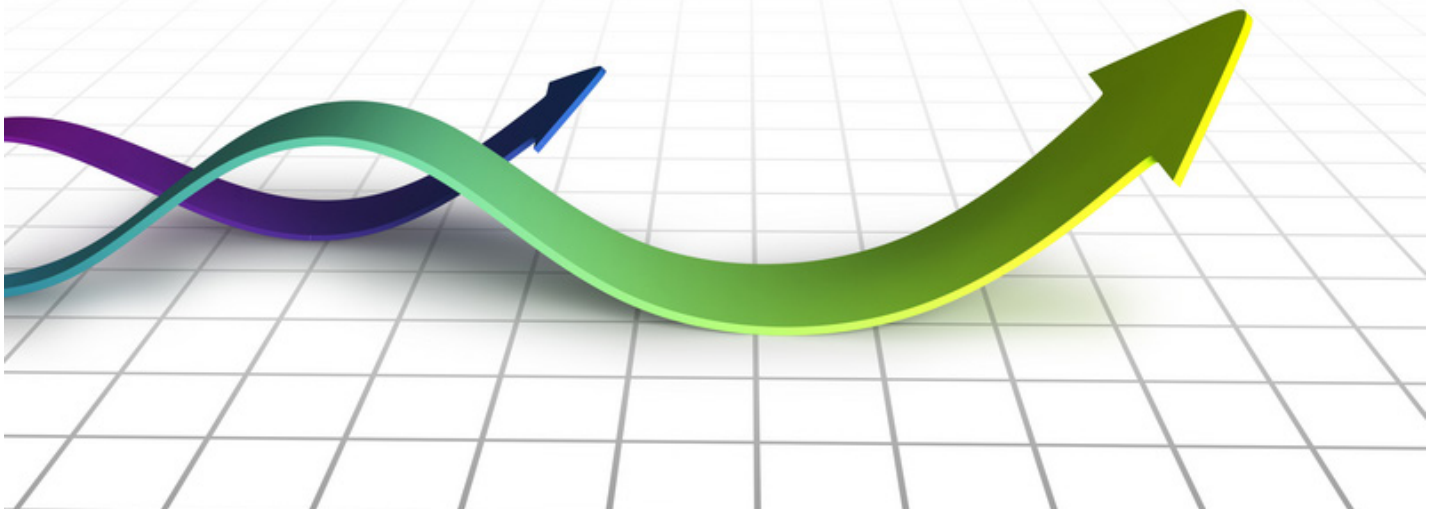


The Affordable Care Act

Montana's Second Steps

by Gregg Davis



Editor's note: This article is the second in a series of articles about key legislative health care reforms as they roll out under the Affordable Care Act passed in March, 2010. The first appeared in the Summer 2010 issue of the Montana Business Quarterly.

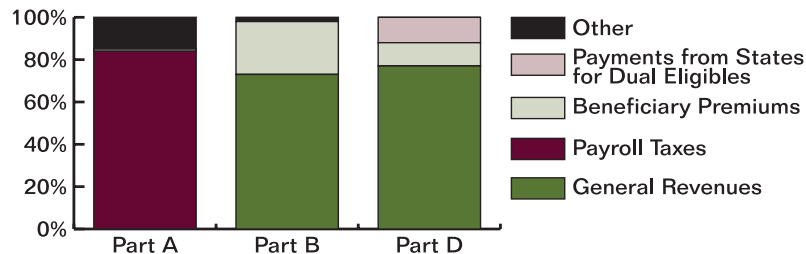
Why the Bull's-Eye on Medicare?

Over the next decade, the Affordable Care Act transforms the health care landscape each year as new provisions take effect. This year, several provisions affect Medicare, and it's no wonder given the magnitude of federal spending on the nation's health insurance program for Americans

age 65 and older. Medicare accounts for 11 percent of \$10.8 trillion in federal government spending, second only to Social Security (23 percent) among the three main federal entitlement programs. The other entitlement program, Medicaid – including the State Children's Health Insurance Program – accounts for 9 percent of total federal spending (U.S. Census Bureau, 2010). Federal payments for 167,000 Medicare beneficiaries living in Montana were more than \$1.2 billion in 2010, the latest year for which data are available.

All four components of Medicare are affected this year. Part A, the Hospital Insurance (HI) program, covers inpatient, skilled nursing facilities, home health, and hospice

Figure 1
Medicare Revenue Sources, 2010



Source: 2009 Annual Report, Boards of Trustees, Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds.

services. Part B, Supplementary Medical Insurance (SMI), covers physician, outpatient, home health, and preventive services. Part C, Medicare Advantage (MA), provides a private alternative to the traditional fee-for-service Medicare plan. Part D provides outpatient prescription drug benefits delivered by private plans under contract with Medicare.

This year, the Affordable Care Act has provisions that transfer more of the cost directly to Medicare beneficiaries. Since general revenues finance three-quarters of all Medicare Part B and Part D programs (Figure 1), shifting some of the burden from taxpayers to Medicare beneficiaries has political appeal in an environment where there's interest in reducing federal spending.

The challenges facing Medicare are obvious. An aging population, health care costs that continue to outpace general inflation, and longer life expectancies will double Medicare spending in the next decade. A decline in the number of tax-paying workers per Medicare beneficiary will further strain the ability of general revenues to sustain Medicare spending.

Changes in Medicare for 2011

This year Medicare beneficiaries will notice several changes, including:

- higher deductibles for Medicare Part A and higher premiums for Part B and Part D coverage for high-income individuals;
- possible reduction in benefits in Medicare Advantage plans;
- bonus payments to primary care providers and possibly better access;
- discounts for prescription drugs;
- elimination of the 20 percent co-pay for the “Welcome to Medicare” physical examination;
- free annual wellness exams with personalized prevention plans; and
- no co-pays or deductibles for 45 Medicare-covered preventive services, including cancer, diabetes, cholesterol, and obesity screenings.

Medicare Part A: Hospital Insurance (HI)

The Part A deductible is the cost a beneficiary must pay for up to 60 days of Medicare-covered inpatient hospital care. This year, the deductible will rise just 3 percent, to \$1,132. Similarly, for skilled nursing facility care, co-insurance has increased only \$4 per day, to \$141.50. Since Medicare Part A is financed through a 2.9 percent payroll tax, 99 percent of all Medicare beneficiaries do not pay a premium for hospital insurance as long as they have 40 quarters or more of Medicare-covered employment. For all others, premiums decreased \$11 per month. The monthly premium will be \$450 assuming fewer than 30 quarters of Medicare-covered employment. For those with greater than 30 quarters but fewer than 40 quarters of Medicare-covered employment, the monthly premium is \$248 in 2011 (Centers for Medicare and Medicaid Services, 2010).

Medicare Part B: Supplementary Medical Insurance (SMI)

Enrollment in Medicare Part B is voluntary, but only 5 percent of the Medicare-eligible population declines coverage. This year standard Part B premiums will increase 4.4 percent, or \$4.90, over the standard Medicare Part B premium in 2010. This premium increase was offset somewhat by new fees imposed on manufacturers and importers of brand-name prescription drugs (Kaiser Foundation, 2010).

Since 2007, beneficiaries whose incomes exceed certain thresholds pay an “income-related” monthly adjustment in addition to the standard premium. But beginning this year, the threshold income levels are no longer indexed to inflation but rather held at 2010 levels for the rest of the decade. As a result, more Montanans will be subject to the income-related premium, paying anywhere from 30 percent to 80 percent of the average per capita cost (\$461.60) for Part B services. In 2007, nearly 5,000 Montanans paid the income-related premium. Table 1 summarizes the monthly premium costs this year for Part B coverage.

Table 1
Medicare Beneficiary Part B Premiums, 2011

| Individual Tax Return Adjusted Gross Income (AGI) | Joint Tax Return AGI | Monthly Increase | Total Monthly Premium, (Percent of Program Cost) |
|---|-------------------------|------------------|---|
| ≤ \$85,000 | ≤ \$170,000 | \$0.00 | \$115.40 (25) |
| > \$85,000 ≤ \$107,000 | > \$170,000 ≤ \$214,000 | \$46.10 | \$161.50 (35) |
| > \$107,000 ≤ \$160,000 | > \$214,000 ≤ \$320,000 | \$115.30 | \$230.70 (50) |
| > \$160,000 ≤ \$214,000 | > \$320,000 ≤ \$428,000 | \$184.50 | \$299.90 (65) |
| > \$214,000 | > \$428,000 | \$253.70 | \$369.10 (80) |

Sources: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services; The University of Montana Bureau of Business and Economic Research.

Table 2
Medicare Beneficiary Part D Premiums, Montana, 2011

Total Per Capita Part D Cost: \$162.47

| Individual Tax Return Adjusted Gross Income (AGI) | Joint Tax Return AGI | Monthly Increase | Total Monthly Premium, (Percent of Program Cost) |
|---|-------------------------|------------------|---|
| ≤ \$85,000 | ≤ \$170,000 | \$0.00 | \$41.43 (25.5) |
| > \$85,000 ≤ \$107,000 | > \$170,000 ≤ \$214,000 | \$15.43 | \$56.86 (35) |
| > \$107,000 ≤ \$160,000 | > \$214,000 ≤ \$320,000 | \$39.81 | \$81.24 (50) |
| > \$160,000 ≤ \$214,000 | > \$320,000 ≤ \$428,000 | \$64.18 | \$105.61 (65) |
| > \$214,000 | > \$428,000 | \$88.55 | \$129.98 (80) |

Sources: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services; The University of Montana Bureau of Business and Economic Research.

Medicare Part C: Medicare Advantage

Almost 29,000 Montanans are enrolled in one of eleven Medicare Advantage plans. The Affordable Care Act froze Medicare Advantage payments for 2011 at 2010 levels. Since Medicare Advantage plans typically offer more benefits than traditional fee-for-service Medicare plans, benefits most likely will be trimmed.

Medicare Part D: Outpatient Prescription Drug Benefit

In Montana, approximately 80 percent of eligible Medicare Part D beneficiaries have prescription drug coverage of some kind. Similar to Medicare Part B, high-income individuals will face a new income-related Part D premium beginning this year. Premiums will rise for individuals with incomes higher than \$85,000 and couples with incomes higher than \$170,000. Part D enrollees will pay different premiums based on the benefit plans they choose.

Only 3 percent of Medicare Part D beneficiaries should pay the income-related premium adjustment in 2011 because high-income individuals are more likely to have prescription drug coverage through an employer-sponsored retiree health plan. But by 2019, almost 9 percent will pay the premium adjustment as more individuals' incomes creep into the threshold income levels. Table 2 shows the premiums for Montana Part D beneficiaries.

Also new this year, Medicare beneficiaries with high prescription drug costs will get a 50 percent discount on select brand-name drugs. These discounts follow the \$250 rebate checks sent last year to those with high prescription drug costs.

Primary Care Services

Montana has 51 primary care physicians per 100,000 people, well below the national standard of 60 – 85 primary care physicians per 100,000 people (Davis, Roberts & White, 2009). This year, Medicare provides a 10 percent bonus to health practitioners if 60 percent or more of the services they provide are for primary care. Access to primary care

for Medicare patients is critical in light of other changes brought about by the health care law, such as free wellness checks, personalized prevention plans, and no-cost Medicare-covered preventive services, which may increase the demand for primary care considerably (U.S. Preventive Services Task Force, 2010). Whether a bonus payment of 10 percent is enough to attract medical personnel to primary care is uncertain, given the more lucrative salaries in other fields of medicine.

What's Ahead for Medicare?

Our nation's health care challenges are certainly not limited to Medicare, or Medicaid for that matter. But the sheer magnitude of these programs makes them a likely target in a deficit-reducing environment. It's certain that Medicare will change, if for no other reason than it has to. Its current trajectory is not sustainable. But lost in the attempts is the key underlying fundamental goal to slow the medical rate of inflation to be more in line with economic growth. This will be the ultimate test for a nation facing an aging population whose health care needs must be met. □

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