

SUMMARY OF KEY CHANGES TO MEDICARE IN 2010 HEALTH REFORM LAW

The comprehensive health care reform legislation (the Patient Protection and Affordable Care Act [PPACA; P.L. 111-148], amended by the Health Care and Education Reconciliation Act of 2010 [HCERA; P.L. 111-152]), includes several provisions related to the Medicare program, summarized below and on the following pages.

- **Phases in coverage in the Medicare Part D drug benefit coverage gap, or “doughnut hole.”** In 2010, Part D enrollees with any spending in the coverage gap will receive a \$250 rebate. Beginning in 2011, enrollees with spending in the coverage gap will receive a 50 percent discount on brand-name drugs, provided by the pharmaceutical industry. The law phases in Medicare coverage in the gap for generic drugs beginning in 2011, and for brand-name drugs beginning in 2013. By 2020, Part D enrollees will be responsible for 25 percent of the cost of both brands and generics in the gap, down from 100 percent in 2010. The catastrophic coverage threshold is reduced between 2014 and 2019.
- **Improves coverage of prevention benefits.** Beginning in 2011, no coinsurance or deductibles will be charged in traditional Medicare for preventive services that are rated A or B by the U.S. Preventive Services Task Force (USPSTF). Medicare will cover a free annual comprehensive wellness visit and personalized prevention plan.
- **Reduces federal payments to Medicare Advantage plans over time and provides bonus payments to plans receiving high quality ratings.** The law freezes benchmarks (the maximum amount Medicare pays plans per county) for 2011, and beginning in 2012, phases in reductions in Medicare Advantage plan payments relative to fee-for-service costs in each county. Beginning in 2012, plans with high quality ratings will receive bonus payments. Plans with bids below the benchmark will generally receive 50 percent of the difference between the plan bid and the benchmark, rather than 75 percent; high-quality plans will receive higher rebates. Plans will be required to maintain a medical loss ratio of at least 85 percent by 2014.
- **Establishes a new Independent Payment Advisory Board to recommend ways to reduce Medicare spending if Medicare per capita growth rates exceed certain targets.** Beginning in 2014, if the growth in Medicare per capita spending exceeds a certain rate, the Board is required to submit recommendations to achieve specified spending reductions. The Secretary of HHS is required to implement the Board's recommendations unless Congress enacts alternative proposals that achieve the same level of savings, with new deadlines and procedures for Congressional deliberations. The 15-member Board, appointed by the President and confirmed by the Senate, is prohibited from recommending changes that would ration care or modify benefits, eligibility, premiums, or taxes, or from recommending payment reductions for certain providers that would take effect prior to 2020.
- **Includes numerous provisions related to provider payments to reduce the growth in future Medicare payments; increases payments for some primary care providers.** The law reduces annual updates for various medical providers (other than physicians), adjusts payments for productivity improvements, and reduces payments to certain hospitals for care delivered to the uninsured. The law provides bonus payments for primary care physicians in underserved areas and increases payments to rural health care providers, but does not address the sustainable growth rate (SGR) formula that determines physician payments.
- **Includes several payment and health delivery system reforms,** including a pilot program to bundle payments for post-acute care, value-based purchasing for providers, and the establishment of accountable care organizations. The law creates a new Center for Medicare and Medicaid Innovation within CMS to test new payment and service delivery models, and establishes a new Federal Coordinated Health Care Office within CMS to improve the integration of care for beneficiaries eligible for both Medicare and Medicaid (the dual eligibles).
- **Modifies and expands the use of income-related premiums under Medicare.** The law freezes the income thresholds for the Part B income-related premium at 2010 levels (\$85,000/individual, \$170,000/couple) through 2019, and adds a new income-related premium for Part D (with income thresholds the same as for Part B and no indexing).
- **Increases the Medicare Hospital Insurance (Part A) payroll tax on earnings** for higher-income taxpayers (more than \$200,000/individual and \$250,000/couple) by 0.9 percentage points from 1.45 percent to 2.35 percent, beginning in 2013, to be deposited into the Part A Trust Fund.

A more detailed description of these and other Medicare provisions in the health reform law and an implementation timeline follows.

MEDICARE PRESCRIPTION DRUG BENEFIT (Part D) REFORMS

- Gradually phases in coverage in the Medicare Part D coverage gap (the “doughnut hole”), reducing the coinsurance rate in the gap from 100 percent of total drug costs in 2010 to 25 percent in 2020.
 - Provides a \$250 rebate for Part D enrollees with any spending in the coverage gap in 2010. (Section 3315, as superseded by Section 1101(a) of HCERA)
 - Establishes a Medicare coverage discount program to provide a 50 percent discount on brand-name drugs to Part D enrollees with spending in the coverage gap. Drug manufacturers are required to provide a 50 percent discount off negotiated prices on brand-name drugs and biologics covered under Part D plans for Part D enrollees with spending in the coverage gap, beginning in 2011. (Section 3301, as modified by Section 1101 of HCERA)
 - Phases in a reduction in coinsurance for generic drugs in the coverage gap, beginning in 2011, and a reduction in coinsurance for brand-name drugs in the gap, beginning in 2013, and reduces the beneficiary coinsurance rate for both brands and generics from 100 percent in 2010 to 25 percent in 2020, until enrollees qualify for catastrophic coverage. Reduces the catastrophic coverage threshold between 2014 and 2019 to provide additional support for those with relatively high drug costs. (Section 3301, as modified by Section 1101 of HCERA)
- Allows payments from the Indian Health Service and AIDS drug assistance programs (ADAP) to count toward enrollees’ true out-of-pocket (TrOOP) threshold used to determine eligibility for catastrophic coverage under Part D. (Section 3314)
- Modifies Part D cost-sharing for full-benefit dual eligibles. Makes Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care. Effective no earlier than January 1, 2012. (Section 3309)
- Improves the determination of Medicare Part D Low-Income Subsidy (LIS) benchmark premiums, by excluding from the benchmark determination any reductions in premium amounts that are attributable to rebate or bonus payments to plans, effective in 2011. (Section 3302)
- Eliminates the tax deductibility of the 28 percent federal subsidy, known as the retiree drug subsidy (RDS), for employers who provide creditable prescription drug coverage to Medicare beneficiaries, effective in 2013. (Section 9012)
- Clarifies that Medicare Part D plans may waive the beneficiary copayment for the first generic prescription filled to encourage use of lower-cost generic drugs without violating federal fraud and abuse provisions. Effective on date specified by the Secretary but in no case earlier than January 1, 2011. (Section 6402, as modified by Section 1303 of HCERA)

OTHER BENEFIT AND COVERAGE CHANGES

- Authorizes Medicare coverage of personalized prevention plan services, including an annual comprehensive health risk assessment, beginning January 1, 2011. Requires the Secretary to publish guidelines for the health risk assessment no later than March 23, 2011, and a health risk assessment model by no later than September 29, 2011. Reimburses providers 100 percent of the physician fee schedule amount with no adjustment for deductible or coinsurance for personalized prevention plan services when these services are provided in an outpatient setting. (Section 4103, as modified by Section 10402)
- Eliminates cost-sharing, including coinsurance and deductibles, for prevention benefits that are rated A or B by the U.S. Preventive Services Task Force (USPSTF), beginning in 2011. Authorizes the Secretary of HHS to modify coverage of Medicare-covered preventive services to conform to the USPSTF recommendations. (Sections 4104-4105)
- Expands coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result, effective upon enactment. (Section 10323)

MEDICARE ADVANTAGE REFORMS

Currently, Medicare Advantage plans receive payments from the federal government to provide Medicare-covered benefits based on a statutory formula; payments vary by county. Medicare payments to Medicare Advantage plans are currently higher, on average, than local fee-for-service costs. Plans receive 75 percent of the difference between the plan bid and the benchmark in the form of a rebate.

- Restructures payments to Medicare Advantage plans by setting payments closer to the average costs of Medicare beneficiaries, by county. In 2011, benchmarks for Medicare Advantage plans will remain the same as they are in 2010.

MEDICARE ADVANTAGE REFORMS (continued)

For most counties, between 2012 and 2013, plan benchmarks will gradually be reduced to levels closer to the costs of enrollees in traditional Medicare in each county. In determining Medicare Advantage payments, the calculation of Medicare fee-for-service costs for a county excludes Indirect Medical Education (IME) payments. [Section 3201, as replaced by Section 1102(b) of HCERA]

- Benchmarks will be 95 percent of fee-for-service costs per enrollee for the counties in the top quartile of fee-for-service costs, and 115 percent of fee-for-service costs per enrollee for the counties in the bottom quartile of fee-for-service costs. Benchmarks will be 107.5 percent and 100 percent of fee-for-service costs per enrollee for counties in the third highest and second highest quartile of fee-for-service costs, respectively. [Section 3201, as replaced by Section 1102(b) of HCERA]
- For counties in which the phased-in change in payments is less than \$30, the new benchmarks will be phased in over 3 years, beginning in 2011, as previously described. The new benchmarks will be phased in over 4 years in counties in which the phased-in change in payments is at least \$30 but less than \$50, and will be phased in over 6 years in counties in which the phased-in change in payments is \$50 or more. [Section 3201, as replaced by Section 1102(b) of HCERA]
- Provides bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for Medicare Advantage plans, with bonus payments of 1.5 percent in 2012, 3.0 percent in 2013, and 5.0 percent in 2014 and later years; provides double bonuses to high quality plans in certain counties. [Section 3201, as replaced by Section 1102(b) of HCERA]
- Modifies rebate system with rebates allocated based on a plan's quality rating. The majority of plans will be allowed to retain only 50 percent of the difference between the plan bid and the benchmark, but plans receiving 3.5 or 4 stars will retain 65 percent of the difference and plans receiving 4.5 or 5 stars will retain 70 percent of the difference. Caps total payments to plans, including bonuses, at current payment levels. Treats low-enrollment plans as having a 4.5 star rating and new plans as having a 3.5 star rating. [Section 3202, as modified by Section 1102(d) of HCERA]
- Prohibits Medicare Advantage plans from imposing higher cost-sharing requirements than traditional fee-for-service Medicare for chemotherapy, renal dialysis, skilled nursing care, and other services the Secretary deems appropriate, and allows plans to charge non-discriminatory cost-sharing for services that have no cost-sharing under traditional fee-for-service Medicare, beginning in 2011. [Section 3202, as modified by Section 1102(d) of HCERA]
- Extends the authority of CMS to adjust risk scores for Medicare Advantage enrollees, and requires the Secretary to adjust risk scores, beginning in 2014. Requires the Secretary to reduce risk scores by at least 5.7 percent in 2019 and future years, until the Secretary implements risk adjustment using Medicare Advantage diagnostic, cost, and use data. [Section 3203, as modified by Section 1102(e) of HCERA]
- Changes the annual enrollment period to October 15 to December 7 of each year, beginning in 2011 for plan year 2012. Beneficiaries enrolled in a Medicare Advantage plan as of January 1 will be allowed 46 days after the beginning of the calendar year to disenroll from the plan and return to traditional fee-for-service Medicare, beginning in 2011; they will not be allowed to switch from one Medicare Advantage plan to another during this time period. [Section 3204]
- Allows SNPs to continue to be offered to beneficiaries until 2014, and requires SNPs to be approved by the National Committee for Quality Assurance, beginning in 2012. Permits SNPs for individuals dually eligible for Medicare and Medicaid to operate without established contracts with state Medicaid programs until 2013. Requires payments to SNPs for individuals with chronic conditions to be risk-adjusted based on the costs of enrollees with the same health conditions, beginning in 2011. Allows the Secretary to adjust payments to SNPs for the dually eligible for enrollees' frailty, beginning in 2011. [Sections 3205-3208]
- Requires Medicare Advantage plans to maintain a medical loss ratio (MLR) of at least 85 percent, beginning in 2014. Requires the Secretary to suspend plan enrollment for 3 years if the MLR is less than 85 percent for 2 consecutive years and to terminate the plan contract if the MLR is less than 85 percent for 5 consecutive years. [Section 1103 of HCERA]

PROVIDER PAYMENT REFORMS

- Reduces annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, and inpatient rehabilitation facilities and psychiatric hospitals and units beginning in 2010. Beginning in 2012, reduces the market basket update for home health agencies, skilled nursing facilities, hospices, and other Medicare providers. [Section 3401]

PROVIDER PAYMENT REFORMS (continued)

- Applies a productivity adjustment to the market basket updates for inpatient and outpatient hospitals, inpatient rehabilitation facilities, psychiatric hospitals and units, long term care hospital services and skilled nursing facilities, beginning in fiscal year (FY) 2012, and applies a productivity adjustment for hospice services, beginning in FY 2013, and for home health, beginning in FY 2014. Applies a productivity adjustment to CPI updates for specified Part B items and services. Productivity adjustments may result in a negative update for services, other than laboratory services. [Section 3401]
- Rebases home health payment amounts, phased in between 2014 and 2017, taking into account the number, mix and intensity of services provided, and the average cost of providing care; authorizes the Secretary to take into account differences between providers (hospital-based versus free-standing; for-profit versus not-for-profit; urban versus rural) and limits the annual adjustments to no more than 3.5 percent per year, relative to payment levels in 2010. Modifies payments for outliers beginning in 2011. Provides 3 percent add-on for rural home health providers for episodes and visits ending between April 1, 2010 and January 1, 2016. [Section 3131]
- Reduces Medicare Disproportionate Share Hospital (DSH) payments to 25 percent of the amount that otherwise would be made beginning in FY 2014, and provides an additional payment to reflect uncompensated care costs, based on a formula that takes into account the aggregate reduction in payments to all hospitals attributable to the reduction in DSH payments, the reduction in uninsured individuals in a year, relative to 2013, and each hospital's share of uncompensated care provided by all hospitals. [Section 3133, as modified by Sections 10316 and 1104 of HCERA]
- Provides a 10 percent bonus payment for primary care services furnished by primary care physicians, and by nurse practitioners, clinical nurse specialists and physician assistants if at least 60 percent of their Medicare allowed charges in a prior period were for primary care services, effective 2011-2015. Also provides a 10 percent bonus payment to general surgeons practicing in health professional shortage areas, from 2011 through 2015. [Section 5501, as modified by Section 10501]
- Provides payments totaling \$400 million in fiscal years 2011 and 2012 to qualifying hospitals in counties in the lowest quartile of Medicare per enrollee spending, adjusted for age, sex, and race. [Section 1109 of HCERA]
- Does not address issues related to the sustainable growth rate (SGR) formula that determines physician payments.

INDEPENDENT PAYMENT ADVISORY BOARD

Establishes a new Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the increase in Medicare per capita growth rates exceed certain targets. [Section 3403, as modified by Section 10320] Since the inception of Medicare in 1965, Congress has had the authority to establish and modify policies affecting all aspects of the Medicare program and the Administration implements policy changes through regulations. MedPAC advises the Congress on payment policies and other matters pertaining to Medicare.

- Beginning in 2014, if the projected per capita Medicare spending growth rate exceeds a target growth rate, the Board is required to submit recommendations to achieve specific spending reductions to the President, who subsequently submits the recommendations to the Congress. The Secretary of HHS is required to issue recommendations if the Board fails to do so, and implement the Board's recommendations (or the Secretary's) unless Congress enacts alternative proposals that achieve the same level of savings.
- The Board is required to submit a proposal to Congress to reduce Medicare spending by a specified amount if the projected five-year average growth rate in Medicare per beneficiary spending is projected to exceed the target growth rate, according to the CMS Office of the Actuary (OACT). Prior to 2018, the target growth rate is the projected five-year average rate of change in the Consumer Price Index for All Urban Consumers (CPI-U) and the CPI for Medical Care (CPI-M). In 2018 and beyond, the target growth rate is the projected five-year average percentage increase in the nominal per capita gross domestic product (GDP) plus 1.0 percentage point.
- If the five-year average rate of growth for Medicare per beneficiary spending exceeds the target growth rate, the Board is required to submit a savings proposal that achieves the lesser of either: (1) the amount by which projected Medicare per beneficiary spending exceeds the target, or (2) total projected Medicare spending for the year multiplied by 0.5 percent in 2015, 1.0 percent in 2016, 1.25 percent in 2017, and 1.5 percent in 2018 and future years.
- The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D prior to 2019.

INDEPENDENT PAYMENT ADVISORY BOARD (continued)

- Prior to 2019, the Board is prohibited from recommending changes in payments to providers and suppliers that are scheduled to receive a reduction in their payment updates in excess of a reduction due to productivity improvements, as specified in the health reform law.
- Beginning in July 2014, the Board is required to produce an annual report with standardized information on system-wide health care costs, patient access to care, utilization and quality of care, including comparisons by region, type of services, types of providers, for both Medicare and private payers, and including information on provider practice patterns and costs.
- The Board is required to submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care, beginning January 1, 2015.
- Provides a direct appropriation for the Board of \$15 million in FY 2012, indexed in future years by the CPI.

DELIVERY SYSTEM REFORMS

Implements several new payment and delivery system innovations, including a pilot program related to post-acute care, value-based purchasing for providers, and the establishment of accountable care organizations (ACOs), and creates a new Center for Medicare and Medicaid Innovations (CMI) to test payment and service delivery models.

- Allows qualifying providers organized as ACOs that meet quality thresholds to share in the cost savings they achieve for the Medicare program, beginning in 2012. To qualify as an ACO, organizations must agree (in a 3-year contract with the Secretary) to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. If an ACO achieves a minimum level of savings, the ACO will receive a share of the savings. (Section 3022, as modified by Section 10307)
- Creates the Center for Medicare and Medicaid Innovations (CMI) to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care, to be established by January 1, 2011. Payment reform models that improve quality and reduce the rate of cost growth could be expanded nationally throughout the Medicare, Medicaid, and CHIP programs. Provides 20 possible models for testing, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the state. Authorizes the Secretary to limit model testing to certain geographic areas. (Section 3021, as modified by Section 10306)
- Reduces Medicare payments that would otherwise be made to hospitals by no more than 1 percent in 2013, 2 percent in 2014, and 3 percent in 2015 and subsequent years, to account for excess (preventable) hospital readmissions, beginning October 1, 2012. Reductions do not apply to critical access hospitals. Requires the establishment of a quality improvement program to assist eligible hospitals in improving their readmission rates. (Section 3025, as modified by Section 10309)
- Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1 percent, beginning in 2015. (Section 3008)
- Establishes a national Medicare pilot program to develop and evaluate paying a bundled payment under traditional fee-for-service Medicare for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. Requires the Secretary to expand the pilot program if it achieves stated goals of improving or not reducing quality and reducing spending. Requires the Secretary to test a continuing care hospital model. Requires the pilot programs to be established by January 1, 2013 and expanded, if appropriate, by January 1, 2016. (Section 3023, as modified by Section 10308)
- Creates the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction, beginning January 1, 2012. High-need beneficiaries are defined as those having 2 or more chronic conditions, a nonelective hospital admission within the past 12 months, previous acute or subacute rehabilitation services, and 2 or more functional dependencies. (Section 3024)

DELIVERY SYSTEM REFORMS (continued)

- Establishes a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures, beginning in 2012. Requires the Secretary to establish quality reporting initiatives for long term care hospitals, inpatient rehabilitation hospitals, hospice programs, psychiatric hospitals, and PPS-exempt cancer centers, effective October 1, 2012. Requires the Secretary to develop plans to implement value-based purchasing programs for skilled nursing facilities and home health agencies (beginning October 1, 2011) and ambulatory surgical centers (beginning January 1, 2011). (Sections 3001, 3004-3006)
- Extends the Medicare incentive payments for the physician quality reporting initiative through 2014, and establishes a mandatory physician quality reporting program beginning in 2015. Eligible professional who report quality data for the applicable year, prior to 2015, will receive bonuses of 1.0 percent in 2011 and 0.5 percent in 2012, 2013, and 2014. Eligible professional who do not report quality data after 2014 will have their Medicare payments reduced by 1.5 percent in 2015 and 2.0 percent in 2016 and subsequent years. Eligible professionals include physicians, practitioners, physical and occupational therapists, qualified speech-language pathologists and qualified audiologists. For years prior to 2015, bonus payments are increased by 0.5 percent if the quality data is submitted on the eligible professional's behalf by a qualified specialty board or Maintenance of Certification (MOC) program, or its equivalent. (Section 3002)
- Amends the physician feedback program to require the Secretary to develop an episode grouper (combining separate but clinically-related services into an episode of care for which the physician, or group of physicians, is accountable). Beginning in 2012, requires the Secretary to provide feedback reports to physicians using the episode grouper, including appropriate adjustments for differences in demographic characteristics and health status, and geographic variation. Requires education and outreach to physicians about the feedback program. (Section 3003)

INCOME-RELATED PREMIUMS

- Modifies the income-related monthly Part B premium, by freezing the income thresholds for the income-related Part B premium at 2010 levels (\$85,000/individual, \$170,000/couple) through 2019, beginning in 2011. (Section 3402)
- Establishes a new income-related monthly Part D premium, requiring higher-income Part D enrollees (those with incomes greater than \$85,000/individual, \$170,000/couple) to pay a higher income-related Part D premium, beginning in 2011. Reduces the federal premium subsidy from 74.5 percent to lower percentages, depending on income. Freezes the income thresholds for the income-related Part D premium at \$85,000/individual, \$170,000/couple through 2019. (Section 3308)

DUAL ELIGIBLES

- Creates a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles, to be established by March 1, 2010. (Section 2602)

WASTE, FRAUD AND ABUSE

- Mandates provider screening, not later than September 23, 2011. Enhances oversight periods for new providers and suppliers, including initial claims of DME suppliers. Requires Medicare and Medicaid program providers and suppliers to establish compliance programs. (Section 6401, as modified by Section 10603 and Section 1304 of HCERA)
- Develops a database to capture and share data across federal and state programs, and increases funding for anti-fraud activities. (Section 6402, as modified by Section 1303 of HCERA)
- Requires providers, physicians, and suppliers to provide, upon request, documentation for DME and home health referrals, effective January 1, 2010. (Section 6406)
- Requires physicians to have a face-to-face encounter with the patient before certifying the need for DME or home health services for Medicare or Medicaid, effective January 1, 2010. (Section 6407, as modified by Section 10605)
- Enhances penalties for marketing violations by Medicare Advantage and Part D plans, effective January 1, 2010. Increases penalties for submitting false claims and for failing to comply with investigations, effective January 1, 2010. (Section 6408)

INCREASE IN MEDICARE PAYROLL TAX ON EARNINGS

- Increases the Medicare Hospital Insurance (Part A) payroll tax for taxpayers with higher incomes (more than \$200,000/individual and \$250,000/couple) by 0.9 percentage points, from 1.45 percent to 2.35 percent, with funds deposited in the Medicare Part A Trust Fund, beginning in 2013. (Section 9015)

FISCAL IMPACT

The Medicare provisions of the health care reform law are estimated to result in a net reduction of \$428 billion in Medicare spending between 2010 and 2019, taking into account \$533 billion in Medicare savings and \$105 billion in new Medicare spending over the 10-year period. In addition, the law generates Medicare-related revenue through the higher Medicare payroll tax (\$87 billion in revenue through 2019), by imposing an annual fee on branded prescription pharmaceutical manufacturers and importers (\$27 billion in revenue through 2019), and by eliminating the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments, beginning in 2013 (\$5 billion in revenue through 2019).¹

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¹ Congressional Budget Office (CBO) , March 20, 2010; Joint Committee on Taxation revenue estimates, March 20, 2010.

Implementation Timeline for Key Medicare Provisions of the 2010 Health Care Reform Law, 2010-2015

2010	
Cost containment	<ul style="list-style-type: none"> Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust payments for productivity Ban new physician-owned hospitals in Medicare
Delivery system reforms	<ul style="list-style-type: none"> Establish a new office within the Centers for Medicare & Medicaid Services (CMS), the Federal Coordinated Health Care Office, to improve care coordination for dual eligibles
Part D	<ul style="list-style-type: none"> Provide a \$250 rebate for beneficiaries who reach the Part D coverage gap
2011	
Cost containment	<ul style="list-style-type: none"> Establish a new Center for Medicare and Medicaid Innovation within CMS Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels (\$85,000/individual and \$170,000/couple), and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012
Medicare Advantage	<ul style="list-style-type: none"> Prohibit Medicare Advantage plans from imposing higher cost sharing for some Medicare-covered benefits than is required under the traditional fee-for-service program Restructure payments to Medicare Advantage (MA) plans by phasing payments to different percentages of Medicare fee-for-service rates; freezes payments for 2011 and 2010 levels
Physician payment	<ul style="list-style-type: none"> Provide a 10 percent Medicare bonus payment to primary care physicians and general surgeons practicing in health professional shortage areas
Part D	<ul style="list-style-type: none"> Begin phasing in federal subsidies for generic drugs in the Medicare Part D coverage gap (reducing coinsurance from 100 percent in 2010 to 25 percent by 2020) Require pharmaceutical manufacturers to provide a 50 percent discount on brand-name prescriptions filled in the coverage gap (reducing coinsurance from 100 percent in 2010 to 50 percent in 2011)
Preventive services	<ul style="list-style-type: none"> Eliminate Medicare cost sharing for some preventive services Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan
2012	
Cost containment	<ul style="list-style-type: none"> Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the savings they achieve for the Medicare program Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions
Delivery system reforms	<ul style="list-style-type: none"> Create the Medicare Independence at Home demonstration program Establish a hospital value-based purchasing program and develop plans to implement value-based purchasing for skilled nursing facilities, home health agencies, and ambulatory surgical centers
Medicare Advantage	<ul style="list-style-type: none"> Reduce rebates for Medicare Advantage plans High-quality Medicare Advantage plans begin receiving bonus payments
Part D	<ul style="list-style-type: none"> Make Part D cost sharing for dual eligible beneficiaries receiving home and community-based care services equal to the cost sharing for those who receive institutional care

2013	
Delivery system reforms	<ul style="list-style-type: none"> Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care
Part D	<ul style="list-style-type: none"> Begin phasing in federal subsidies for brand-name drugs in the Part D coverage gap (reducing coinsurance from 100 percent in 2010 to 25 percent in 2020, in addition to the 50 percent manufacturer brand discount)
Tax changes	<ul style="list-style-type: none"> Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9 percent (from 1.45 percent to 2.35 percent) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments
2014	
Cost containment	<ul style="list-style-type: none"> Independent Payment Advisory Board comprised of 15 members begins submitting legislative proposals containing recommendations to reduce Medicare spending if spending exceeds a target growth rate Reduce Disproportionate Share Hospital (DSH) payments initially by 75 percent and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care
Medicare Advantage	<ul style="list-style-type: none"> Require Medicare Advantage plans to have medical loss ratios no lower than 85 percent
Part D	<ul style="list-style-type: none"> Reduce the out-of-pocket amount that qualifies for Part D catastrophic coverage (through 2019)
2015	
Cost containment	<ul style="list-style-type: none"> Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1 percent

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THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

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