Health Reform and Medicare

July 15, 2010

While other issues in health reform received greater fanfare, there were significant changes made to Medicare law. The following is a time line of just a few of the changes you can expect.

Beginning in 2010, the following program changes will take effect:

- Provides a $250 rebate to people with Medicare in the doughnut hole. (The so-called doughnut hole is the $3,600 gap in the drug benefit when consumers pay full price.)
- Requires the Secretary, within 90 days of enactment, to establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families.
    - Sunsets in 2014 when the Exchange is established.
    - Participating employment-based plans would submit claims to the Secretary.
    - The program would reimburse plans for 80 percent of costs of benefits provided per enrollee that are between $15,000 and $90,000 (adjusted based on CPI).
    - Requires plans to use the funds to lower costs borne by plans and beneficiaries.
    - Requires participating plans to implement programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions.
    - Appropriates $5 billion for the program.
- Authorizes the Food and Drug Administration to approve generic versions of biologics, which treat diseases such as diabetes, and allows for generic versions into the market after 12 years.
- Creates the new Federal Coordinated Health Care Office within the Centers for Medicare & Medicaid Services (CMS) to provide care coordination for dual eligibles—people who are enrolled in both Medicare and Medicaid.
- Many provisions to reduce fraud within the Medicare program take effect, including tighter restrictions on physician self-referrals and a requirement for claims to be filed within one year of service.
- List of violations and penalties for Medicare Advantage (MA) or Part D plans are expanded and includes:
    - enrollment of individuals in a MA or Part D plan without their consent,
    - transfer of an individual from one plan to another for the purpose of earning a commission,
    - failure to comply with marketing restrictions or applicable implementing regulations or guidance, or;
    - the employment of or contracting with an individual or entity that commits a violation.
    - Effective on enactment.
- Payment for Bone Density Tests. Restores payment for (DXA) services furnished during 2010 and 2011 to 70 percent of the Medicare rate paid in 2006.
- Provides Medicare coverage and medical screening services to individuals exposed to environmental health hazards as a result of a public health emergency declaration under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA).
- Makes Senior Housing Facility Demonstration Permanent. Allows MA plans that operate in continuing care retirement communities and provide specified services to continue to operate under the MA program.

In 2011 the following changes will occur:

- The OEP will be replaced with an Annual Disenrollment Period (ADP). Medicare Advantage enrollees only will be allowed to make a one-time switch to Original Medicare [1] or choose Part D coverage. Original Medicare beneficiaries will loose their ability to make a plan change beyond the annual election period**.**
- Effective January 1, 2011, eliminates the option for Medicare to purchase power-driven wheelchairs with a lump-sum payment at the time the chair is supplied. Medicare would continue to make the same payments for power-driven chairs over a 13-month period. The purchase option for complex rehabilitative power wheelchairs would be maintained.
- Beginning in 2011, authorizes the Secretary to deny bids submitted by MA plans that propose to significantly increase beneficiary cost sharing or decrease benefits.
- Special rule for widows and widowers regarding eligibility for low-income assistance. Allows the surviving spouse of an LIS-eligible couple to delay LIS redetermination for one year after the death of a spouse. Effective date January 1, 2011.
- Brand Drug manufacturers will provide a 50% discount and the government will provide a 7% discount on generic drugs for consumers in the gap in 2011. Discounts will increase with each passing year until the consumer's share of costs in the coverage gap is 25% for both brand-name drugs and generics in 2020.
- Improve prevention by covering preventive services and eliminating cost-sharing for preventive services in Medicare; increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates.
- Provides 10% bonus payments to primary care doctors working in areas with physician shortages through 2015
- Provide Medicare higher payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.
- Creates a new CMS Innovation Center that will explore effective ways to create efficient payment systems that are patient-centered and incentivize high-quality care.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan. Also provides incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Prohibits Medicare Advantage plans from charging enrollees more than Original Medicare for *certain* medical services, including chemotherapy administration, renal dialysis and skilled nursing care and other services as determined by the HHS Secretary.
- Freezes Medicare Advantage payment rates at 2010 levels. In following years will continue phase-in of Medicare Advantage payment reforms to reduce government payments to insurance companies.
- Allows Medicare Advantage enrollees to switch to Original Medicare from January 1 to March 15 but not to another Medicare Advantage plan.
- Freezes inflation indexing for Medicare-related Part B premiums for people with high incomes.
- Raises drug plan premiums for individuals earning over $85,000 and couples earning over $170,000.

In 2012, the following changes will occur:

- Eliminates prescription drug copayments for certain dual-eligibles receiving home- or community-based long-term care.

[1] (PPACA § 3204, page 338)

- Creates a new Medicare Independence at Home demonstration program for chronically ill Medicare beneficiaries to receive primary care services in their homes and to incentivize better coordination of care.
- Reduces payments to hospitals with high rates of preventable hospital readmissions in effort to promote higher quality outcomes.
- Provides incentives for physicians and other providers to form Accountable Care Organizations (ACOs) to encourage better communication among providers across care settings. Purpose is to reduce costs and provide higher-quality care. ACOs are networks of health providers to provide a range of health care services for patients. Providers who participate in ACOs that meet quality targets and achieve savings to Medicare may share in those cost-savings. ACOs must meet specific consumer-centered criteria, such as the creation of individualized care plans for patients.
- Establishes a "value-based" purchasing system for hospitals and ambulatory surgical centers. Medicare would link payments to hospitals to their performance on quality measures. Home health agencies and skilled nursing facilities are also required to develop value-based purchasing programs.
- Provides bonus payments to high-performing Medicare Advantage plans but reduce rebates for Medicare Advantage plans.
- Creates a single Annual Enrollment Period (AEP) for drug and health plan changes, which begins on October 15 and ends on December 7.

Beginning in 2013, the following changes will occur:

- Repeals deduction for the subsidy for employers who maintain prescription drug plans for Medicare Part D eligible retirees. The employer's allowable deduction for retiree prescription drug expenses must be reduced by the amount of the tax-free subsidy payment received.
- Extension for Specialized MA Plans for Special Needs Individuals until 2014.
- Creates a pilot program to evaluate bundled payments for inpatient hospital services, outpatient hospital services, physician services, and post-care services, including follow-up care after release from a hospital. Under a bundled payment system, Medicare pays one payment for a group of services offered in a single episode of care, whether administered under Part A or Part B, instead of paying for each individual service separately. The program will test if such payment reforms lead to better care coordination, higher-quality care for patients and lower costs.
- Begin reporting and make payment adjustments based in part on control of 10 hospital acquired conditions established by CMS.
- CMS to establish robust physician compare website.
- Increases the Medicare Part A payroll tax by 0.9% for individuals earning over $200,000 and couples earning over $250,000. In addition there is a new 3.8% tax on certain unearned investment income for individuals earning over $200,000 and couples earning over $250,000.

Beginning 2014, the following changes will occur:

- Reduces the out-of-pocket exposure beneficiaries pay for catastrophic coverage in Medicare Part D (effective through 2019).
- Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided.
- Limits Medicare Advantage plan earnings and administrative expenses to 15% of Medicare payments (85% Medical Loss Ratio). Such plans that dip below 85% requirement will be suspended from MA program for 3 years.

- Establishes an Independent Payment Advisory Board with mandate to implement Medicare provider payment changes to meet savings targets (hospitals are exempted).
    - Congress's ability to overturn or amend payment changes will be limited. The proposals do not have to consider the cost-shifting on employer-sponsored plans.
    - The Board cannot change Medicare eligibility or reduce benefits or premium subsidies, but can make limited changes to how drug plan premium subsidies are calculated.
    - The Board can make non-binding recommendations on private sector to improve quality and constrain rate of costs growth.