COLORADO CENTER on LAW & POLICY

Justice and Economic Security for *all* Coloradans

Affordable Care Act at 3: Strengthening Medicare

ISSUE BRIEF
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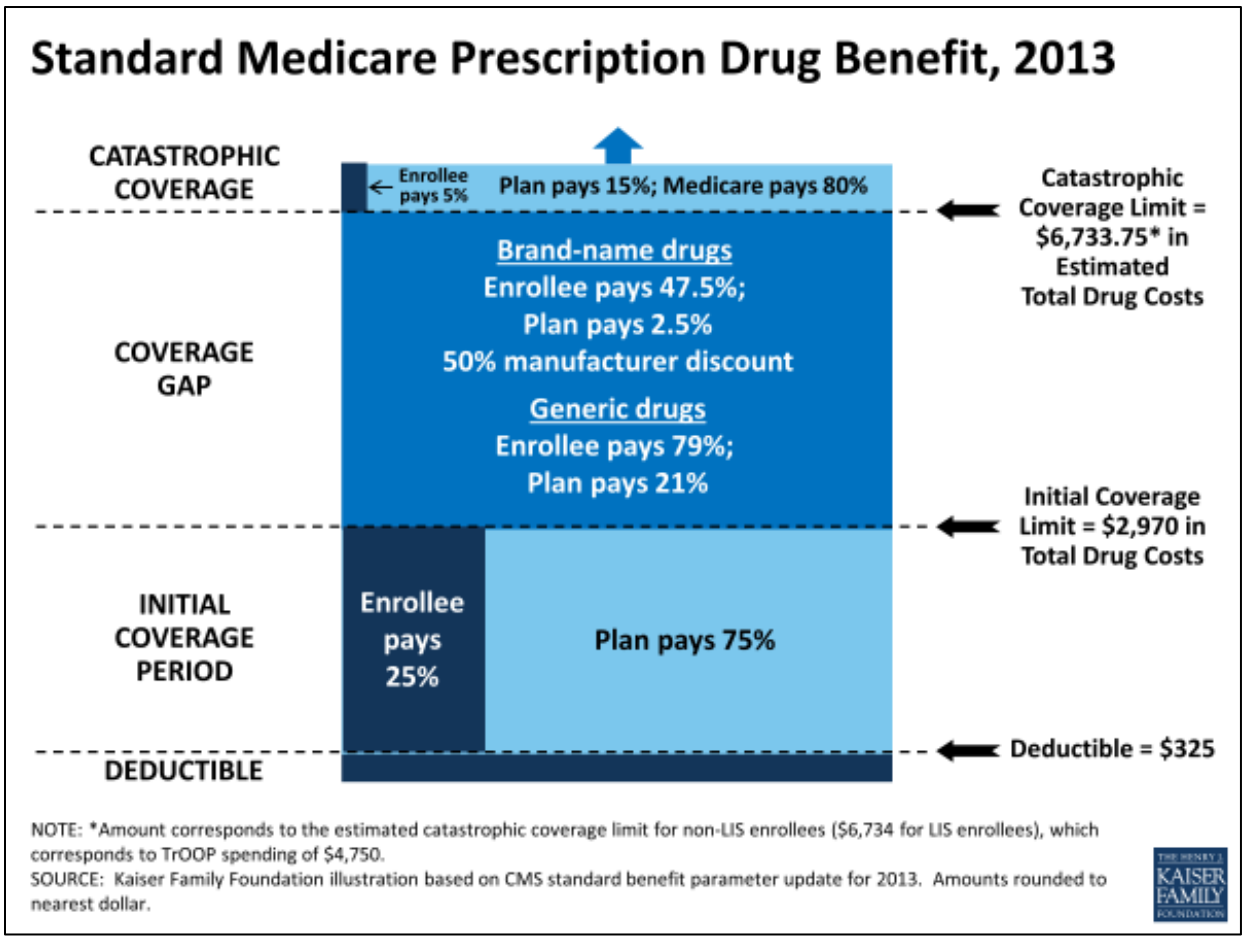
The Colorado Center on Law and Policy is a nonprofit, nonpartisan research and advocacy organization seeking justice and economic security for all Coloradans.

March marked the third anniversary of the passage of the health reform law, known as the Affordable Care Act (ACA). When fully implemented, the law will fundamentally transform the American health care system, providing affordable, quality health insurance to 30 million otherwise uninsured Americans. The law makes significant changes to Medicare, the federal program that provides health insurance to more than 49 million seniors and disabled people across the country, including more than 660,000 people in Colorado. The ACA strengthens benefits for Medicare recipients, creates incentives for quality care and helps to improve the long-term financial stability of the program.

Strengthening Benefits

The ACA made several important improvements to benefits for Medicare recipients. In order to incentivize care that will help prevent illness, Medicare now covers more than 20 preventive services without cost or co-pay. These services include cancer screenings, diabetes screenings, wellness visits, flu shots and smoking cessation counseling. Since its passage, tens of millions of seniors have received preventive services under this provision of the ACA. In 2012 alone, 34 million people received preventive services through Medicare at no cost, including 215,000 Coloradans in the first nine months of 2012.

Seniors and other Medicare beneficiaries will also receive increased prescription drug benefits under the ACA. Since 2006, Medicare beneficiaries have been able to obtain prescription drug coverage through Medicare. Before the ACA, the standard Medicare prescription drug benefit included a deductible ($325 in 2013) and covered 75 percent of prescription costs until total prescription costs reached an initial coverage limit ($2,970 in 2013). Beneficiaries were responsible for all of their prescription costs in excess of the initial coverage limit until their costs exceeded the catastrophic limit ($6,734 in 2013). Beneficiaries were only responsible for 5 percent of any costs that exceeded the catastrophic limit. The gap in coverage between the initial coverage limit and the catastrophic limit is often referred to as "the doughnut hole."



Source: "The Medicare Prescription Drug Benefit Fact Sheet." Kaiser Family Foundation. www.kff.org.

The ACA closes the doughnut hole. In 2010, the law provided each beneficiary who hit the doughnut hole with a $250 rebate. Starting in 2011, beneficiaries whose costs reached the coverage gap received a 50 percent discount on all brand name drugs. By 2020, beneficiaries will pay only 25 percent of the negotiated price for brand and generic prescription drugs above the initial coverage limit.

The U.S. Department of Health and Human Services (HHS) estimates that closing the doughnut hole has saved 6.3 million seniors and other Medicare beneficiaries $6.1 billion since 2010. In the first 9 months of 2012, nearly 30,000 Coloradans saved $18.6 million on prescription drugs, an average of $627 each.

Additionally, the ACA eliminates all prescription drug cost sharing for some of the poorest Medicare recipients. Many dual eligible individuals, those who qualify for both Medicare and Medicaid, qualify for subsidies that help them cover the cost of their Medicare prescription drug coverage. Beneficiaries who receive the maximum subsidy have no deductible, minimal cost sharing in the initial coverage period and doughnut hole, and no cost sharing above the catastrophic limit. If these beneficiaries are in a nursing home or medical institution, they have no cost sharing. However, some dual eligible individuals who would otherwise need institutional care receive care at home. Before the ACA, these individuals would have still had some prescription drug cost sharing because they were not residents of an institution. The ACA completely eliminates prescription drug cost sharing for dual eligible individuals receiving care at home who would otherwise need institutional care. More than 70,000 Coloradans are eligible for both Medicare and Medicaid and many will benefit from the elimination of prescription drug cost sharing under this provision.

Improving Healthcare quality

Traditionally, Medicare has paid providers based on the volume of procedures and tests they perform (fee-for-service) but has not held them accountable for reducing complications and improving patient outcomes. The Affordable Care Act makes a number changes to Medicare that seek to encourage doctors and hospitals to provide better quality care.

Medicare has historically paid hospitals each time a patient is admitted to the hospital even if that admission was preventable. Patients are often readmitted within days of being discharged from a hospital. Readmissions are often caused by complications or infections from the initial hospitalization, a lack of attention to a patient's medication needs, and poor communication between providers and patients. In 2005, 6.2 percent of Medicare patients who were admitted to the hospital were readmitted within seven days, and 84 percent of these readmissions were preventable. Preventable readmissions cost Medicare billions of dollars annually and cause patients unnecessary harm.

Following the recommendation of the Medicare Payment Advisory Commission (MedPAC), the ACA holds hospitals accountable for preventing readmissions. The law requires Medicare to reduce hospital payments based on the amount of preventable readmissions for high volume or high rate conditions, such as heart failure or pneumonia. This provision seeks to incentivize better care coordination for patients being discharged and is estimated to save $7.6 billion over the first 10 years.

The ACA also holds hospitals accountable for reducing health conditions that are acquired during a hospital stay. Before 2008, Medicare paid hospitals more for treating preventable conditions that were acquired during a patient's hospital stay. While Medicare has stopped paying more for hospital-acquired complications for many conditions, starting in 2015, the ACA will reduce payments by one percent for hospitals with the highest hospital-acquired complication rates.

In order to improve care coordination, the ACA also establishes a voluntary, pilot program that bundles payments for hospitals, providers and other services. The Bundled Payments for Care Improvement initiative (BCPI) links payments for multiple services that beneficiaries may receive for a given episode of care. The program is testing four different models for defining a care episode and hospitals can apply those models to 48 different clinical conditions, such as hip fracture or stroke. Beginning earlier this year, hundreds of hospitals across the country, including five in Colorado, began participating in the BCPI initiative.

Finally, the ACA creates the Center for Medicare and Medicaid Innovation. The center is tasked with researching, testing and developing new payment methods that will reduce costs and improve health care quality. Among other programs, the center is leading the BPCI initiative and working with states to better coordinate care for beneficiaries who are eligible for both Medicare and Medicaid.

Changing payments to providers and insurance plans

The ACA makes changes to how hospitals, doctors and insurance companies are paid for providing care to Medicare patients. Many of these are based on data-driven recommendations by MedPAC and attempt to more closely align Medicare payments with the cost of providing care.

Medicare uses a complicated formula to pay hospitals for the treatments they provide. Since 1986, this payment formula has included payment increases for hospitals that treat a large number of low-income patients. These payments, known as disproportionate share hospital (DSH) payments, are meant to compensate hospitals for the potentially higher cost of providing care to poorer patients and to ensure access to hospital care. However, in 2007, MedPAC found that DSH payments overcompensated for increased patient costs and did not appropriately focus on uncompensated care. In light of this

recommendation, the ACA reduced Medicare DSH payments to hospitals by 75 percent beginning in 2014. These payment reductions are expected to save the Medicare program over $22 billion through 2019.

The ACA better aligns payments to insurance companies that offer Medicare Advantage (MA) plans and ties payments to the quality of care these plans provide. MA plans cover all Medicare benefits and may offer beneficiaries additional benefits not covered by traditional Medicare. Medicare pays plans a per-person amount that is determined by a bidding process. Medicare compares the plan's bid to a benchmark, the maximum amount Medicare would pay in a given geographic area for services. For example, benchmarks in Colorado range from $701 per enrollee in Costilla County to $986 in Rio Blanco County. If the plan bid is higher than the benchmark, the difference is made up by beneficiary premiums. If the plan bid is lower than the benchmark, Medicare pays plans a rebate based of the difference between the benchmark and the bid. Rebates must be used to provide benefits not covered by traditional Medicare. Before health reform became law, benchmarks in many areas were 50 percent larger than the maximum payments under traditional Medicare. Further, plans were paid regardless of the quality of care they provided.

The ACA changed the way MA benchmarks and rebates were calculated. MA plan benchmarks now range from 95 to 115 percent of per-capita spending in traditional Medicare. Counties with the highest per capita spending will receive lower benchmarks. Additionally, Medicare rewards plans that provide better quality care. Plans receive increases in their benchmark if they receive at least a quality rating of 4 on 5-star rating scale. Plan quality also impacts the size of the rebate plans can receive if their bid is below the benchmark. Low quality plans receive a 50 percent rebate while high quality plans receive a 70 percent rebate. These changes are estimated to save Medicare $135 billion by 2019. In 2012, more than 225,000 Coloradans were enrolled in 55 MA plans.

Increasing Medicare Sustainability

More and more Americans are relying upon Medicare for their health care. In 2010, Medicare spending totaled $524 billion, including over $5 billion in Colorado. By 2020, Medicare spending is expected to comprise more that 17 percent of the federal budget. As America's population ages and health care costs continue to rise, the ACA includes a number of provisions aimed at raising revenue, decreasing unnecessary costs, and increasing the long term sustainability of the program.

Medicare is paid for by a combination of payroll taxes, premiums and general government revenues. Coverage of hospital services under Medicare (Medicare Part A) is paid for by the Hospital Insurance Trust fund. Eighty-five percent of this fund is supported by the Medicare payroll taxes. Since 2008, payments from the Hospital Insurance Trust fund have exceeded income to the fund and, in coming years, the fund is not expected to be able to meet all of its financial obligations. Revenue increases and payment changes contained within the ACA are expected to extend the life of the Hospital Insurance trust fund until 2024, eight years beyond projections prior to the passage of the law.

Coverage for doctor and outpatient services (Medicare Part B) is funded by the Supplementary Medical Insurance Trust fund which is supported by beneficiary premiums and general revenues. By law, premiums must be set to cover 25 percent of Part B spending and, as Medicare costs rise, beneficiaries pay larger premiums, and Part B requires additional general revenues in order to operate.

The Affordable Care Act includes additional taxes on high-income earners to help pay for the increasing costs of providing Medicare. Before health reform, employees and employers each paid a 1.45 percent payroll tax that helps fund Medicare Part A. The Affordable Care Act levies an additional 0.9 percent tax on income in excess of $200,000 ($250,000 for joint income tax filers) helping to increase revenue

to the Hospital Insurance Trust fund. The Affordable Care Act also levies a 3.8 percent tax on certain unearned income, such as investments and dividends. These provisions are expected to raise over $210 billion by 2019.

The ACA raises additional revenue by requiring higher income earners to pay more in Medicare premiums. Since 2007, higher income Medicare recipients have paid larger premiums for Medicare part B coverage. Approximately two million beneficiaries who make more than $85,000 a year ($170,000 for joint filers) pay more for their premiums. The income threshold above which beneficiaries pay higher premiums is indexed to inflation. The ACA freezes these income levels from 2011-2019, and, over time more Medicare seniors will pay higher Part B premiums. Additionally, the law requires high-income beneficiaries to pay higher premiums for their Medicare prescription coverage.

In an effort to control Medicare costs without limiting Medicare benefits, the ACA creates the Independent Payment Advisory Board (IPAB). This 15-member panel is tasked with developing proposals that constrain Medicare spending while protecting access to care. When Medicare spending is projected to exceed rates of inflation defined by the law, IPAB must develop proposals that will limit Medicare spending below specified targets. IPAB cannot make recommendations that would ration care, raise revenues, increase premiums, increase cost-sharing or modify Medicare eligibility. IPAB's recommendations must be submitted to Congress by January 15th of each year. The proposals automatically take effect if Congress does not pass a law changing them by August 1st of the same year. When amending IPAB's recommendations, Congress must achieve the same savings while preserving Medicare benefits, premiums and cost sharing. IPAB members are appointed by the president and must be confirmed by the Senate.