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STRENGTHENING MEDICARE

For more than 40 years, Medicare has offered critical health and financial stability for senior citizens, people with disabilities, and those with end-stage renal disease, providing coverage for over 45 million individuals this year. The health reform legislation contains substantial payment and delivery system reforms that reward efficient delivery of quality care and change the incentives in today's health care system to encourage value instead of simply volume. It makes investments that will enable beneficiaries to continue to access high-quality, affordable care, while encouraging prevention and care coordination for those with chronic conditions. These efforts will help modernize the program and strengthen Medicare's financial health, protecting both beneficiaries and taxpayers.

MEDICARE IMPROVEMENTS:

Primary Care and Coordinated Care

1. Increases reimbursement for primary care services and encourages training of primary care physicians;
2. Encourages more collaboration and accountability among providers via bundling of payments and advancing of Accountable Care Organizations (ACOs);
3. Extends key protections for rural providers to ensure access to care in rural areas;

Affordability and Quality of Care

1. Provides a $250 rebate for any Medicare Part D (prescription drug benefit) enrollee who enters the "donut hole" in 2010 and begins filling the donut hole in Part D in 2011 and closing the donut hole completely by 2020.
2. Drug manufacturers will provide 50 percent discounts on brand-name drugs in the donut hole to reduce costs beginning in 2011 and through the phase-out.
3. Eliminates out-of-pocket expenses for preventive services in Medicare;
4. Requires Medicare Advantage plans to spend at least 85 percent of revenue on medical care and improving quality of care, rather than on profit and overhead;
5. Improves the low-income programs in Medicare by:
6. Making sure low-income individuals have information about their Part D plans;
7. Eliminating cost sharing for certain individuals dually eligible for Medicare and Medicaid;
8. Reducing "churning" of low-income Part D enrollees between drug plans each year.
9. Enhances nursing home transparency and accountability requirements related to resident protection and quality of care (see the Medicaid fact sheet for description of other policies related to nursing facilities);

10. Begins value based purchasing for hospitals and starts other providers on the path toward value based purchasing.
11. Creates a new Center for Medicare & Medicaid Innovation within CMS to allow for testing and expansion of promising payment models within those programs.

EXTENDS Program Solvency BY NINE YEARS OR MORE

1. Improves payment accuracy to ensure that Medicare pays the right amount for health services;
2. Expands funding and authority to fight waste, fraud and abuse;
3. Eliminates overpayments to private Medicare plans.

MEDICARE PART D

HEALTH REFORM LEGISLATION CLOSES THE "DONUT HOLE" AND IMPROVES THE MEDICARE PART D DRUG PROGRAM

The Medicare Part D program was passed into law in 2003 and has been offering drug benefits to Medicare enrollees since January 1, 2006. The program has helped millions of seniors obtain prescription drug coverage. However, advocates have identified a number of problems with the program, including difficulties posed by the so-called "donut hole", where seniors lose coverage entirely for a portion of the year; burdens that cause many eligible low-income enrollees to miss out on benefits; and inadequate consumer protections for Part D enrollees. The health reform bill includes many important improvements to the Part D program.

CLOSES THE PART D DONUT HOLE

1. Gives a $250 rebate to all Part D enrollees who enter the donut hole in 2010.
2. Provides a 50 percent discount on brand-name drugs in the donut hole, beginning in 2011.
3. Phases in additional discounts for brand-name and generic drugs to close the donut hole completely by 2020.
4. A typical senior who hits the donut hole will save over $700 in 2011, and over $3,000 by 2020.

IMPROVES ACCESS AND INFORMATION FOR LOW-INCOME BENEFICIARIES

1. Expands access to plans with a $0 premium for low-income beneficiaries by changing the calculation of which plans are eligible, and reduces the number of these enrollees who would have to switch plans each year to maintain a $0 premium.
2. Allows widows and widowers to more easily retain their low-income eligibility.
3. Ensures that low-income enrollees assigned to new Part D drug plans receive important information about their plan.
4. Provides new funding for state programs to assist low-income and other Part D enrollees with enrollment into plans that cover their drugs.

STRENGTHENS CONSUMER PROTECTIONS FOR SENIORS AND THE DISABLED

1. Creates a uniform exceptions and appeals process and provides instant access to allow Part D enrollees to appeal plan decisions if they are denied necessary drugs.
2. Improves Part D plans' complaint systems and CMS monitoring of complaints.
3. Improves formulary requirements to guarantee that Part D enrollees have access to necessary drugs.
4. Creates new penalties for false or misleading marketing or enrollment of individuals in Part D plans.

MEDICARE ADVANTAGE PLANS

Background

When private insurance companies first petitioned to join Medicare in the 1980s, they asserted they could provide more care for less than it costs Medicare to provide its services and agreed to be paid 5 percent less than Medicare fee-for-service rates to prove that point. Today, these same companies – now called Medicare Advantage (MA) plans – are paid on average 14 percent more than it costs to provide care through the traditional fee-for-service Medicare program. These overpayments drain the Medicare trust fund, raise premiums for all Medicare enrollees, and cost taxpayers $12 billion a year.

Health Insurance Reform Trims Overpayments, Rewards Quality and Efficiency

The proposal in the Reconciliation bill is a compromise between the House and Senate bills. Payment rates for private plans that contract with Medicare will be set to certain benchmarks that are linked to local Medicare spending. In addition:

- Payment benchmarks range from 95 percent of local Medicare spending in relatively high spending parts of the country, to 115 percent in relatively low spending areas;
- High-quality plans that improve their enrollees' health receive an increase in their payment;
- Plans that are more efficient and provide care for less than the maximum payment rate get to keep a rebate of anywhere from 50 to 75 percent of the difference, depending on the quality ranking of the plan. This money can be used to offer extra benefits or reduce cost sharing.

Seniors Will Have Better MA Choices

Payment rates in 2011 will simply be frozen, with no reduction in the levels from 2010. Plans will have three years to transition to the reformed payment system, with up to seven years for counties facing more significant changes. Efficient plans that offer true value will be able to adapt to these changes over the transitional period and continue to offer coverage.

Seniors will have the guarantee that their premium dollars will pay for care and not pad profit margins. The bill requires MA plans to spend at least 85 percent of their revenue on clinical services and activities that improve quality of care.

Insurance companies have protested that these reforms will hurt their ability to do business, trying to scare seniors currently enrolled in MA plans. However, the non-partisan Congressional Budget Office disputes this -- estimating that after ten years, 9.1 million people will be enrolled in these plans. The reforms ensure that Medicare beneficiaries' premiums are not artificially inflated to subsidize private insurance companies, and Medicare stays solvent and stable into the future.