Medicare

Much of the Affordable Care Act's focus on Medicare relates to controlling Medicare expenditures by the federal government. However, portions of ACA do affect Medicare beneficiaries who are enrolled in Medicare Parts A, B, C, and D. ACA was silent on Medicare supplement plans but, these plans still may find themselves in the mix eventually.

The parts of ACA that remain after the Supreme Court ruling affecting Medicare beneficiaries include a host of new programs and panels tasked with reprogramming the traditional Medicare model into a more cost-efficient system, one that will be self sustaining well into the future.

Reshaping Medicare, of course, comes with some sacrifices. Beneficiaries may lose some freedoms of choice of providers and providers may be required to band together into more cost efficient enterprises.

Independent Home Demonstration Programs (IHDPs)…These are pilot programs designed to install and test the viability of "at home" primary care programs. They will allow home-bound patients to receive medical care at home and, in theory, better manage chronic illnesses when transport to a medical facility is difficult.

Independent Payment Advisory Board (IPAB)…The IPAB will consist of professionals appointed to the board to oversee and make recommendations to the Secretary of HHS to control the rising costs of Medicare claim expenditures. ACA specifically forbids rationing of care, raising premium rates or, changing benefits to beneficiaries. That means, the traditional fee-for-service reimbursement model is likely to undergo changes, perhaps to "outcomes" based remuneration to providers. It will then be incumbent upon beneficiaries to take an active role in managing their health as providers begin to reduce the number of Medicare patients they allow into their practices.

Accountable Care Organizations (ACOs)…This is perhaps the most ambitious undertaking in Medicare reform. AN ACO will organize groups of healthcare providers under a common grouping or ACO. An ACO will include hospital(s), PCPs, specialists and, ancillary providers in a defined geographic area.

Each Medicare beneficiary may elect the PCP of his/her choice or Medicare will assign one to the beneficiary if he/she does make an election. The PCP will act as the gatekeeper for all referrals to specialists.

All providers who accept Medicare patients would be required to join an ACO. The problem arises when a preferred specialist of a beneficiary is not part of that particular ACO. It is not clear yet how referrals from one ACO to another ACO would be handled.

The purpose of ACOs is to promote transparency and ease-of-access to medical records and treatment regimens. Tracking and monitoring quality of care are other objectives of ACOs. The expectation is

that, in the long term, Medicare expenditures should go down when redundant testing will be unnecessary and providers will have access to a common bank of medical records.

Innovation Centers (ICs)…These will be "think tanks" established by Medicare to work toward cost reductions of Medicare, Medicaid and CHIP. ICs will be tasked with coming up with innovative approaches to deliver quality healthcare at lower costs.

It should be noted, ACOs and the IPAB have been met with much resistance and may be stricken either by the Secretary of HHS or through legislative action.

ACA and Original Medicare

Part A and Part B are known as Original Medicare. Part A is hospital coverage. Part B is outpatient coverage. Most of the reforms to Medicare under ACA pertain to reshaping Parts A and B.

ACA does pay some attention to Parts C and D, Part C being Medicare Advantage plans and Part D…the Medicare prescription plan.

With the Supreme Court's decision public now, here is what will take place in the months and yers to come or, what has already begun.

-Payroll taxes attributable to Medicare will go up .9% for individuals making $200,000/year or $250,000 for joint income tax filers.

-Benefits are not likely to be affected by what remains of ACA, although CMS already has the authority to set Part B premiums annually as well as deductibles for Parts A and B.

-New panels seem to be transitioning Medicare from traditional-fee-for-service arrangements into outcomes-based models, even resembling HMO programs, or at the least, exclusive PPO groups. Most of ACA's attention to Original Medicare focused on panels and other programs affecting providers more than beneficiaries. However, if the ACOs do finally find their way to accepted practice, the behavior of beneficiaries must necessarily change.

The resistance to panels from all segments of the healthcare economy make implementation of some of the panels or organizations questionable at best.

Part C…

Part C plans arose from the Medicare Modernization Act of 2005, and later amendments. ACA is modifying Plan C (Medicare Advantage) plans somewhat. There are four types of insurance plans under Part C: HMO, PPO, Private-fee-for-service (PFFS), and Regional PPO. The insurance companies that offer these plans are responsible for paying claims. Medicare does not pay the claims, nor is the patient required to present his/her Medicare ID cared at the time of service.

Part C plans may only be offered in defined geographic areas. In areas where two or more HMO or PPO plans are offered, PFFS plans may not be offered. A PFFS plans offers extra benefits from Original Medicare, like HMO and PPO plans but, with no network affiliations or restrictions. However,

healthcare providers are under no compulsion to accept the terms and conditions of the PFFS plan. Accepting a beneficiary as a patient does not necessarily mean the provider accepts the plan.

HMO and PPO plan providers are contracted with the carriers directly and must accept the terms and conditions of those Part C plans if they accept the beneficiary as a patient. HMO and PPO plans may have limited or no out-of-network benefits. The exception is emergency care, which must be treated as in-network.

The Lubbock area has at least two HMO or PPO plans so, PFFS plans may not be offered. Instead, those PFFS plans must leave the service area or contract with provider networks. If they offer out-of-network benefits equal to in-network benefits, the plan is called a Regional PPO.

ACA is extracting $50 billion/year for the first 10 years of ACA to help finance the rest of ACA. Much of that $50 billion is coming from reimbursements to insurance companies who offer Part C plans. Those plans that do not meet "benchmark" standards of performance will be most adversely affected. They will see their reimbursements drop. The higher ranked plans will see some modest increases in subsidies from the government to pay claims.

What does this mean for beneficiaries on Medicare Part C plans? Part C plans in some areas that charged low or no premiums, will see higher premiums to beneficiaries because of the complicated formula. Generally, a plan with a 3.5-star rating by CMS (Centers for Medicare Medicaid Services) or higher (out of 5 stars maximum), will see increased subsidies. Medicare rewards plans with efficient cost saving measures.

Lower income beneficiaries will be impacted most by the new mandates of ACA. They could be forced to pay premiums in the future if their plan receives fewer subsidy dollars by not meeting the ACA benchmark standards. PACE programs for disabled low income beneficiaries under age 65 are not affected. ACA keeps these plans fully funded.

Those beneficiaries who receive "extra help" from Medicare to pay their Medicare Part B and Part D premiums will not be adversely affected. However, ACA now forbids Part C plans from offering assistance to help beneficiaries pay their part B premium.

ACA also froze the 2012 reimbursement rates to Part C plans at the 2011 level. Normal reimbursement growth will resume after 2012.

ACA also imposes a Medical Loss Ratio (MLR) on Part C plans. The MLR is 85%. That is, part C plans must pay out 85% of funds received (premiums, subsidies and reimbursements) in claims. If, at the end of an accounting year, the plan is short of hitting the 85% claim-payment level, the excess funds must be returned to Medicare. Penalties are applied to insurance plans that do not meet the MLR over time. Penalties include a freeze on new business or even expulsion of in-force Part C plans for a period of time.

Medicare supplement plans

As discussed briefly earlier, Medicare supplement plans are largely unaffected by ACA because they are considered "supplemental" benefit plans. Supplemental plans are specifically excluded by ACA from its mandates.

Medicare supplement plans already have a 65% MLR. However, any excess funds here to toward reduction of premiums by beneficiaries.

A provision in ACA directs Medicare supplement plans to incorporate a minimal cost-sharing on plans C and F which currently have nominal out-of-pocket expenses to insureds. The thought behind this is that if insureds have "skin in the game" they will be more prudent with utilization of healthcare services. ACA is suggesting that physician copays as perhaps an alternative to the 100% coverage now available.

Medicare Part D (Medicare prescription drug plan)

ACA does not address much with Part D plans either. The little attention paid to Part D, received a lot of news coverage. ACA proposed to close the so-called "donut hole" or coverage gap on prescription drugs. This is the gap where beneficiaries paid 100% of the costs for brand name drugs after exhausting the initial coverage period benefits.

In 2012 the donut hole was closed by 50%. The federal government negotiated a 50% discount for brands with drug companies who wished to participate in Part D plans. The beneficiary pays 50% to the pharmacy. The 50% paid by the beneficiary and the 50% discount both counted toward satisfying the $4400 exposure in the donut hole.

ACA did not reduce the $4400. It simply applied the 50% discount as well. As a result, beneficiaries pay $2200 in 2012, while in the donut hole.

ACA requires 75% closure of the donut hole under the same scenario above by 2020.