

What Health Care Reform Means for Medicare

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Nora Super

Director, Federal Government Relations
Health and Long-Term Care
AARP

Health Care Reform Law Improves Medicare

The new health care law:

- Improves, protects and sustains Medicare;
- Greatly improves long-term care options for Americans with chronic needs.
- Stops insurance companies from denying affordable care based on age or pre-existing conditions; and

It will help slow the growth of health care costs while improving access to high quality, affordable care.

How the New Health Care Law Benefits Helps People on Medicare

If you are on Medicare: Your guaranteed Medicare benefits are protected and you will receive improved benefits. Changes to Medicare will lower the out-of-pocket cost for prescription drugs you need to stay healthy and expand the preventive care you can get for free, while making sure you can continue to see your doctor.

How did HCR reduce costs in the Medicare program?

- The new law creates incentives that will encourage hospitals, doctors, and other providers to provide quality care at a lower cost.
- Additional Medicare savings come from reducing extra payments to private insurance companies; cracking down on waste, fraud and abuse; and identifying savings through a new Independent Payment Advisory Board.

What are the benefits of these changes?

- These changes will help slow the growth of health care costs, reduce out-of-pocket expenses, and reduce the federal budget deficit over time.

Other Medicare Improvements

- No copayments or deductibles for preventive care benefits
- Improving pay for doctors and hospitals in rural communities;
- Improving pay and access to primary care doctors and nurses.
- Cracking down on waste, fraud and abuse

Medicare Changes

To identify savings from Medicare, the laws:

- Provide new money for prosecutors and other enforcement tools to reduce the 3-10% of Medicare spending that results from fraud
- Create incentives that will encourage hospitals, doctors and other providers to provide higher quality care at a lower cost (\$174 billion)
- Reduce excess payments to private managed care plans called “Medicare Advantage” while changing payment structure to reward quality and access (\$135 billion)
- Reduce Medicare’s spending on uncompensated care by expanding the number of Americans who have insurance (\$22 billion)
- Increase income-related premiums for higher income Medicare beneficiaries (\$36 billion)
- Identify savings through a new Independent Payment Advisory Board (\$16 billion)
- Reforms home health provider payments (\$40 billion)

Investments in Preventive Care

•The ACA makes changes to Medicare coverage for preventive care services. Beginning January 1, 2011, millions of Medicare beneficiaries will be able to access many important preventive services without incurring any cost-sharing obligations. This policy represents an important step in eliminating barriers to preventive services for Medicare beneficiaries.

Starting on January 1, 2011, Medicare will also cover an annual wellness visit and accompanying personalized prevention plan for all beneficiaries. The visit and personalized prevention plan will be free. The free personalized prevention plan includes the following:

- A health risk assessment, for which HHS is to develop guidelines
- Individual and family medical history
- A list of current providers providing care
- A list of prescription medications
- Height, weight, and body mass index (BMI) or waist circumference measurements
- Blood pressure measurements
- Detection of cognitive impairments
- A screening schedule for appropriate preventive services over the next five to ten years
- A list of risk factors and conditions for which interventions are recommended or under way
- Personalized health advice and referrals as appropriate

Medicare Advantage

How did HCR change Medicare Advantage?

- Medicare Advantage (MA) plans will continue to be offered.
- Beginning next year (and phased-in over time), MA plans will be paid more in line with traditional Medicare payments.

What are the benefits of these changes?

- These changes are intended to address flaws in the current payment approach that result in excess payment to private MA plans compared with the traditional Medicare program, geographic disparities in payment, and lack of incentives to provide high quality care.

What's AARP's position?

- AARP supports these changes because they result in savings that will be used to fund other priorities such as improving prescription drug benefits and preventive care for all Medicare beneficiaries. AARP also supports the continuation of high quality choices for Medicare beneficiaries.

MA Payment Changes

- MA payments will gradually move closer to fee-for-service payments
- Geographic location and quality will affect payment
- Plans that provide higher quality care will be eligible for bonuses if they achieve at least 4 stars in a 5-star evaluation system
- Plans will be limited in the amount spent on administrative expenses

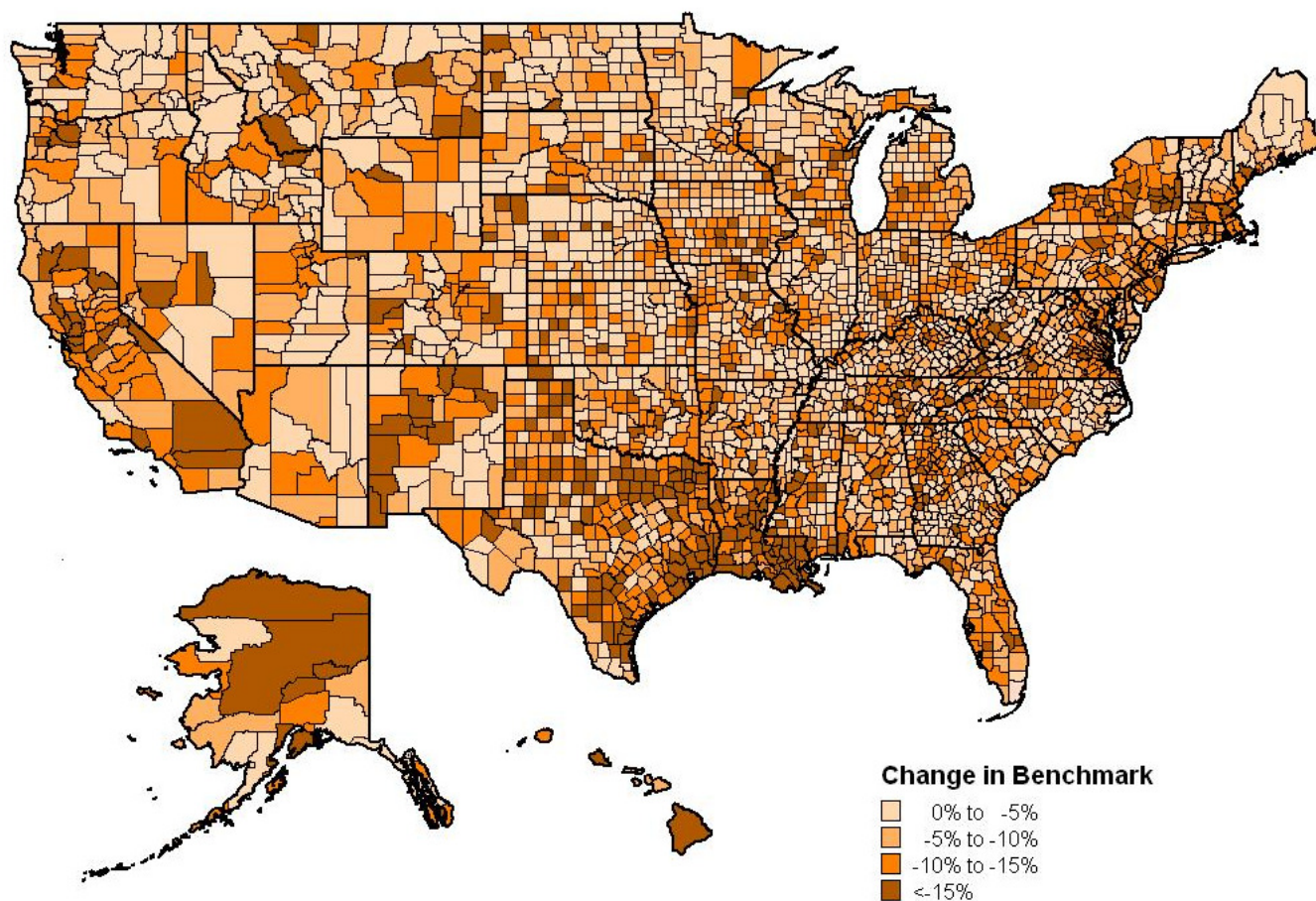
MA Payment Savings

- **MA payment changes will result in significant savings to the federal government that can be used for other priorities such as improving prescription drug benefits and preventive care for all Medicare beneficiaries.**
- The Congressional Budget Office (CBO) estimates that federal spending for MA will be reduced by \$135 billion between 2010 and 2019.
- CBO also projects that over this period, there will be 4.8 million fewer MA enrollees than there would have been under current law. More than half of the decrease will likely occur in plans located in high-cost areas such as Miami and Los Angeles.

What Does this Mean for the Enrollee?

- Cost-sharing charges for specified services will be pegged to Medicare limits
 - MA plans will not be allowed to impose higher cost-sharing charges than in traditional Medicare.
- MA enrollees will be able to switch plans at newly specified times
 - In 2011, MA enrollees will be able to switch to traditional Medicare in the first 45 days of the year
 - In 2012, the annual election period for all of Medicare will be from October 15 – December 7
- “Extra benefits” (or beneficiary rebates) like dental services or vision care, or reduced cost-sharing, will likely be reduced
 - Each individual plan will make this determination

Actual Impact of MA Payment Changes Will Vary Greatly Across the Country



Medicare Advantage in West Virginia

- As of March 2010, a record 11.1 million beneficiaries, nearly 1 in 4, were enrolled in Medicare Advantage
 - Even though the total number of plans declined between 2009-2010
- In West Virginia, 21 percent of all beneficiaries are in Medicare Advantage plans
- However, a single firm accounts for more than 57 percent of all enrollment (Humana)

The Doughnut Hole

What is the doughnut hole and what's the big deal?

- They called it the “doughnut hole,” but it felt more like cliff.
- Between the Initial Coverage Limit (\$2,830 in 2010) and the Catastrophic Coverage Limit (\$6,440 in 2010), beneficiaries would pay Part D premiums but receive *no help with your drug costs*. Officially, this is known as “Medicare Part D Coverage Gap.”
- As a result, many beneficiaries did not get the medication they needed.



Closing the Doughnut Hole

- **Some immediate relief**
 - One time check of \$250.00 for people who fall into the gap this year.
 - In 2008, 31,700 West Virginians hit the doughnut hole.
- **More relief on the horizon**
 - 50% discount on brand-name drugs, starting January, 2011 with discounts on generics phased in after that.
- **The doughnut hole will be closed by 2020.**
 - Between now and that day, beneficiaries will get help with their out-of-pocket drug costs, primarily in the form of significant discounts.
 - By 2020, beneficiaries will pay a consistent 25% coinsurance over what used to be the coverage gap.



The Doughnut Hole: Past and Future

Four Phases of Drug Spending under Part D

| Drug Spending | Annual Deductible | Initial Coverage Period (period after meeting your deductible and before hitting the Coverage Gap) | Coverage Gap or “Doughnut Hole” | Catastrophic Coverage Period (period after emerging from the Coverage Gap) |
|---|--|---|--|---|
| THE PAST Before Health Care Reform | Pay monthly premium and <u>100%</u> of cost of Rx. | Pay monthly premium and <u>25%</u> of cost of Rx (copay or coinsurance). | Pay monthly premium and <u>100%</u> of cost of Rx. | Pay monthly premium and <u>5%</u> of cost of Rx. |
| THE FUTURE After Health Care Reform | Pay monthly premium and <u>100%</u> of cost of Rx. | Pay monthly premium and <u>25%</u> of cost of Rx (copay or coinsurance). | Pay monthly premium and <u>25%</u> of cost of Rx (copay or coinsurance). | Pay monthly premium and <u>5%</u> of cost of Rx. |

Fighting Fraud & Abuse

- New health law adds \$300 million to fight fraud and abuse.
 - More Prosecutors
 - New Computer Systems: (High tech crime requires high tech solutions)
 - Coordination between agencies
 - Coordination between state and federal governments
 - New payment rules (No more “pay & chase”)

Improving Transparency

- ACA takes a number of steps to link Medicare payments to the quality of care, which will involve enhanced measurement of quality as well as public reporting on hospitals' and other facilities' performance. For example, hospitals that participate in Medicare value-based purchasing programs will have to meet quality measure reporting requirements specified by the HHS Secretary, and the Secretary will publicly report each hospital's:
 - Performance on each quality measure that applies to it,
 - Performance on each condition or procedure, and
 - Overall performance.
- The Physician Quality Reporting Initiative, which provides incentive payments to physicians who report certain quality measures to the Medicare program, is extended, and beginning in 2014 Medicare payments to physicians who do not participate will be reduced.
- In addition, the HHS Secretary must implement a plan to make physician performance information publically available, much as hospital performance information is now available on the Hospital Compare website

Improving Efficiency of Medicare

- MedPAC has concluded that Medicare's fee-for-service reimbursement system rewards excessive care and does not encourage service coordination or quality care. Several provisions in the ACA are consistent with MedPAC recommendations to provide adequate incentives to produce appropriate, high-quality care at an efficient price.
- For example, a provision in the ACA requires the establishment of a national, voluntary pilot program that will bundle payments for physician and hospital as well as post-acute care services with the goal of improving patient care and reducing spending.

Improving Efficiency of Medicare

- Another provision establishes rewards for accountable care organizations that meet quality-of-care targets and reduce costs per patient relative to a spending benchmark with a share of the savings they achieve for the Medicare program. CBO estimates that this shared savings program will save Medicare \$4.9 billion over FY2010-2019.
- The ACA also requires the creation of a Center for Medicare and Medicaid Innovation within CMS. The purpose of the center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients. Successful models could be expanded nationally. CBO estimates that this provision will lead to an additional savings of \$1.3 billion over 10 years.

Transitional Care Benefits

- ACA does not create a Medicare new transitional care benefit, but it does include a number of provisions to help better coordinate care, including per se, in Medicare or Medicaid. It creates several programs based on promising models for improving transitional care for people with chronic conditions. These new programs include the following:
- The Medicare Community-Based Care Transitions Program. This \$500 million five year program will make grants to hospitals with high readmission rates in partnership with community-based organizations that include multiple health care stakeholders. Grantees will be required to deliver at least one transitional care intervention
- Incentives to reduce Medicare hospital readmissions
- The Medicare Independence at Home demonstration
- Medical Home models in Medicare and Medicaid
- Community Health Teams to support Medical Homes, regardless of payer type



Key Medicare Reform Timeline

2010

- Medicare prescription drug “donut hole”
\$250 beneficiary rebate
- Cracking down on waste, fraud, and abuse
– funding, enforcement and screening for
providers

2011

- Income-relating Part D premiums and freezing of income-relating thresholds
- Medicare annual wellness exams and elimination of cost-sharing for preventive services
- Numerous Medicare payment changes (primary care bonus, power-driven wheelchairs, advanced imaging services, home health update reduced)

2011 continued

- Medicare, Medicare Advantage benefit and payment reform
- Part D discounts begin in donut hole

2011 (continued)

- Freezes MA payment rates at 2010 levels
- MA cost sharing restrictions
- Simplification of annual election period (MA to traditional Medicare)

2012

- Waives Part D cost-sharing for full duals in HCBS
- Four-year Medicare Graduate Nursing Education demonstration program begins
- Medicare Hospital Readmission Reduction Program begins
- Hospital value-based purchasing rewards begin

2013

- Higher Medicare payroll tax on wages exceeding \$200,000/individual; \$250,000/couples
- New Medicare tax on net investment income for taxpayers with incomes exceeding \$200,000/individual; \$250,000/couples
- Mandatory medication therapy management for Part D enrollees with chronic conditions

2014

- State exchanges/all major insurance reforms
- Premium subsidies and cost-sharing subsidies for Exchange insurance
- Individual and employer responsibility requirements
- HCBS spousal impoverishment protections
- Medicare Advantage plans must have minimum 85% medical loss ratio



2015

- State Exchanges must be self-sustaining
- Minimal cost-sharing in Medigap C and F plans
- States may enroll CHIP kids in Exchange plans
- GAO study on affordable coverage/premium assistance credits

Conclusion

- The CMS Office of the Actuary projects that savings to the Medicare Part A trust fund will extend its solvency 12 additional years, from 2017 under previous law to 2029 as a result of health reform.
- Health care cost growth is a major challenge throughout the health care system. However, there are many provisions in health care reform that are intended to help slow cost growth, including programs to test new ways to organize and pay for care while improving its quality.
- In addition, real improvements to the program – such as new preventive benefits and closing the Part doughnut hole – will improve the program for current and future participants.



Questions for Nora