Health Reform and Medicare:

A Timeline of Implementation

2010

- Provides a $250 rebate to people with Medicare in the doughnut hole. (The doughnut hole is the $3,600 gap in the drug benefit when consumers pay full price.)
- Authorizes the Food and Drug Administration to approve generic versions of biologics, which treat diseases such as diabetes, and allows for generic versions to enter the market after 12 years. This means more affordable versions of biologics will be available to consumers.
- Improves care coordination for dual eligibles—people who are enrolled in both Medicare and Medicaid—through the creation of the new Federal Coordinated Health Care Office within the Centers for Medicare & Medicaid Services (CMS).
- Many provisions to reduce fraud within the Medicare program take effect, including tighter restrictions on physician self-referrals and requirements for claims to be filed within one year of service.
- Reduces updates to annual market baskets, which are used to determine annual payment adjustments, for home health care, inpatient hospitals, skilled nursing facilities, hospice and other Medicare providers, and adjusts market baskets to account for provider productivity.

2011

- Manufacturers will provide a 50 percent discount on brand-name drugs and the government will provide a 7 percent discount on generic drugs for consumers in the gap in 2011. Discounts will increase with each passing year until the consumer's share of costs while in the gap is 25 percent for both brand-name drugs and generics in 2020. (For a full explanation and chart of the phase-out see Health Reform and Medicare: Closing the Doughnut Hole.)
- Eliminates deductibles and coinsurance for preventive services recommended by the U.S. Preventive Services Task Force.
- Provides coverage of annual wellness visit and personalized prevention plan at no charge.
- Provides 10 percent bonus payments to primary care doctors working in areas with physician shortages.
- Creates a CMS Innovation Center that will explore effective ways to create efficient payment systems that are patient-centered, that preserve and incentivize high-quality care.
- Reduces market basket updates for providers beginning in 2011.
- Prohibits private "Medicare Advantage" plans from charging enrollees more than Original Medicare for *certain* medical services, including chemotherapy administration and skilled nursing care.

2011 (continued)

- Freezes “Medicare Advantage” payment rates at 2010 levels. In subsequent years, continues to phase in private “Medicare Advantage” payment reforms, which reduce government subsidies to insurance companies. The reforms aim to better match coverage costs in the private Medicare insurance market to those in the Original Medicare program.
- Allows Medicare Advantage enrollees to switch to Original Medicare during the first 45 days of the new year.
- Freezes inflation indexing for Medicare-related Part B premiums for people with high incomes.
- Raises drug plan premiums for individuals earning over $85,000 and couples earning over $170,000.
- Creates a new voluntary national insurance program for long-term care services (Community Living Assistance Services and Supports [CLASS] Program), financed through voluntary payroll deductions. After five years of contributing to the program, should a person require services in the future, the fund would provide a lifetime benefit averaging $50 a day depending on the needs of the person.

2012

- Eliminates prescription drug copayments for certain dual-eligibles receiving home- or community-based long-term care.
- Creates a new Medicare Independence at Home demonstration program for chronically ill Medicare beneficiaries to receive primary care services in their homes and to incentivize better coordination of care.
- Reduces payments to hospitals with high rates of preventable hospital readmissions in order to promote higher quality outcomes.
- Provides incentives for physicians and other providers to form Accountable Care Organizations (ACOs) to encourage better communication among providers across care settings, reduce costs and provide higher-quality care. ACOs are networks of health providers that work together to provide a range of health care services for patients. Providers who participate in ACOs that meet quality targets and achieve savings to Medicare may share in those cost-savings. ACOs must meet specific consumer-centered criteria, such as the creation of individualized care plans for patients.
- Establishes a “value-based” purchasing system for hospitals. Medicare would link payments to hospitals to their performance on quality measures. In addition, requires development of value-based purchasing programs in other areas, including home health agencies and skilled nursing facilities. The purpose is to create a more efficient system that will reduce costs while also providing patients with higher-quality care and better health outcomes.
- Provides bonus payments to high-performing private “Medicare Advantage” plans.
- Creates a single Annual Enrollment Period (AEP) for drug and health plan changes, which begins on October 15 and ends on December 7.

2013

- Establishes a pilot program to evaluate bundled payments for inpatient hospital services, outpatient hospital services, physician services, and post-care services, including follow-up care after release from a hospital. The program will test if such payment reforms lead to better care coordination, higher-quality care for patients and lower costs. Under a bundled payment system, Medicare pays one payment for a group of services offered in a single episode of care, whether administered under Part A or Part B, instead of paying for each individual service separately.
- Increases the Medicare Part A payroll tax by 0.9% for individuals earning over $200,000 and couples earning over $250,000. In addition, adds a 3.8% tax on certain unearned investment income for individuals earning over $200,000 and couples earning over $250,000.

2014

- Reduces the out-of-pocket amount consumers in the doughnut hole must pay in order to qualify for catastrophic drug coverage under Part D.
- Limits “Medicare Advantage” plan profits and administrative expenses to 15 percent of Medicare payments.
- Establishes an Independent Payment Advisory Board with mandate to implement Medicare provider payment changes to meet savings targets. Congress’s ability to overturn or amend payment changes will be limited. However, the Board cannot change Medicare eligibility or reduce benefits or premium subsidies, but is allowed to make limited changes to how drug plan premium subsidies are calculated.
- Creates a national health exchange that includes standardized health packages that meet minimum coverage requirements. Individuals and small-businesses with less than 100 employees will be able to purchase insurance through the exchange. The exchange administers tax credits to help lower-income people obtain coverage.
- Implements general insurance reforms for the non-Medicare population, including people in the two-year waiting period for Medicare. These reforms include guaranteed issue of plans, prohibition on coverage exclusions based on a pre-existing condition, and limiting age rating of premiums to three to one.
- Requires all U.S. citizens and legal residents to obtain qualifying health coverage. Those without coverage will be assessed a tax penalty.