included on the “exchange” where individuals and families without medical insurance can purchase coverage. No Republicans are likely to support the bill, and a number of Democrats and independents are opposed to the public option, as well as alternative provisions of the bill that they claim are too costly.

In place of the public option, Senate Majority Reid has proposed a two-faceted scheme. The first component would be modeled after the Federal Employees Health Benefits Program (FEHBP), which is administered by the Office of Personnel Management (OPM). Coverage on the exchange would be provided by private insurers under the management of OPM, which would have control over spending.

Additionally, Senate Democrats also propose to allow people ages 55 to 64 to “buy-in” to the government-run Medicare program. These premiums would be hefty, costing an estimated \$7,600 a year per person,

according to a budget office analysis of an earlier version of the proposal.

Democratic leaders have refused to divulge details on either the OPM coverage plan or the Medicare “buy-in” option, waiting for a CBO cost analysis due some time this week. They have been careful to note, however, that benefits on the purchased Medicare plan for people 55 to 64 would not be identical to the federally run program.

The estimated 4 million people aged 55 to 64 who presently do not have health insurance are typically in much poorer health than the general population. The insurance industry group America’s Health Insurance Plans says that more than 25 percent of Americans in their early 60s who sought coverage on their own last year were denied it. According to the CBO, if people in the 55-64 age group were required to pay the full cost of Medicare benefits, they could pay up to \$635 a month for coverage.

Senator Joe Lieberman, independent of Connecticut, appearing on the CBS “Face the Nation” television program Sunday, reiterated his opposition to any government-run insurance program, as well as the proposed long-term care insurance program.

Democratic Senator Ben Nelson (Nebraska) insists that he will not support the Senate bill unless it contains extreme limits on abortion funding. An amendment sponsored by Nelson that would have imposed limits in the legislation on the provision of the legally protected right to abortion was defeated on December 8.

It is becoming increasingly clear that the Senate health care legislation will be sliced and diced to cater to the various demands of reluctant Senate Democrats and independents in an effort to ensure its passage, rendering an already retrograde piece of legislation even more reactionary, and that Obama will sign whatever version of the bill comes across his desk.



To contact the WSWS and the
Socialist Equality Party visit:

wsws.org/contact