



HEALTH INSURANCE REFORM AT A GLANCE 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

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

AFFORDABILITY AND QUALITY OF CARE

- 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.
- 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.
- Eliminates out-of-pocket expenses for preventive services in Medicare;
- 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;
- Improves the low-income programs in Medicare by:
 - Making sure low-income individuals have information about their Part D plans;
 - Eliminating cost sharing for certain individuals dually eligible for Medicare and Medicaid;
 - Reducing "churning" of low-income Part D enrollees between drug plans each year.
- 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);
- Begins value based purchasing for hospitals and starts other providers on the path toward value based purchasing.
- 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 12 YEARS

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