



Health Policy Brief

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Health Reform's Changes In Medicare.

The newly enacted legislation contains a mix of provisions—some to expand benefits, and others designed to slow the program's growth rate.

WHAT'S THE ISSUE?

In March 2010, Congress enacted the Patient Protection and Affordable Care Act to expand health insurance and reform the health care delivery system. The package also included significant changes to Medicare, the federally run health insurance program for the elderly and disabled. These include important new benefits for enrollees, new taxes to shore up Medicare's financing, and cutbacks in the growth of payments to hospitals and other providers. This brief describes health reform provisions related to Medicare that will take effect beginning in 2010.

WHAT'S THE BACKGROUND?

The Medicare program is the largest health insurance program in the country. It has four parts: Part A, primarily for inpatient hospital services; Part B, for outpatient services such as visits to the doctor; Part C, for private health insurance that provides Medicare benefits, known as Medicare Advantage (MA) plans; and Part D, for outpatient prescription drugs, also delivered through private health insurance policies.

Medicare is run by the Centers for Medicare and Medicaid Services (CMS), which uses pri-

vate insurance companies to process and pay claims. Most beneficiaries are in traditional, fee-for-service Medicare under which doctors, hospitals, and medical suppliers bill the government directly for services covered under Parts A and B. About 25 percent of beneficiaries are enrolled in Medicare Advantage.

When changes are made in the benefits that Medicare covers or in the amounts it pays providers, as is the case with the new health reform law, the impact is significant. The changes affect the health care received by the large and growing Medicare population. In addition, because of its size and status as a national program, Medicare coverage and payment policies are a reference point for private health insurers and other payers, which frequently follow Medicare's lead in changing policies. And because of the size and scope of Medicare, its coverage and payment policies have a significant impact on the health care delivery system, as providers respond to the financial incentives inherent in the way that Medicare pays them.

CHANGES BEGIN SOON: The new health reform law includes numerous Medicare provisions that will take effect over the next five years. Within several years, for example, some payments to Medicare Advantage plans will be cut, but those plans will be eligible for bonuses

if they can show that they provide high-quality health care. As outlined below, many other provisions take effect as soon as this year.

WHAT'S IN THE LAW?

EXPANDED PRESCRIPTION DRUG COVERAGE:

The design of the Medicare prescription drug program includes a so-called coverage gap or "doughnut hole": after a beneficiary incurs a certain amount of charges for prescription drugs, he or she is temporarily responsible for paying 100 percent of his or her drug costs. The health reform law provides a \$250 rebate for individuals who fall into the coverage gap in 2010. The rebate will go to an estimated 3.4 million beneficiaries who will fall into the coverage gap this year. Beginning in 2011, the coverage gap will be reduced in stages, until it is eliminated in 2020. Also beginning in 2011, beneficiaries who fall into the coverage gap over the next several years will be able to purchase brand-name medications at half price, under an agreement reached with major pharmaceutical companies.

IMPROVED LOW-INCOME SUBSIDY FOR DRUG

COVERAGE: Medicare subsidizes drug benefits for people whose incomes are at or below 150 percent of the federal poverty level and who have limited assets. The new health reform law contains several provisions to improve this subsidy. For example, if a couple qualifies for the subsidy and one of the spouses dies, the surviving spouse can continue to receive the subsidy for a full year before his or her eligibility for the subsidy is redetermined. Additional funding is also provided under the reform law to make certain that eligible people know about and sign up for the subsidy.

EXPANDED COVERAGE OF PREVENTIVE

SERVICES: Currently, Medicare covers only certain preventive services, such as mammograms and colonoscopies. Beneficiaries have to pay 20 percent of the amount that Medicare allows for these services. Beginning 1 January 2011, that will change. Colonoscopies and other colorectal cancer screening will be done at no charge to beneficiaries. Medicare also will pay the full cost of an annual wellness visit. Beneficiaries won't have to pay any amount out of pocket for preventive services that are highly recommended by the U.S. Preventive Services Task Force, such as mammograms. Medicare is also authorized under the health reform law to offer incentives for beneficiaries to complete "behavior modification" programs that could teach them how to eat better and exercise more.

PRIMARY CARE IMPROVEMENTS: Medicare payment rates tend to be higher for the types of services provided by specialists than for the types of services typically provided by primary care practitioners. The new law provides a 10 percent increase in payment for primary care services (such as those given at a doctor's office or nursing facility, or through a home visit) provided by primary care practitioners, if at least 60 percent of their Medicare charges in a prior period were for primary care services. The bill also provides for a 10 percent increase in payments to general surgeons located in areas that have been determined by the government not to have enough health professionals. These additional payments are for a five-year period beginning 1 January 2011.

INCREASED PREMIUMS FOR HIGH-INCOME

BENEFICIARIES: This year, Medicare beneficiaries with incomes above a certain threshold pay higher Part B premiums. The new law freezes that threshold amount at 2010 levels for 2011-2019, instead of allowing it to be adjusted for inflation. The law effectively imposes an income-related premium for higher-income Part D enrollees as well, by lowering how much the government will pay toward drug coverage for people above a certain income threshold.

INCREASED MEDICARE TAXES FOR HIGH-

INCOME HOUSEHOLDS: Beginning in 2013, the Medicare payroll tax that funds the Hospital Insurance (Part A) Trust Fund will increase for high-income households. Specifically, the Medicare tax rate will increase from 1.45 percent to 2.35 percent on wages earned over \$200,000 for a single filer and over \$250,000 for married couples filing jointly (over \$125,000 for a married individual filing separately). This provision will be in effect for tax years after 31 December 2012. The proceeds from these higher taxes will go into the Part A Trust Fund.

Also, a new tax will apply to investment income for high-income households. This 3.8 percent tax will apply to the net investment income of individuals with a modified adjusted gross income over \$200,000 (\$250,000 for joint filers). The proceeds of this tax will help fund Medicare Part B.

REDUCTIONS IN PAYMENTS AND OTHER

REQUIREMENTS FOR MEDICARE ADVANTAGE PLANS: The federal government pays more for beneficiaries enrolled in these plans than for beneficiaries in fee-for-service Medicare. That additional funding provides enrollees with additional benefits, such as reduced cost sharing and coverage of items not covered by

\$250

Rebate

The new law provides a \$250 rebate to beneficiaries whose drug spending places them in the "doughnut hole" in 2010.

"Starting in 2011, beneficiaries won't have to pay out of pocket for many preventive services."

85%

Premium dollars toward claims

Medicare Advantage plans will be required to pay at least 85% of the premium dollars they collect as medical claims.

“The new law expands the Medicare agency’s authority to experiment with changes to payment and service delivery models.”

About Health Policy Briefs

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traditional Medicare, which are seen as necessary to attract enrollees to these managed care plans. However, all Medicare beneficiaries, not just those enrolled in Medicare Advantage plans, have ended up footing the bill for these extra payments.

The new law freezes the extra Medicare payments to Medicare Advantage plans in 2011 and begins to reduce the payments to plans in 2012. It also requires Medicare Advantage plans to pay at least 85 percent of the premium dollars they collect for medical claims. However, it also makes it possible for Medicare Advantage plans to receive higher payments if they demonstrate that they are providing high-quality care to enrollees.

REDUCTION IN THE GROWTH OF PAYMENTS TO MEDICARE PROVIDERS:

Most Medicare payments to providers are adjusted each year—usually upward—to stay in step with inflation. Beginning in 2010, the new law reduces these increases for certain providers, including hospitals, home health agencies, skilled nursing facilities, and hospices. In addition to the reductions, future updates will also have to take into account increases in productivity in the rest of the economy. Overall, this means that payments to providers won’t grow as fast as they have in the past.

SPECIAL PROVISIONS FOR RURAL HOSPITALS:

Although the reform package will slow the rate of growth of Medicare payments to most types of providers, including hospitals, there are special provisions in the law to protect rural hospitals. These include very small rural hospitals that don’t treat many Medicare patients, which will receive a small payment boost under the new reform law in 2011 and 2012.

RESOURCES

Robert A. Berenson and Bryan Dowd, “[Medicare Advantage Plans at a Crossroads—Yet Again](#),” *Health Affairs* 28, no. 1 (2009): w29-w40 (published online 24 November 2008).

Congressional Research Service, “[Medicare Provisions in PPACA \(PL 111-148\)](#).”

Kaiser Family Foundation, “[Explaining Health Care Reform: Key Changes to the Medicare Part D Drug Benefit Coverage Gap](#).”

ENCOURAGEMENT FOR INNOVATION IN CMS PROGRAMS: Congress often mandates that the CMS test changes to payment or coverage policies through demonstration projects, to gather evidence about the impact of those changes and associated operational issues. The new law expands the agency’s authority to experiment with changes to payment and service delivery models. It also requires that by 1 January 2011 the CMS create a new center, the Center for Medicare and Medicaid Innovation, to lead the task of experimentation. The law gives the center the authority to implement successful pilot programs nationwide.

WHAT’S NEXT?

The CMS is expected to issue regulations to guide how provisions will be implemented in the coming weeks and months. Plans, providers, physicians, and beneficiaries will begin responding to the changes in the law.

As the Medicare Advantage payment changes go into effect, beneficiaries may or may not see changes in benefit offerings. The Hospital Insurance (Part A) Trust Fund will get a boost from the health reform legislation; although earlier it was projected to be exhausted in 2017, intermediate projections now show that it will not be exhausted until roughly 2026.

In the longer term, additional changes to the Medicare program may be identified through the Center for Medicare and Medicaid Innovation or developed as recommendations by a new Independent Medicare Advisory Board. It is also likely that the bipartisan National Commission on Fiscal Responsibility and Reform, recently appointed by President Obama, will recommend further changes to Medicare. ■

Kaiser Family Foundation, “[Implementation Timeline](#).”

Kaiser Family Foundation, “[Medicare: A Primer](#),” February 2010.

Patient Protection and Affordable Care Act (HR 3590) and Health Care and Education Affordability Reconciliation Act (HR 4872). Details are available online at <http://thomas.loc.gov/>

[Section-by-Section Analyses of HR 3590 and HR 4872.](#)