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STATE HEALTH REFORM BILLS INTRODUCED

Michigan's version of health reform was unveiled in March by Representative Marc Corriveau (D-Northville) and Senator Tom George (R-Kalamazoo). House Bills 6034—6037 and Senate Bills 1242—1245 reflect compromises hammered out by Corriveau and George after receiving input from stakeholder groups. One major thrust is the creation of new standard and enhanced policies providing more affordable coverage for some of the 1+ million uninsured in Michigan. The policies will be 'guarantee issue' meaning insurers can't turn sick customers away. The premiums will be subsidized for those with annual incomes under 300% of poverty ($32,508 in 2010) and insurance companies will face lower risks by getting reinsurance for claims between $80,000 and $800,000.

Premiums can vary based on age and geographic location. So-called age rating is at 4-to-1, meaning that if a policy costs $300/month for a 20-year-old, the same policy would cost four times as much – $1,200/month – for a 60-year-old. (The new federal law will cap age rating at 3-to-1, but not until January 1, 2014.) Geographic rating means that policies can vary based on health costs in different parts of the state. This will likely mean that policies cost more for residents of Southeast Michigan than other parts of the state. Healthy behavior will be rewarded with lower premiums for no smoking, healthy weight and compliance with health screenings.

Reforms to Blue Cross Blue Shield (BCBS) – a controversial element of earlier efforts – are also part of the new package. A new approval process for premium increases would allow quicker approval of cost-of-living increases without lengthy challenges from the Attorney General. Any increases over and above would be subject to the current scrutiny and could be challenged. This new process would apply to both BCBS and commercial insurers selling individual policies.

Also incorporated are consumer protections, including: reducing coverage limits for pre-existing conditions from 12 months to 6 months; no pre-existing condition exclusions for customers moving from group to individual coverage; insurers cannot cancel policies or raise rates if a customer gets sick; adults up to age 26 can be covered under their parent's plan; and no more gender discrimination in the pricing of health insurance.

NATIONAL HEALTH REFORM
PART I – CHANGES IN MEDICARE

History was made in March when President Barack Obama signed into law two bills reshaping every aspect of the nation's health care system. The new laws include $500 billion in Medicare savings ("cuts") over the next 10 years, triggering an avalanche of questions and concerns from older Michiganians. This article will explain where the savings come from, and summarize other aspects of reform affecting the Medicare program specifically. Future articles will cover other aspects of health reform including changes in Medicaid, and initiatives in Long Term Care.

PROBLEM	BEFORE REFORM	AFTER REFORM
Out-of-pockets costs for Medicare are a financial hardship for beneficiaries. As a result, some forgo treatments and services.	Most Part D plans have a coverage gap that starts with $2,830 in total drug costs. In this "donut hole," seniors pay 100% of their drug costs until they have spent $4,550 out-of-pocket that year. These figures go up every year.	For 2010 only, any senior with spending in the donut hole will receive a $250 rebate check. In 2011, seniors in the donut hole will get a 50% discount on brand name drugs and a 7% discount on generics. These discounts will increase gradually until the donut hole is eliminated in 2020.
	The catastrophic coverage level for drugs goes up every year. This is the level of spending where the copay drops to 5%.	The catastrophic coverage level is lowered from 2014 through 2019 so more seniors qualify.
	Drug copays are waived for nursing home residents on Medicare and Medicaid, but not dual eligibles in the MI Choice Medicaid Waiver, which provides an alternative to nursing homes.	Drug copays are waived for dual eligibles in both nursing homes and the MI Choice Medicaid Waiver beginning 2012.
	Medicare Advantage plans have latitude in setting deductibles and copays. Some charge higher amounts than original Medicare.	Medicare Advantage plans are prohibited from charging higher deductibles and copays than original Medicare.
	Preventive services are covered by Medicare but some beneficiaries don't use them because of deductibles and copays.	Deductibles and copays for preventive services are eliminated in Medicare starting 2011. Annual checkups are covered with no deductibles or copays in 2011.
Some primary care doctors won't accept Medicare.	Medicare pays primary care doctors significantly less than specialists.	Primary care doctors will receive a 10% bonus for treating Medicare beneficiaries from 2011-2015. Government subsidies for medical education are changed in 2011 to favor primary care doctors.

PROBLEM	BEFORE REFORM	AFTER REFORM
Medicare costs are rising rapidly and outpacing revenues.	The Medicare Part A Hospital Trust Fund will run out of money in 2017.	The life of the Hospital Trust Fund is extended for 9 years to 2026.
	Medicare providers (hospitals, etc.) get annual increases in payment rates.	Annual increases are maintained but reduced starting 2011, cutting the annual growth rate from 7% to 6%. Savings = $360 billion over 10 years.
	Medicare Advantage Plans (HMOs, PPOs, etc.) were originally created to save money, but now cost 14% more than original Medicare, on average. Plans have latitude in how much they spend on overhead and profits.	Payments to plans are frozen in 2011 and restructured gradually beginning in 2012 so that payments, on average, are equal to original Medicare. Plans get bonuses if they meet quality benchmarks. Plans are limited to 15% for overhead and profits beginning 2014. Savings = $140 billion over 10 years.
	Seniors with annual incomes above $85,000 for individuals and $170,000 for couples pay higher Part B premiums.	The threshold for higher Part B premiums is frozen at $85,000/indi and $170,000/couple from 2011 through 2019. Seniors at these levels will pay higher Part D drug premiums as government subsidies are reduced.
	The Medicare payroll tax of 1.45% applies to all wages and is part of the FICA tax.	In 2013, the Medicare payroll tax will increase to 2.35% for wages over $200,000 for individuals and $250,000 for couples. Taxpayers at these levels will also pay a new 3.8% Medicare tax on investment income.
	Medicare provider payment rates are decided by Congress, which is heavily lobbied by provider groups.	In 2014, a Medicare Independent Payment Advisory Board will adjust provider payments if costs exceed targets. Congress' ability to overturn changes is limited. The board cannot change eligibility or benefits.
	Medicare provider payments are not designed to reward efficiency.	New payment models will be developed to reward efficiency and discourage duplication and waste.
Fraud and abuse is a problem in Medicare.	Programs are in place to combat fraud and abuse but the problem is still growing.	Medicare providers will be more thoroughly screened starting 2010. Increased funds will be devoted to catching criminals. Coordination with IRS will identify Medicare providers that aren't paying taxes.

PROBLEM	BEFORE REFORM	AFTER REFORM
Quality of care is inconsistent and can be improved.	Hospital-acquired infections are a growing problem.	In 2015, Medicare hospital payments will be reduced for hospital-acquired infections.
	Primary care doctors and specialists don't talk to each other. Hospitals don't communicate with their patients' primary care physicians. Lack of communication and coordination leads to repetitive interviews and forms, duplicate tests, overmedication, drug interactions, incorrect diagnoses, etc.	In 2012, providers can join together to create "Accountable Care Organizations" that will improve communication, coordination and enhance the quality of care. ACOs that meet quality benchmarks will receive financial bonuses.
	When a person is discharged from the hospital, inadequate patient education, preparation and aftercare lead to unnecessary readmissions. 20% of Medicare patients return to the hospital within 30 days of discharge, costing $20 billion/year.	In 2012, hospital payments will be adjusted to reduce preventable readmissions.
	Medical errors in hospitals cause more preventable deaths each year than auto accidents, cancer or AIDS. Provider payments are not designed to reward quality care.	Innovative pilot programs will be launched to test new ideas that can improve quality, including electronic medical records.
		A website will be launched in 2011 comparing physicians on quality measures for the Medicare program, called "Physician Compare."
The annual open enrollment period for drug plans and Medicare Advantage plans is too short and coincides with holidays.	The annual open enrollment period for Advantage Plans and drug plans is November 15 through December 31.	Starting 2012, the annual open enrollment period for Advantage plans and drug plans is October 15 through December 7.

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