

How Will the Patient Protection and Affordable Care Act Affect Seniors?

Timely Analysis of Immediate Health Policy Issues

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The population over the age of 65 will be affected in a number of ways by the Patient Protection and Affordable Care Act (PPACA) even though the law is primarily aimed at non-elderly population. There will be increases in premiums for high-income people, cutbacks in the advantages some seniors gain from Medicare Advantage plans, and reductions in cost-sharing in the prescription drug benefit and for preventive services. It is likely that the sustainable growth rate (SGR) formula will continue to be overridden periodically to head off major fee cuts but not permanently fixed. Therefore physician fees will continue to be adjusted upward by less than the inflation rate for medical practices. There will still be some additional efforts to increase primary care fees to encourage access in Medicare. But increased demand for services by the non-elderly who will become insured could potentially threaten access to care for seniors. Reductions in rates for other providers such as hospitals and nursing homes have been suggested by the Medicare Payment Advisory Commission (MedPAC) and the Congressional Budget Office (CBO) for several years and should not adversely affect access for Medicare beneficiaries,¹ though having them in place for several years could lead to significant differences between private and Medicare rates.² There are large numbers of provisions that introduce new payment and delivery system

Prescription drug coverage and preventive care for seniors will improve, but some will see insurance premiums rise.

reforms that could either benefit or harm access to care for seniors.

Beneficiary Provisions

Premiums

The PPACA threshold for the higher income-related Medicare Part B premiums (\$85,000 for an individual and \$170,000 for a couple) is frozen from 2011 through 2019. Freezing the threshold will have the effect of making an increasing number of people each year subject to the higher premiums. This provision provides \$25.0 billion in revenue.³ PPACA also reduces the Medicare Part D subsidy for those with incomes above \$85,000 (for an individual) and \$170,000 (for a couple), effective 2011. Reducing the Medicare Part D subsidy represents savings in the amount of \$10.7 billion over ten years making this a relatively small provision of the bill.⁴

It is interesting to note that the current Medicare premium is \$110.50 per month and increases to \$154.70 per month when the \$85,000/\$170,000 threshold is reached and continues to increase as incomes increase. Those eligible for Medicare Savings Programs (MSP) will continue to receive assistance with premiums up to 120 percent of the federal poverty level. Individuals with incomes above MSP eligibility levels will pay the full

premium. This amounts to about 10 percent of income for those just above MSP levels. Because premiums do not increase with incomes, premiums as a share of incomes decline until the high-income threshold is reached. Thus, low-income seniors with incomes above Medicaid or MSP eligibility levels will have to pay more in Part B as a percentage of income than will low-income non-elderly individuals under health reform. Further, the benefit package seems to be at about the level of a 70 percent actuarial value plan, or a silver plan, under health reform; however, unlike the plans offered to the non-elderly, there are no out-of-pocket limits. Individuals can pay more for more comprehensive coverage through Medi-gap policies. This is similar to buying up to a gold or a platinum plan in an exchange. Without supplemental coverage, there are circumstances in which individuals will have to pay more for Medicare coverage and obtain less protection than it will now be offered to the non-elderly.

The Medicare Drug Benefit

The main enhancement was to phase down the beneficiary coinsurance rate in the Medicare Part D coverage gap from 100 percent to 25 percent by 2020. This is accomplished by the following: For brand drugs,



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pharmaceutical manufacturers will be required to provide a 50 percent discount on prescriptions filled in the gap beginning in 2011, in addition to federal subsidies of 75 percent of brand-name drug cost by 2020 (phased in beginning 2013). There are also federal subsidies for generics of 75 percent in 2020 (phased in beginning 2011). The cost-sharing reductions save Medicare beneficiaries about \$43 billion over ten years.

Preventive Services

The statute also eliminates cost-sharing for Medicare covered preventive services that are recommended by the U.S. Preventive Services Task Force and waives the Medicare deductible for colorectal cancer screening. Medicare is authorized to cover personalized prevention services, including a comprehensive health risk assessment annually.

Medicare Advantage Plans

One of the most significant impacts will be on seniors enrolled in Medicare Advantage (MA) plans. Currently, the federal government provides a significant subsidy to MA plans (currently about 9 percent more than the cost to the plans for providing the statutory Medicare benefits, assuming SGR-imposed cuts do not actually occur). Most of the additional payments to plans result in extra benefits for MA enrollees, including buying down part of standard cost-sharing, filling in some of the Part D doughnut hole, and providing particular services, such as eye glasses, hearing aids and health club memberships. The legislation restructures payments to MA plans by setting payments to different percentages of traditional Medicare spending rates as calculated at the

county level, with higher payments for areas with low traditional Medicare rates (up to 115 percent) and lower payments (as low as 95 percent) for areas with high traditional Medicare rates. Phase-in of the revised rates will take place over three to six years, depending on area, beginning in 2011. There is also provision for a pay-for-quality enhancement in payments for qualifying plans.

The long phase-out of the overpayments and the different benchmarks based on traditional Medicare spending attempt to mitigate the post-BBA 1997 problem of MA plans leaving the market and significantly reducing extra benefits. Different from the late 1990s, there are many more MA plans of different kinds in all markets to absorb beneficiaries whose plan may leave the program. Nevertheless, surely the extra benefit offerings, now valued at over \$1,000 per year, will be reduced. Low-income seniors above Medicaid or MSP eligibility levels have disproportionately higher enrollment in MA now and will be affected directly. At the same time, the reductions in the overpayments produce about \$136 billion of Medicare savings and were needed to try to establish a more level playing field for competition between private plans and traditional Medicare. The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary recently estimated that over the decade enrollment in MA will drop about one-third from the current 24 percent of all beneficiaries.⁵

Reduced Provider Payment Rates

Hospitals, Skilled Nursing Facilities and Home Health Agencies

Section 3401 provides broad revisions in the approach to setting market basket updates for most provider categories by incorporating a productivity adjustment into the update, beginning in various years, and implements additional market basket reductions for certain providers. These legislated reductions in market basket updates and other changes in provider payments represent most of the CBO-scored savings in Medicare, while extending the projected exhaustion date of the Part A trust fund by about a decade. These cuts in provider payment rates are not expected to have major impacts on Medicare beneficiaries although that is a possibility in the long run. The recent report from CMS actuaries argue that the impact of sustained reductions in market basket updates to reflect productivity gains may eventually have adverse effects on beneficiaries and on providers.⁶ In general, the argument that CBO has made is that market basket updates overstate cost increases to providers because of productivity increases, particularly hospitals, therefore payments can be cut, though some hospitals will need to reduce costs in response.⁷ In areas where Medicare payments are now less than cost, MedPAC has argued that this has more to do with commercial payments being too high rather than Medicare payments being too low.⁸ The real issue is the effect on providers and in turn on beneficiaries if payment increases are less than inflation over a sustained period of time. At some point these could be a serious cause for concern. Payments to home health agencies and nursing facilities are

more than adequate in general but there are problems in some areas and for some kinds of patients as well.

Physicians

For physicians, there is no productivity adjustment provision, as the sustainable growth rate provision which remains in law, provides for payment cuts if increases in physician expenditures per beneficiaries exceeds the growth in gross domestic product. Congress annually (or even more often) overrides the SGR trigger for payment reductions and sets rate increases below medical inflation for physicians.

A few other payment changes deserve mention. Along with a number of provisions designed to increase the supply of the health care workforce, including establishment of a national commission tasked with reviewing health care workforce and projected workforce needs and creation of a Primary Care Extension Program to support primary care practices, there are a few provisions that could affect primary care physicians, partly designed to increase the supply of physicians able to care for the aging population. Specifically, beginning in 2011, primary care physicians and general surgeons practicing in health professional shortage areas will receive a 10 percent Medicare bonus payment for five years. This provision represents new spending, with an exemption from the usual budget-neutrality adjustment that affects the Medicare Fee Schedule. There is also a provision to give the Secretary greater authority to identify and adjust misvalued codes in the physician fee schedule, although CMS lacks the resources needed to obtain the data necessary for improving the accuracy of time estimates that are a core component of valuing services. If CMS is able to take this on, there

should be redistribution within the budget neutrality provisions toward primary care, away from particular specialties.

It should be noted that independent of PPACA, CMS has been actively attempting to correct some misvalued codes, leading to some controversy about whether Medicare payments are acceptable to physicians. Although MedPAC consistently concludes that surveys have not shown a spike in access problems for beneficiaries because of physician non-participation, there are increasing anecdotal reports of physicians, especially primary care doctors, not accepting new Medicare patients, except for “age-ins” from their own practices. These various legislative provisions and regulatory actions will have an impact on physicians’ willingness to see Medicare patients going forward. These problems of access to physicians, particularly primary care doctors, will likely be worsened by the increased demand for services from the newly insured.

The Independent Payment Advisors Board

The law establishes an Independent Payment Advisory Board (IPAB) comprised of 15 full-time members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate, as determined by the CMS Chief Actuary. Recommendations from the Board to reduce spending could begin as early as 2014, although hospitals and hospices are exempt from further reductions through 2019. The Board’s role is carefully circumscribed – its jurisdiction is over payment; it is prohibited from “rationing” care, increasing revenues, and changing benefits, eligibility or beneficiary

cost-sharing. The new Board will continue to function alongside of MedPAC, which remains advisory to Congress. The IPAB also can make recommendations for private payments, which is important because there are limits on how much Medicare rates can deviate from the private market before access problems emerge. But because Congress has no jurisdiction over privately negotiated rates, such recommendations would not have the same force as the IPAB’s Medicare payment recommendations would have.

Improving Quality and Health System Performance

PPACA has provisions to test new organizational and payment models in Medicare, with the view that testing in Medicare (and in multi-payer pilots and demonstrations) could lead to overall health system performance improvement. The centerpiece of this activity is the establishment 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 quality and reduce costs. Successful models can be expanded without obtaining new legislative authority, and pilots and demonstrations need not be budget neutral as currently required under long-standing Office of Management and Budget guidance. The law appropriates \$10 billion for the activities of the Center.

In addition to the broad authority provided to the new Center, specific provisions are designed to test particular models of innovation including: accountable care organizations, a national pilot program on payment bundling, the “independence at home” model of geriatric home care and a hospital

readmissions reduction program. In addition, there are numerous provisions designed to increase the number and relevance of performance measures and simultaneously expand the role of pay-for-reporting and pay-for-performance (the latter initially an extension of the current Medicare value-based payment program for hospitals).

Most policy analysts think positively of the potential of new delivery and payment approaches to improve care, first, for Medicare beneficiaries, and, subsequently, for all patients if successful. However, some of the new payment and organizational models might have implications for beneficiaries' current access to care. For example, an ACO might or might not have some limitations on freedom of choice. In some versions,

beneficiaries may be assigned to ACOs without their knowledge because their freedom of choice is not affected. Yet, the organization they have been assigned to have altered financial incentives, which some would argue beneficiaries have a right to know about. In short, all of these payment and value-purchasing initiatives may have implications for access, cost and quality, which have a beneficiary dimension that will deserve more attention than received thus far.

Conclusion

Seniors will benefit from reductions in cost-sharing for the Medicare prescription drug benefit and the elimination of cost-sharing for recommended Medicare covered preventive services. However, there will be reductions in the benefits some seniors now gain from Medicare Advantage plans as well as higher premiums for higher-income people. Provider rate cuts should not adversely affect access for Medicare beneficiaries, though they could if they are left in place indefinitely. There are many new payment and delivery system reforms that offer promise for cost containment and most likely benefit seniors but have some potential to harm access to care.

Notes

¹ Medicare Payment Advisory Commission. 2008. "Report to Congress: Medicare Payment Policy." Washington, DC: Medicare Payment Advisory Commission, March; Congressional Budget Office. 2008. "Budget Options: Health Care." Washington, DC: Congressional Budget Office, December.

² Center for Medicare and Medicaid Services, Office of the Actuary. 2010. "Estimated Financial Effects of the Patient Protection and Affordable Care Act." Baltimore, MD: Center for Medicare and Medicaid Services, April

³ Congressional Budget Office. 2010. Letter to the Honorable Nancy Pelosi providing estimates of the spending and revenue effects of the reconciliation proposal. Washington, DC: Congressional Budget Office, March 20.

⁴ Congressional Budget Office. 2010.

⁵ Center for Medicare and Medicaid Services. 2010.

⁶ Center for Medicare and Medicaid Services. 2010.

⁷ Congressional Budget Office. 2008.

⁸ Medicare Payment Advisory Commission. 2008.

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About the Authors and Acknowledgements

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