FactSHEET

Understanding the New Health Reform Law

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Helping People with Medicare

People with Medicare stand to gain a lot from health reform. The new law includes provisions that will make health care more affordable for the seniors and people with disabilities who rely on Medicare. The law also makes much-needed changes to how Medicare pays for health care. These changes will make the Medicare program stronger and more financially secure for today's beneficiaries and for their children. Below we discuss some of the key aspects of health reform that concern Medicare.

Making Health Care More Affordable

■ Eliminating the "Doughnut Hole"

Why we need it:

The Medicare Part D drug program is infamous for including a large gap in coverage called the "doughnut hole." In 2011, the doughnut hole begins after beneficiaries incur $2,840 in total drug costs. At that point, drug coverage stops until beneficiaries spend an additional $3,608 out of their own pockets (on top of their monthly premiums). This is especially problematic if beneficiaries get sick, as they may be hit with significant drug costs right when they need help the most. More than 3.4 million people with Medicare fall into the doughnut hole each year. Without reform, this gap would have continued to widen—it was projected to grow to nearly $6,000 by 2018.

What health reform does:

It gradually eliminates the Part D doughnut hole by 2020, and it provides help for seniors between now and then. Under the new law, people with Medicare who fell into the doughnut hole in 2010 received a one-time $250 rebate. Starting in 2011, those in the doughnut hole will receive a 50 percent discount on brand-name prescription drugs and other discounts on generic drugs. These discounts will increase each year until the doughnut hole is completely eliminated by 2020.

■ Eliminating Cost-Sharing for Preventive Care

Why we need it:

In the past several years, Medicare has added much-needed coverage for preventive care, such as screenings for cancer and diabetes, so that these conditions can be detected and treated early on. However, many of these services come with substantial deductibles and co-insurance, which discourage people from getting the care they need. Traditionally, Medicare has also not covered annual physical exams, which means it can be harder for beneficiaries to obtain regular preventive care.

What health reform does:
It eliminates co-insurance and deductibles for all preventive services that are covered under Medicare. This will make preventive care more affordable for people with Medicare and will encourage them to get the preventive care they need. Medicare will also now cover a free annual physical exam so that beneficiaries can discuss their health care needs and concerns with their doctor and make sure that they are getting the appropriate screenings.

More Help for People with Limited Incomes

Why we need it:
The Part D low-income subsidy provides vital help with out-of-pocket prescription drug costs to Medicare beneficiaries with limited incomes, including full coverage of their Part D premium. But since the program began in 2006, several problems have emerged.

First, the plans that are available—and what they charge in premiums—vary from year to year, which makes it difficult for beneficiaries to maintain stable coverage. Every year, different Part D plans qualify to enroll low-income beneficiaries with a zero premium, but these plans may not necessarily offer zero premiums the following year. The year-to-year changes in plan availability can be quite drastic, and new plans often have different coverage rules than the old ones. As a result, every year, more than 1 million low-income beneficiaries must make a decision: Should they change their Part D plans to avoid paying premiums, or should they pay premiums to avoid changing plans? Frequent changes in coverage disrupt the continuity of care for these needy beneficiaries. And beneficiaries who stay in plans that no longer qualify for a full premium subsidy may incur out-of-pocket premium costs they can ill afford.

A separate problem involves dual eligibles (people with both Medicare and Medicaid coverage) who receive long-term supports and services. Those who live in long-term care institutions such as nursing homes do not have to pay copayments for their drugs. However, if they instead want to move out of the institution and into the community or an assisted living facility (taking advantage of their state's home- and community-based care Medicaid waiver program), they are required to pay copayments. In effect, this policy penalizes people financially who want to move out of long-term care institutions.

What health reform does:
It improves the Part D low-income subsidy by changing how the Part D low-income premium subsidy is calculated, starting in 2011. This should increase the number of zero premium plans that are available to low-income beneficiaries. As a result, fewer of these beneficiaries should have to choose between changing plans each year to avoid incurring a premium and having to pay premiums to keep their plan.

In addition, beginning in 2012, the law eliminates the higher drug copayments paid by dual eligibles who want to receive long-term supports and services at home or in the community rather than in an institution. As of January 2012, people who qualify for their state's Medicaid home- and community-based care waiver program will no longer have to pay copayments for their prescription drugs under Part D.

A More Secure Medicare—Now and in the Future

■ Promote Quality and Coordination of Health Care

Why we need it:

Historically, Medicare has not done a good job of coordinating care for its beneficiaries. For example, it has not supported systems for doctors to talk to each other so that they can better manage their patients' overall health. Medicare typically pays doctors and other providers by the procedure, not for taking the time to talk to their patients or doing the extra work needed to coordinate their care. This payment system drives up health care costs and does not promote better health.

What health reform does:

It moves Medicare to a more coordinated system that promotes primary care (as opposed to specialty care) and collaboration among health care providers. Primary care physicians will receive higher reimbursements. In addition, a new office within Medicare will be responsible for developing new ways to deliver better care. And several new programs will allow Medicare to pay groups of doctors, hospitals, and other providers together rather than individually. All of these measures should encourage providers to work together to improve health care quality and reduce the number of unnecessary procedures and hospitalizations.

■ Fix the Medicare Advantage Payment System

Why we need it:

Private Medicare Advantage (MA) plans were introduced to Medicare because they were supposed to be a cheaper alternative to the traditional Medicare program. However, they have turned out to be more expensive. The Medicare program has been paying Medicare Advantage plans an average of 14 percent (more than $1,000 per person each year) more than it costs traditional Medicare to provide the same care. This has added hundreds of billions of dollars of costs to Medicare. It also adds more than $3 a month to every Medicare beneficiary's monthly premiums—even for the 75 percent of beneficiaries who are not in Medicare Advantage.

These overpayments generate considerable profits for the insurance companies that run Medicare Advantage plans. Not surprisingly, many new Medicare Advantage plans have entered the Medicare market to take advantage of these overpayments. But there is no evidence that these new private plans provide any better care than traditional Medicare.

What health reform does:

It rolls back overpayments to private Medicare Advantage plans. Insurance companies that run Medicare Advantage plans will no longer benefit from billions of dollars in subsidies and will not have a financial edge over traditional Medicare. Under the new law, payments to Medicare Advantage plans will be gradually reduced until they average about the same as traditional Medicare. For 2011, payment rates to these private plans will be frozen at their current levels. After that, the rates will gradually be reduced over the next three to seven years. Payments to Medicare Advantage plans will also be adjusted to reflect regions of the country where

Medicare rates are particularly high or low. In addition, high-quality plans will be eligible to receive bonus payments.

The reductions in overpayments to Medicare Advantage plans will strengthen Medicare's finances without diminishing access to any of Medicare's guaranteed benefits. Although each Medicare Advantage plan will have to decide how it wants to adjust its benefits package to reflect the new payment rates, all plans will have to continue to provide all of the services that are guaranteed by Medicare.

■ Strengthen Medicare's Finances while Protecting Benefits

Why we need it:
Before the health reform law was enacted, Medicare's Part A (hospital insurance) trust fund was projected to have insufficient funds to pay full benefits by as soon as 2017. Although Medicare would continue to operate after that time, future benefits could have been in jeopardy if nothing had changed. Shoring up Medicare's financing now means that benefits are more secure for current and future Medicare beneficiaries.

What health reform does:
It extends the Medicare trust fund by 12 years without reducing any of Medicare's guaranteed benefits. The new law makes several important changes to Medicare financing: Hospitals and other providers have accepted reductions in payments as part of health reform. In addition, private Medicare Advantage plans will lose their unjustified subsidies. Other changes, including raising the Medicare payroll tax for high-income people, further improve the program's financial health. And while these savings are substantial, they represent a very small proportion of Medicare's overall budget. Before the health reform law was passed, Medicare was projected to grow at a rate of about 6.8 percent a year. Under the new law, Medicare will still grow by about 5.5 percent a year—a reduction of only 1.3 percentage points a year. This modest reduction is sufficient to put the program on a firmer fiscal footing while allowing enough growth in the program to serve beneficiaries both today and in the future.

Conclusion: Big Progress for Medicare and Its Beneficiaries

The health reform law represents a leap forward for Medicare. The law corrects some of the programs longstanding weaknesses by making prescription drugs and preventive health care more affordable. Programs for low-income beneficiaries are also improved. In addition, the law puts Medicare on a more sustainable fiscal path by reducing overpayments to private plans and laying the groundwork for a more efficient system. This is good news for the seniors and people with disabilities who rely on the program today, and for the millions of Americans who will depend on Medicare in the future.

This fact sheet is part of a series of fact sheets, issue briefs, and special reports designed to help the public understand the new health reform law.