Health Care Reform and Medicare

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How does the Affordable Care Act affect people on Medicare?

The *Affordable Care Act* signed by the President in March, 2010, enacted comprehensive reforms to our health care system with the goal of assuring access to affordable quality health care for all Americans. In addition to providing coverage for the millions of Americans currently without health insurance, the Act also contains numerous provisions that affect the Medicare program. The Medicare-related provisions are directed at improving the fiscal soundness of the program and promoting quality and efficiency, as well as expanding some benefits.

The following is a summary of the timeline for implementation of the provisions relating to the Medicare program.

2010

Begins narrowing the Medicare prescription drug coverage gap (the “donut hole”) by providing a $250 rebate to Medicare beneficiaries in the gap. The coverage gap refers to prescription drug costs incurred after total drug spending for the year (2010) exceeds $2,830 and continues until total drug spending for the year reaches the threshold for catastrophic coverage ($6,440). Beneficiaries pay a small co-pay ($6.30 for brand name drugs and $2.50 for generics, or 5% of the cost, whichever is greater) for drug costs incurred after the catastrophic coverage limit is reached. These amounts are adjusted each year.

Reduces projected Medicare payments to hospitals, home health agencies, nursing homes, hospices, and other providers.

2011

Provides Medicare beneficiaries in the prescription drug coverage gap with a 50% discount on brand name drugs. The share of drug costs paid by Medicare beneficiaries will continue to decease until it reaches 25% in 2020. At that time the donut hole will be eliminated and Medicare beneficiaries will pay a standard 25% co-pay for drug costs after the deductible is met and until their total drug spending reaches the threshold for catastrophic coverage.

Provides Medicare beneficiaries a free annual wellness visit and waiver of all cost sharing (co-pays and deductibles) for prevention services.

Provides a 10% Medicare bonus to primary care doctors and a 10% Medicare bonus to general surgeons practicing in a designated Health Professional Shortage Area, such as inner cities and rural communities.

Freezes the extra payments to Medicare Advantage (managed care) plans, the first step in reducing the subsidy paid to the private insurers who operate these plans which serve about 25% of the Medicare population. The average payment per Medicare beneficiary to Medicare Advantage plans is 14% higher than the average payment for a Medicare beneficiary in original fee-for-service Medicare. The reductions would be phased in over three to seven years. Medicare Advantage plans will be required to pay out in medical claims at least 85 percent of the premium dollars they collect.

Creates a new Center for Medicare and Medicaid Innovation within CMS (Centers for Medicare and Medicaid Services) to develop pilot programs to test more efficient ways of paying hospitals, doctors, nursing homes, and other providers who care for Medicare patients from admission through discharge

Freezes the threshold for income-related Medicare Part B premiums for 2011 through 2019. The 2010 threshold is $85,000 for an individual and $170,000 for couples.

Reduces the Medicare Part D premium subsidy for individuals with incomes above $85,000 and couples with incomes over $170,000.

Note: The Act created a long term care insurance program (the Community Living Assistance Services and Supports "CLASS" program) that was intended to provide a modest cash benefit to help individuals pay for in-home care services or for nursing home expenses. Benefits would begin after the individual had made premium payments for five years. The Act provided that cash benefits must be not less than an average of $50.00 per day. Premiums would be paid through voluntary payroll deductions and all employees would be automatically enrolled in the program unless they chose to opt out. No taxpayer funds could be used to support the program. The Secretary of Health and Human Services was required to develop the details of the CLASS benefit plan by October 1, 2012. However after extensive study and actuarial analysis the Secretary determined that, given the likelihood of "adverse selection" [those who were more likely to need the benefit would opt to stay in the program and younger, healthier individuals would opt out] the premiums that would have to be charged to participants would be too high to sustain the program. Thus the Secretary announced in 2011 that HHS would not take any further steps to implement the program.

2012

Initiates Medicare payment reform by encouraging hospitals and doctors to join together in quality-driven “accountable care organizations” similar to the Mayo Clinic. Organizations that meet quality thresholds will share in the cost savings they achieve for the Medicare program.

Directs CMS to track hospital readmission rates for certain high-cost conditions and implements a payment penalty for hospitals with the highest rates of preventable readmissions.

2013

Increases the Medicare payroll tax on couples making more than $250,000 and individuals making more than $200,000. The tax rate (employee share) on wages above those thresholds would rise to 2.35 % from the current 1.45%. Also adds a new tax of 3.8% on income from investments for couples making more than $250,000 and individuals making more than $200,000. The 3.8% tax will be applied to the lesser of the total investment income or the amount by which the taxpayer's adjusted gross income (from all sources) exceeds the threshold.

Imposes a 2.3% sales tax on medical devices. Eyeglasses, contact lenses, hearing aids and many everyday items purchased at drug stores are exempt.

2014

Prohibits health insurers from denying or limiting coverage to individuals with medical problems, charging higher rates to those in poor health, or refusing to renew a health insurance policy based on health status. Premiums can only vary by age (no more than 3 to1), place of residence, family size and tobacco use. These requirements do not apply to Medicare supplement (Medigap) policies or Medicare Advantage plans, which are regulated under separate federal and state laws.

Establishes an Independent Payment Advisory Board to develop and submit proposals to Congress aimed at extending the solvency of Medicare, lowering health care costs, improving health outcomes for patients, promoting quality and efficiency, and expanding access to evidence-based care.

2015

Continues narrowing the Medicare prescription drug coverage gap.

Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1%.

Creates a physician value-based payment program to promote increased quality of care for Medicare beneficiaries.

2016

Continues narrowing the Medicare prescription drug coverage gap. The Medicare beneficiary enters the “donut hole” when total drug costs for the year exceed $3,310. The beneficiary then pays 45% of the cost of brand name drugs and 58% of the cost of generic drugs until the “out of pocket threshold” of $4,850 is reached. The 50% discount on brand name drugs and the 5% plan subsidy on brand name drugs count toward the out of pocket threshold, in addition to the beneficiary’s actual out of pocket costs. After the out of pocket threshold is reached the beneficiary enters the “catastrophic coverage period”. The beneficiary then pays a $7.40 copay for brand name drugs and a $2.95 copay for generic drugs, or 5% of the cost of the drug, whichever is greater, for the remainder of the year.

2020

The prescription drug coverage gap is phased out. Medicare beneficiaries will pay a standard 25% co-pay for their drug costs after the deductible is met until they reach the threshold for Medicare catastrophic coverage, at which point their co-pays will drop to no more than 5%.