HEALTH REFORM BRIEF

Medicare Changes Include Care Coordination and Prescription Drug Costs

KANSAS HEALTH INSTITUTE

KHI/12-HR1 • January 2012

As the main source of health insurance for 420,000 Kansans, Medicare plays an important role. But the program's rising cost remains a concern.

Online readers can select the words underlined in blue to get more in-depth information.

Introduction

About one of every six Kansans is enrolled in Medicare, the public health insurance program that primarily covers people age 65 and older or those younger than 65 with permanent disabilities. But because Medicare is complex and uses unfamiliar titles and acronyms, like Part B and MA, many people do not understand how it works.

The federal health reform law known as the Affordable Care Act (ACA) doesn't include big changes for Medicare. But it does make a few adjustments that are important to understand, especially for the 420,000 Kansans and millions of other Americans enrolled in the program.

The rising cost of Medicare — from $519 billion in 2010 to a projected $929 billion in 2020 — remains a concern for policymakers as they wrestle with the federal budget deficit. Medicare accounted for roughly 12 percent of the federal budget and nearly a fifth of all U.S. health care expenditures in 2010.

While federal budget concerns put Medicare in the fiscal spotlight, ongoing legal and political challenges make it uncertain whether the ACA, including the provisions that would alter Medicare, will be fully implemented.

This brief, the fifth in a series about health reform, explains how Medicare works and how it will be affected by the ACA.

What is Medicare?

Medicare is divided into four categories of coverage, known as Parts A, B, C and D, which are outlined in Table 1. While payroll taxes and premiums help cover the program's cost, financial assistance is available for some low-income Medicare beneficiaries. In some cases, people are eligible for both Medicare and Medicaid services; they are known as "dual eligibles."

As the main source of health insurance coverage for Americans 65 and older, Medicare plays an important role. Roughly 12 percent of the Kansas population falls into that age group, which is similar to the national average.

The ACA and Medicare

The ACA includes a few changes that affect Medicare. Among other things, the health reform law:

- Raises Medicare premiums for certain people, as shown in Table 2.
- Reduces or eliminates the patient's share of the cost for preventive services.
- Lowers prescription drug costs for enrollees.
- Encourages coordinated care among providers, health care facilities and patients.
- Changes the way private insurance carriers are paid for Medicare Advantage plans.

A few of these changes already are in effect, while others are scheduled for future years. Although some ACA components — like those related to Part D drug coverage prices — will occur across the country, others are optional pilot and demonstration projects.

With the ACA in place for more than a year, many Kansans already have seen changes to their Medicare coverage. However, some policymakers have concerns about the sufficiency of the law's strategies to contain Medicare costs and improve the program's quality.

Prevention and Wellness

Several ACA provisions that are likely to affect many, if not all, Kansas Medicare enrollees are those focused on expanding access to preventive and wellness services. In 2011, Medicare stopped charging co-payments and deductibles for recommended preventive services, such as colonoscopies and mammograms. The program also now covers a yearly free comprehensive wellness visit and personalized prevention plan. According to the U.S. Department of Health and Human Services, approximately 14,700 Kansans in Medicare received their wellness visit by early November 2011.

While most of these services are aimed at preventing chronic disease, opinions vary about exactly how disease prevention saves money. By reducing the number of people with costly diseases, the health care system should incur fewer costs down the road. However, many people fear that in the short term, the system may see increased costs because of these additional services — particularly with no shared cost to the patient. Concern about the actual current cost and potential future savings of these provisions is just one of many sources of disagreement about the ACA.

The Doughnut Hole

In 2010, around 265,000 Kansans received Medicare prescription drug coverage, paying an average monthly premium of $55.62. While participating in those plans, many of them hit a gap in the drug coverage commonly referred to as the "doughnut hole." Once an individual reaches a certain dollar amount, which includes drug payments by the plan and the participant, he or she has to pay the full cost of medications — up to a limit of $4,700 in 2012. As outlined in Table 3, that full-cost payment section is the doughnut hole.

Table 1. **Medicare Plans and Coverage**

	What does it cover?	Who pays for it?	Who is eligible?
Part A	Inpatient hospital services, skilled nursing facility care, some home health and hospice services.	Part A is paid for through a payroll tax — 2.9 percent — split equally between employers and workers.	Legal residents who have paid payroll taxes for 10 or more years, and U.S. citizens.
Part B	Outpatient care like doctor appointments, some home health and preventive services.	Part B is paid for with federal funds as well as premiums. The average monthly premium in 2011 was $114.50, but people with higher incomes pay a slightly higher premium.	Although Part B is voluntary, 95 percent of people enrolled in Part A are also in Part B. Most people who enroll in Part A are automatically enrolled in Part B unless they specifically decline.
Part C	Parts A and B, often combined with other services. Part C plans, also known as Medicare Advantage or MA plans, are administered through a private carrier.	People enrolled in MA plans pay the private carrier — such as Blue Cross Blue Shield — what they would ordinarily pay the government for their Medicare coverage.	People eligible for Part A and enrolled in Part B can choose to enroll in an MA plan. Only about 46,000 Kansans are enrolled in MA plans.
Part D	Prescription drug services. Part D was established in 2003.	Most people in Part D plans pay premiums for that coverage.	People who want Part D coverage must get it from a private "stand-alone" plan or through an MA plan that includes drug coverage.

To fill part of the doughnut hole, the ACA starts by providing prescription discounts that grow over time and rebate checks to reduce the coverage gap. Whether this approach is effective remains to be seen, and its funding is tied to cost-savings measures elsewhere in the health reform law.

Approximately 41,000 Kansas seniors received a $250 rebate check when they reached the doughnut hole in 2010. Kansans who reach the doughnut hole are eligible for 50 percent discounts on brand-name medications they purchase. As of September 2011, the most recent data available, more than 23,000 Kansans have received a drug discount — totaling around $12.9 million. Additional drug discounts are scheduled to phase in to largely close the coverage gap by 2020.

Better Care Coordination

Many of the Medicare changes described so far involve expanded services or reduced charges to beneficiaries, highlighting what many critics see as the major flaw of the ACA — that it does not do enough to address rising health care costs. However, it does include a number of pilot programs and demonstration projects, largely involving Medicare, aimed at changing the way health care is delivered and financed. Among these are complicated-sounding efforts like bundled payments and value-based purchasing methods. The goal of these reforms is to move away from a fee-for-service system that can drive up costs to an outcome-based payment system that rewards quality health care.

One of the more talked-about Medicare reform models is the Accountable Care Organization (ACO) shared savings program. An ACO is a group of doctors and other health care practitioners — including hospitals or other institutions — that work together to provide care. The model crafted in the ACA allows these groups of providers to share any Medicare savings they generate by providing coordinated, high-quality care. While some see value in this team approach to health care, others predict few providers will participate given that the possibility for savings is just that — a possibility, not a guarantee.

Medicare Advantage

One of the ACA's more contentious Medicare changes will have a smaller impact in Kansas. Of the thousands of Kansans who are enrolled in Medicare, around 46,000 — or nearly 11 percent of enrollees — choose Medicare Advantage (MA) plans. These MA plans are basically a combination of various parts of standard Medicare coverage but are administered through a private carrier, like Blue Cross Blue Shield, and often include some additional services.

MA plans cost more — according to a 2008 Congressional report, 13 percent more on average — than standard Medicare plans. Providers of MA plans say the higher prices reflect their corresponding higher quality of care. Although many MA plans get high ratings for their quality, reports show that the plans do not provide higher quality of care on average when compared with traditional Medicare plans.

Table 2. **Dollars and Sense**

One of the cost-savings provisions of the ACA involves increasing Medicare costs for the highest earners. Changes to Parts B and D premium payments are estimated to generate $36 billion in savings between 2010 and 2019. An increase to the Part A payroll tax is projected to yield $87 billion in Medicare revenue during the same time period.

Before the ACA	Under the ACA
Part B participants with incomes above $85,000 for an individual or $170,000 for a couple pay more for Part B plans through an additional income-based premium.	The percentage of Medicare enrollees required to pay this extra cost will climb from 5 percent in 2011 to 14 percent in 2019. In 2007, close to 13,000 Kansans paid this additional Part B cost.
No additional income-based Part D premium.	A new income-based Part D premium will function like the additional Part B premium for those with higher incomes. By 2019, approximately 9 percent of all Part D enrollees will be subject to the income-based premium.
Participants with incomes above $200,000 for an individual or $250,000 for a couple pay the standard Part A payroll tax of 1.45 percent.	This tax climbs to 2.35 percent. Fewer than 3 percent of Kansas households report having annual income above $200,000.

Table 3. **Filling the Doughnut Hole**

Monthly premium — Ms. Smith pays a monthly premium throughout the year.			
1. Yearly deductible →	**2. Co-payment (what you pay at the pharmacy)** →	**3. Coverage gap** →	**4. Catastrophic coverage**
Ms. Smith pays the first $320 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a co-payment, and her plan pays its share for each covered drug until their combined amount, plus the deductible, reaches $2,930.	Once Ms. Smith and her plan have spent $2,930 for covered drugs, she is in the coverage gap. In 2012, she gets a 50 percent discount on covered brand-name prescription drugs and she pays 86 percent of the plan's cost for covered generic drugs. What she pays, and the discount paid by the drug company, counts as out-of-pocket spending and helps her get out of the coverage gap.	Once Ms. Smith has spent $4,700 out-of-pocket for the year, her coverage gap ends. Now she only pays a small co-payment for each drug until the end of the year.

Source: *Medicare and You 2012*, Centers for Medicare and Medicaid Services.

The ACA reduces the amount that the federal government will pay MA plans over time and limits the amount of cost-sharing these plans can charge beneficiaries. The Congressional Budget Office estimated that the health reform law's changes to MA plans would reduce enrollment in the plans nationwide by several million. Enrollment changes in Kansas are likely to occur as well.

Conclusion

While the ACA is expected to change many aspects of health care and insurance, its effect on Medicare will be more minimal.

The health reform law does aim to adjust several elements of the program that covers 420,000 Kansans. Some changes, like free preventive care, are a certainty, while other elements, like ACO shared savings programs, depend on participation.

Taken as a whole, the ACA changes to Medicare are projected to reduce Medicare spending by $428 billion between 2010 and 2019, though those results are far from certain. The country's financial crisis makes it likely that the Medicare program will be a target of debt committees and budget balancers.

Amid the debate surrounding the ACA and the national debt crisis, one certainty is that Medicare consumes a substantial portion of the country's financial resources to provide care to an older and at-risk population.

More Information

This publication is the fifth in a series of briefs about the impact of health reform in Kansas. It is based on work done by Suzanne Schrandt, J.D., and Gina Maree, M.S.W., LSCSW. Other contributions were made by Susie Fagan; Duane Goossen, M.P.A.; Jim McLean; Cathy McNorton and Robert F. St. Peter, M.D. This document and the other briefs in the series are available online at www.khi.org.

Funding for this project was provided by the United Methodist Health Ministry Fund, a philanthropy based in Hutchinson, and the Kansas Health Foundation in Wichita, a philanthropic organization whose mission is to improve the health of all Kansans.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

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KHI/12-HR1 • January 2012