

The Affordable Care Act: Before and After

Medicare Drug and Health Benefits

Before the ACA

Over three million beneficiaries per year reached the Medicare prescription drug coverage gap, also known as the “doughnut hole,” requiring them to pay for 100 percent of the cost of their drugs. People in the doughnut hole sometimes skipped doses, split their pills, or didn’t take any medications altogether because of the high costs of their drugs.

Beneficiaries with Original Medicare were required to pay 20 percent of the cost of most preventive services out of pocket. Medicare Advantage plans could charge what they wanted for preventive services.

Medicare covered a one-time Welcome to Medicare visit during the first 12 months of Medicare enrollment.

Private Medicare health plans, also known as Medicare Advantage plans, must cover all health services that Original Medicare covers, but they can require beneficiaries to pay more for certain services. Medicare Advantage plans were not restricted in how much they spent on administrative costs such as profits versus actual medical services.

After the ACA

The Affordable Care Act will eliminate the coverage gap or “doughnut hole” in Medicare prescription drug coverage by phasing it out over time. Each year the share of costs paid by consumers for both generic and brand-name drugs in the coverage gap will decrease until it reaches 25 percent—the share people pay before they hit the gap—in 2020. In 2012, people who reach the coverage gap will receive a 50 percent discount on brand name drugs and a 14 percent discount on generic drugs. Last year over three million people benefited from lower drug costs.

Under both Original Medicare and Medicare Advantage plans, most preventive care services are free of charge to beneficiaries, meaning you won’t have to pay a co-pay, coinsurance or deductible when you receive a service. Some examples of the preventive services that now have no cost sharing include mammograms, certain colonoscopies, prostate cancer screenings, depression screenings, obesity screenings and counseling, diabetes screenings and screenings for heart disease. In 2011, over 20 million people with Medicare received free preventive services.

The Affordable Care Act added an Annual Wellness Visit with a primary care provider to the Medicare benefit. Beneficiaries are entitled to this visit every year, and Medicare pays for the full cost of the visit. While not a head-to-toe physical, the annual wellness visit will allow you to meet with your doctor to develop a prevention plan based on your needs. For example, providers may provide a health risk assessment, which is a questionnaire that looks at your health status, injury risks, and urgent health needs. Providers will also take and update family and medical histories, make a list of beneficiaries’ medications, and create a schedule for preventive services.

Though Medicare Advantage plans must still provide all benefits that Original Medicare provides and can charge more for some services, Medicare plans cannot charge more than Original Medicare for specific services such as chemotherapy and dialysis. This will help plans from discriminating against beneficiaries with serious health conditions such as cancer. Under the Affordable Care Act, beginning in 2014, plans must spend at least 85 percent of revenue on medical services for plan members, instead of profits and marketing costs.

Strengthening Medicare’s Financial Outlook

Before the ACA

The Medicare Hospital Trust Fund was due to become insolvent in 2016.

After the ACA

The Affordable Care Act extended the solvency of the Medicare Hospital Trust Fund for an additional 8 years, until 2024.

The U.S. Department of Health and Human Services (which administers Medicare) and the U.S. Department of Justice used “pay and chase” methods to detect and prosecute waste, fraud and abuse. This meant Medicare would often pay bills and then try to recollect payments for fraudulent claims after the fact. In 2008, the government recovered \$2.14 billion in fraudulent Medicare payments.

Medicare paid Medicare private (Medicare Advantage) plans 9 percent more per enrollee than it cost to provide care for the same person under Original Medicare.

Individuals earning over \$85,000 and couples earning over \$170,000 pay higher Part B premiums but do not pay higher Part D Medicare drug plan premiums.

The Affordable Care Act strengthens Medicare prepayment review processes to prevent fraud, waste and abuse. The law increases coordination between the U.S. Department of Health and Human Services, U.S. Department of Justice, and state governments to detect fraud and expands government authority to suspend payment for services or items during fraud investigations. In addition, the law strengthens penalties on providers who engage in fraud, waste and abuse. In 2011, the government recovered \$4.1 billion in fraudulent Medicare payments.

Over a number of years, the Affordable Care Act will gradually reduce payments to Medicare private insurance companies to bring them more in line with costs under Original Medicare. Medicare private health plans will still be required to provide coverage that is at least as good as Original Medicare.

In addition to paying higher Part B premiums, individuals earning over \$85,000 and couples earning over \$170,000 will pay higher Part D Medicare drug plan premiums.

The law slows annual increases in Medicare payments to hospitals, skilled nursing facilities and home health agencies to encourage greater efficiency. The law does not cut payments to Medicare providers and actually increases payments for primary care.

The law establishes an Independent Payment Advisory Board to implement policies that will slow Medicare spending. If Congress takes no action, recommendations made by the board could occur automatically. However, the board cannot change Medicare eligibility or reduce benefits for beneficiaries.

Quality of Care Under Medicare

Before the ACA

While Medicare measured plan quality, plans would be paid under the same formula regardless of their quality.

Medicare pays providers for the quantity of care provided to patients, but not the quality of care. Medicare provider payments do not encourage or reward providers who do better at coordinating their patients' care or communicating with their patients' other providers about their care.

After the ACA

High quality Medicare Advantage plans will receive extra bonus payments to encourage private plans to increase the quality of care they provide to enrollees.

The Affordable Care Act tests a variety of delivery system reforms and care models to improve care quality and care coordination by promoting better communication and coordination among providers, patients and caregivers to help prevent problems like harmful drug interactions, unnecessary hospitalizations, conflicting diagnoses and failures to connect people with community based services that can help them manage their health. For example, the law lowers payments to hospitals with high readmission rates to create incentives for hospitals to help people get the care they need after they leave the hospital, so they don't need to go back. Another program involves Accountable Care Organizations (ACOs). Accountable Care Organizations are teams of doctors, hospitals and other providers that work together to coordinate patients' care. The law rewards Accountable Care Organizations that slow spending growth and meet quality performance standards. It is important to note that providers enroll in Accountable Care Organizations, patients do not and Medicare beneficiaries under Original Medicare will still be able to see any Medicare provider they choose. Other policies boost incentives for providers to report on different quality measures, including quality measures that account for the patient's experience.