



CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education



The Impact of Health Reform on Medicare

CDA/SMP Conference

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Presented By:

David Lipschutz, Staff Attorney



Our Focus

California Health Advocates

provides quality Medicare and related healthcare coverage information, education and policy advocacy.

www.cahealthadvocates.org

- **Policy** – Conduct public policy research to support recommendations for improving rights and protections for Medicare beneficiaries and their families
- **Training** – Provide timely and high-quality information on Medicare through our website, fact sheets, policy briefs and educational workshops
- **Advocacy** – Bring the experiences of Medicare beneficiaries to the public, and especially legislators and their staff at federal and state levels, through media and educational campaigns



Outline

- I. Overview
- II. Benefit Changes
- III. Payment Reforms
- IV. Additional Resources



I. OVERVIEW



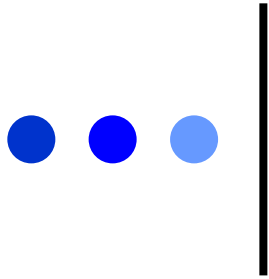
Health Care Reform Bills

- Health Care Reform (HCR) accomplished through two bills:
 - Patient Protection and Affordability Care Act of 2010 (PPACA) (Public Law 111-148) – signed into law March 23, 2010
 - Health Care and Education Reconciliation Act of 2010 (HCERA) (Pub. L. 111-152) – signed into law March 30, 2010
- Implementation will require regulations, rules, guidance, etc. ...



Overview: Impact on Medicare

- No cuts in guaranteed benefits
- Some benefit improvements
 - Higher income individuals will pay more for some things (approx. 5% of beneficiaries)
- Greater fiscal stability
 - Extends life of Part A Trust Fund
- Potential for greater care coordination, increased quality and lower costs



II. BENEFIT CHANGES

- Part D
- Part C
- Election Periods
- Preventive/Screening Services
- Low Income Subsidy (LIS)



Part D Coverage Gap Rebate (2010)

- \$250 Rebate for those who reach donut hole (this year only) \$2830-\$6356.25
 - Due on 15th day of third month following the end of calendar quarter in which coverage gap entered
 - Ex: Reach donut hole in April (2nd quarter) – rebate due Sept. 15th
 - Not eligible: those with LIS.



Part D Coverage Gap – Gradually Closed (2011-2019)

- Starting 2011, coverage gap decreases each year until 2020 when enrollee pays 25% coinsurance
- Same result for brand name and generics, but get there different ways ...
 - Brand: 2011 – 50% discount; starting in 2013, plans begin to pay additional subsidies
 - Generic: 2011 – plans begin to pay subsidies, starting at 7% of costs



Part D – Other Changes

- Starting in 2011, payments made to AIDS Drug Assistance Program (ADAP) and Indian Health Services (IHS) will count towards TrOOP
- Uniform exceptions and appeals process by 2012
 - Accessible by phone and internet
 - Uniform coverage determination forms
- Both Medicare and Medicaid will cover benzodiazepines and barbiturates (2014)



Election Periods – Changes in Fall 2011 (Effective 2012 Plan Year)

- **Annual Coordinated Election Period (ACEP)**

- Timeframe changes from **Nov15 –Dec31** to: **October 15 – December 7**
- Change plans or switch to Original Medicare

- **MA Annual Disenrollment Period**

- (OEP) - Eliminated

- Timeframe changes **Jan-Feb-Mar** to: **January 1 – February 15**
- Allows individual in an MA plan to return to Original Medicare only.



Higher Part B and D Premiums for Higher Income Individuals - 2011

- Income Related Monthly Adjustment Amount (IRMAA) Part B premiums (already in effect) – threshold frozen between 2011 and 2019
 - Meaning more people may reach threshold requiring them to pay a higher portion of their Part B premium
- Reduction in Part D premium subsidies – those with higher income (\$85,000/individual and \$170,000/couple) will have to pay a higher portion of their Part D premium, effective January 1, 2011



Expanded Preventive Services (2011)

- No out of pocket cost sharing for most Medicare covered preventive and screening services
- (No Part B Deductable \$155 and co-pays 80/20)
- Annual Wellness Visit
 - Every 12 months, starting 12 months after the Welcome to Medicare Exam
 - No cost-sharing for this visit (or Welcome Exam)
 - Covers a range of personal risk assessment and prevention plan services



Medicare Advantage – MOOP (2011)

- MOOP – All local MA plans must establish a mandatory maximum out-of-pocket (MOOP) liability amount inclusive of all Medicare Parts A and B services, the amount of which will be set annually by CMS
 - MOOP will be \$6,700 in 2011
 - Voluntary MOOP may be lower – if plans choose to adopt, can have more flexibility in establishing cost-sharing amounts



Maximum Cost-Sharing – MA and Part D (2011)

- Maximum allowable cost-sharing – cannot exceed levels established by CMS
 - MA plans -- for specified A and B services
 - Two sets of Parts A and B cost-sharing thresholds, one applicable to plans choosing the higher, mandatory MOOP, and the other applicable to those choosing the lower, voluntary MOOP
 - Also limits cost-sharing for certain services to no more than in Original Medicare
 - chemo, dialysis, SNF stays
 - Part D plans – will be reviewed for acceptable cost-sharing tiers



LIS – Fall 2010

- Expected that fewer LIS beneficiaries will be reassigned Part D plans for 2011
 - Part D benchmark calculations changed
2009= 9 plans 2010 =6 plans
 - Part D sponsors with premiums slightly above benchmark can adopt an optional *de minimus* policy meaning full LIS enrollees wouldn't pay additional premium amount



LIS – 2011 and 2012

- LIS enrollees who will be reassigned to new benchmark plans in the Fall of 2011 for the 2012 plan year
 - Will receive a personalized notice from CMS comparing the cost of their 2011 plan to their cost in the plan to which they will be reassigned
 - Notice will explain how to request a coverage determination, exception and redetermination
 - Notice must arrive within 30 days of reassignment
- LIS eligibility for widowers – if death of spouse would affect LIS eligibility, extends such eligibility for one year beyond date eligibility would otherwise end (starting 2011)
- Starting 2012, full dual eligibles who receive certain Medicaid home-based care, including home and community based services (HCBS) will be exempt from Part D cost-sharing
 - Similar to those now in institutional settings



PAYMENT REFORMS

- Overview
- New Offices/Boards
- Pilots/Demonstrations
- Medicare Advantage



U.S. Health Costs - Unsustainable

- Overall, health spending continues to spiral upwards with little/no connection to better health outcomes
- Medicare spending is driven by the rest of the health care system (and vice versa)
 - 14% of federal budget currently spent on Medicare
- If overall health costs not brought under control, very likely that Medicare would face deep cuts in the future



Health Care Reform and Medicare Spending

- Health Care Reform bills projected to save approx. \$450 billion over 10 years
 - “Bends the cost curve” – Slows growth in overall health care spending 2% per year
 - Projected 5.4% growth per year vs. 6.6%
 - *But see CMS Actuary’s Report to Congress (April 2010)*
- Slows increases in Medicare payment rates for all health care providers (except physicians)
 - Reform proposals do not address systemic issues re: physician payments (“doc fix”)
 - Temporary postponement of scheduled 21% reduction in payment to physicians – still needs to be addressed long-term



New Offices/Boards

- Federal Coordinated Health Care Office (2010)
 - To improve integration of care for dual eligibles
- Independent Payment Advisory Board (IPAB)
(Recommendations due to Congress Jan. 2014)
 - Unelected board with authority to make Medicare spending decisions re: providers
 - Each year Medicare spending exceeds annual targets, Board must propose ways to reduce payments to providers
 - Board could put proposals into effect unless Congress modifies or rejects proposals
 - Board cannot change benefits and out-of-pocket costs for beneficiaries



Demonstrations/Pilot Programs

- Center for Medicare and Medicaid Innovation created with broad authority to test payment innovations aimed at providing care more efficiently, effectively, including:
 - Medical Homes – improve access to primary care, provide patient-centered coordinated care
 - Accountable Care Organizations (ACOs) – assume responsibility for quality and cost across the continuum of patient care
 - Bundling of post-acute care payments



Changes to Medicare Advantage (MA) Financing

- Medicare Advantage plans currently paid an average of 13% more than what Original Medicare would spend on a beneficiary
- Health Care Reform restructures how MA plans are paid
 - No benefits promised under Original Medicare will be cut
 - Freezes 2011 payment at 2010 level
 - Phases down payments over time
 - From average of 13% of FFS costs in 2009 to average of 10% of FFS costs when fully phased-in by 2016 (Biles, B. – *Georgetown*, March 2010)
 - Payment rates will still vary, based upon local FFS costs
 - Some payments increased, others same or reduced
 - Payments will range from 15% to 9% FFS costs
 - Bonus payments for high-quality plans



Medicare Advantage Changes ...?

- Result of payment changes?
- MA is a market-based program and insurance companies make business decisions year-to-year
 - Some MA plans may reduce some extra benefits, increase premiums and/or cost-sharing
 - Some MA plan sponsors may pull out of Medicare



IV. Additional Resources

- See:

- Commonwealth Fund:
<http://www.commonwealthfund.org/>
- Kaiser Family Foundation: <http://www.kff.org/>
- National Council on Aging:
<http://mymedicarecommunity.org>
- National Committee to Preserve Social Security and Medicare: <http://ncpssm.org>
- Center for Medicare Advocacy:
<http://medicareadvocacy.org>