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The Affordable Care Act – a stronger Medicare program in 2012

Today, the Centers for Medicare & Medicaid Services (CMS) released a second annual report detailing how millions of seniors and people with disabilities with Medicare continued to experience lower costs on prescription drugs and improved benefits in 2012 thanks to the Affordable Care Act.

Since the law's enactment, 6.1 million Americans with Medicare who reached the Part D coverage gap, also known as the "donut hole," have saved over $5.7 billion on prescription drugs. Drug savings of $2.5 billion in 2012 are higher than the $2.3 billion in savings for 2011. In 2012, people with Medicare in the "donut hole" received a 50 percent discount on covered brand name drugs and a 14 percent discount on generic drugs. As a result of the Affordable Care Act, coverage for both brand name and generic drugs will continue to increase over time until the coverage gap is closed.

The Affordable Care Act is also removing barriers for people with Medicare from accessing preventive services, many of which previously required cost-sharing for patients. In 2012, many recommended preventive services were offered to people with Medicare, with no deductibles or co-pays, meaning that cost is no longer a barrier for seniors and people with disabilities who want to stay healthy by detecting and treating health problems early. Use of preventive services has expanded among people with Medicare. In 2012 alone, an estimated 34.1 million people with Medicare benefited from Medicare's coverage of preventive services with no cost-sharing.

Under the Affordable Care Act, the Medicare program also performed well in several other areas in 2012:

- Compared to 2011, people with Medicare continued to pay moderate premiums for Medicare Part B benefits, which cover outpatient care, doctors' services, lab tests, durable medical supplies, and other services.
- Those who enrolled in Medicare Advantage and prescription drug plans paid average premiums lower than what they paid in 2010, and they had access to a wide range of plan choices.
- New techniques were implemented to detect, prevent and fight health care fraud.

New data shows that since Affordable Care Act enactment, over 6.1 million Medicare beneficiaries have saved over $5.7 billion on prescription drugs

The Affordable Care Act makes prescription drug coverage (Part D) for people with Medicare more affordable. It does this by gradually closing the gap in drug coverage known as the "donut hole." For many people enrolled in Medicare Part D, the "donut hole" occurs after they and their plan spend a certain amount of money for covered drugs, but before they hit catastrophic coverage in which they are only responsible for a small percent of their drug costs. Prior to the Affordable Care Act, an individual in the "donut hole" had to pay the full costs of prescription drugs.

The Affordable Care Act is closing the "donut hole" over time; first, by providing a one-time $250 check to those that reached the "donut hole" in 2010, then by providing discounts on brand-name drugs for those in the "donut hole" beginning in 2011, and finally by providing additional savings each year until the coverage gap is closed in 2020. People with Medicare in the "donut hole" receive the discounts when they purchase prescription drugs at a pharmacy or order them through the mail, until they reach the catastrophic coverage phase. Since its enactment in 2010, the law has saved 6.1 million seniors and people with disabilities more than $5.7 billion on brand-name prescription drugs.

The HHS Assistant Secretary for Planning and Evaluation projected average savings per Medicare beneficiary to be approximately $5,000 from enactment through 2022, while those with high prescription drug spending are projected to save much more – over $18,000. These projections, in addition to prescription drug plan data on 2012 spending, demonstrate that those with high drug costs are seeing considerable savings thanks to the Affordable Care Act.

In 2012, more than 3.5 million seniors and people with disabilities who reached the Medicare Part D coverage gap received discounts on brand- name prescription drugs. These individuals with Medicare received more than $2.5 billion in discounts, or an average of $706 per beneficiary. Savings for covered generic drugs while in the "donut hole" in 2012 totaled $105 million for 2.8 million beneficiaries.

In 2012, coverage gap discounts allowed seniors and people with disabilities to save money on a wide variety of drugs, including:

- Blood Sugar Lowering Drugs: $435,794,413
- Asthma and Other Lung Related (non-cancer) Disease Drugs: $297,234,514
- Triglyceride and Cholesterol Lowering Drugs: $240,495,663
- Drugs Used to Lower Blood Pressure: $138,497,053
- Anti-dementia Drugs: $120,878,582
- Drugs Used to Treat Ulcers: $101,888,578
- Cancer Drugs: $97,263,505
- Anti-depression Drugs: $85,047,907
- Autoimmune Disease Anti-inflammatory Drugs: $56,715,485
- Psychiatric Drugs: $56,295,844
- All Other Drug Therapeutic Uses: $872,688,178

Most of the savings are on drugs for chronic conditions, suggesting that people with Medicare who must continuously take medications are benefitting most from the help provided by the Affordable Care Act. Drugs managing chronic conditions such as high blood sugar, high blood pressure and high cholesterol accounted for almost 33 percent of savings and may have helped patients avoid hospitalization. About 11 percent of the savings were for drugs treating mental illness, which were designed to help people with Medicare maintain healthy and active lives.

In 2013, people with Medicare in the coverage gap are expected to save 52.5 percent on brand- names drugs and 21 percent on generics. These savings will increase each year until the coverage gap is closed in 2020.

The schedule below illustrates how the coverage gap will be closed, with information on drug savings for those in the coverage gap.

	Percentage Medicare Part D Enrollees will Save	
	Brand-name Drugs	**Generic Drugs**
2014	52.5 percent	28 percent
2015	55 percent	35 percent
2016	55 percent	42 percent
2017	60 percent	49 percent
2018	65 percent	56 percent
2019	70 percent	63 percent
2020	75 percent	75 percent

State-by-State savings from discounts while in "donut hole"

State or Territory	Overall	2011	2012		
	Total Savings	Total Gap Discount Amount	Total Gap Discount Amount	Total Number of Beneficiaries	Average Discount per Beneficiary
Nation	**$5,760,182,946**	**$2,311,220,975**	**$2,502,799,722**	**3,547,246**	**$706**
Alabama	$77,248,493	$31,807,551	$31,020,512	48,264	$643
Alaska	$4,059,730	$1,685,133	$ 1,794,910	2,278	$788
Arizona	$102,237,394	$39,489,954	$44,963,599	65,267	$689
Arkansas	$50,287,595	$21,076,421	$20,151,382	32,420	$622
California	$453,865,739	$182,381,722	$182,776,196	299,896	$609
Colorado	$59,645,855	$24,459,701	$24,339,969	37,733	$645
Connecticut	$78,759,336	$26,238,636	$41,932,782	47,677	$880
Delaware	$23,199,385	$10,010,926	$9,945,279	12,134	$820
District Of Columbia	$3,877,623	$1,638,772	$1,554,101	2,319	$670
Florida	$378,403,475	$152,489,277	$160,882,589	237,344	$678
Georgia	$161,956,926	$62,484,234	$72,511,462	99,057	$732
Guam	$396,918	$193,400	$151,268	242	$625
Hawaii	$20,299,348	$7,266,854	$6,931,057	18,474	$375
Idaho	$22,498,985	$9,225,783	$9,076,120	14,584	$622
Illinois	$235,327,301	$101,529,128	$95,923,083	133,889	$716
Indiana	$144,142,629	$61,466,902	$60,251,646	85,784	$ 702
Iowa	$64,928,785	$27,600,109	$25,848,452	39,260	$ 658
Kansas	$59,331,172	$24,968,485	$24,040,920	36,383	$661
Kentucky	$111,548,906	$43,289,351	$50,916,143	72,391	$703
Louisiana	$88,538,619	$32,316,242	$42,280,622	60,016	$ 704
Maine	$16,777,237	$6,775,456	$6,738,800	11,413	$590
Maryland	$84,167,415	$32,760,447	$37,572,535	48,949	$768
Massachusetts	$96,478,961	$39,363,887	$39,401,173	59,062	$667
Michigan	$153,484,151	$51,330,931	$79,375,077	106,707	$744
Minnesota	$88,256,958	$36,587,311	$34,886,726	54,175	$644

State or Territory	Overall	2011	2012		
	Total Savings	Total Gap Discount Amount	Total Gap Discount Amount	Total Number of Beneficiaries	Average Discount per Beneficiary
Mississippi	$50,711,580	$21,440,317	$20,640,606	32,649	$632
Missouri	$119,340,191	$49,676,876	$48,850,222	75,201	$650
Montana	$16,312,364	$6,873,650	$6,554,211	9,992	$656
Nebraska	$37,869,126	$16,129,674	$15,237,679	23,049	$661
Nevada	$32,957,815	$13,138,217	$13,511,767	22,122	$611
New Hampshire	$20,592,230	$8,764,923	$8,261,770	12,400	$666
New Jersey	$298,658,849	$100,215,225	$165,432,302	169,373	$977
New Mexico	$28,824,261	$9,785,022	$14,035,655	18,867	$744
New York	$407,663,891	$174,321,559	$170,460,384	226,569	$752
North Carolina	$168,022,642	$69,004,496	$70,173,968	106,207	$661
North Dakota	$14,605,374	$6,324,593	$5,576,642	9,069	$615
Northern Marianas	$20,778	$7,400	$11,628	14	$831
Ohio	$278,731,176	$103,052,894	$138,548,148	178,931	$ 774
Oklahoma	$73,501,520	$30,231,254	$29,036,648	50,306	$577
Oregon	$62,104,279	$25,284,269	$24,228,337	41,787	$580
Pennsylvania	$392,036,508	$162,464,895	$167,692,364	222,703	$753
Puerto Rico	$138,997,203	$60,344,237	$56,178,122	85,781	$655
Rhode Island	$20,564,235	$8,599,052	$8,006,683	13,834	$579
South Carolina	$84,380,387	$34,834,645	$35,663,279	52,686	$677
South Dakota	$16,514,484	$7,131,754	$6,415,501	9,997	$642
Tennessee	$124,281,720	$52,445,394	$49,981,151	80,991	$617
Texas	$338,487,681	$142,557,143	$140,233,380	206,304	$680
Utah	$33,522,667	$13,125,156	$14,767,407	20,994	$703
Vermont	$11,778,974	$5,103,378	$4,890,789	6,390	$765
Virgin Islands	$1,111,261	$465,126	$447,678	717	$624
Virginia	$131,746,125	$52,691,826	$57,675,792	80,522	$716
Washington	$94,903,807	$38,175,084	$40,929,219	56,996	$718
West Virginia	$69,376,641	$25,993,424	$33,655,461	37,752	$891

State or Territory	Overall	2011	2012		
	Total Savings	Total Gap Discount Amount	Total Gap Discount Amount	Total Number of Beneficiaries	Average Discount per Beneficiary
Wisconsin	$103,180,245	$40,549,410	$46,472,971	63,553	$731
Wyoming	$8,938,778	$3,745,183	$3,710,847	5,421	$685

*Totals may not sum due to missing codes for some data and rounding

*The "Overall Total Savings" discount column also includes amounts for those beneficiaries that received a $250 check in 2010

*2010 data is as of June 2012; 2011 and 2012 data is as of December 2012

*Each "Total " column above is based upon independent analyses and cannot be intermingled

Estimated 34.1 million with Medicare used one or more free preventive service in 2012

By making certain preventive services available with no cost-sharing obligations, the Affordable Care Act is helping Americans take charge of their own health. Americans can now better afford to work with health care professionals to prevent disease, detect problems early when treatment works best, and monitor health conditions.

In the Medicare program, the Affordable Care Act eliminated coinsurance and the Part B deductible for recommended preventive services, including many cancer screenings and other important benefits. For example, before the law's passage, a person with Medicare could pay as much as $160 in cost-sharing for some colorectal cancer screenings. In addition to covering these preventive services with no out-of-pocket costs for people with Medicare, the law also added another important new preventive service — an Annual Wellness Visit with a health professional. This Visit complements the "Welcome to Medicare" Visit which allows people joining Medicare to evaluate their current health conditions, prescriptions, medical and family history and risk factors, and make a plan for appropriate preventive care with their primary care professional.

In addition to the Annual Wellness Visit, Medicare has added coverage of new preventive services, such as annual depression screenings, through its National Coverage Determination process. These new services are exempt from both the Part B deductible and coinsurance/copayment thanks to the Affordable Care Act.

Traditional Medicare[1]

Since becoming available without cost-sharing in 2011, over 30.5 million people with traditional Medicare (79.5 percent) have taken advantage of one or more free preventive service. That includes 2,951,704 African Americans (73.3 percent), 638,512 Hispanic persons (73.9 percent), 135,803 American Indians (69.7 percent), and 583,540 Asian- Americans (80.9 percent). Last year alone, nearly 26.1 million seniors and people with disabilities with traditional Medicare (about 73.5 percent), used at least one free preventive service.

The tables below present the cumulative number of unique enrollees in traditional (Part B) Medicare who used free preventive services in 2011 and 2012.

Since enactment of the Affordable Care Act, services added and exempt from both the Part B deductible and coinsurance/copayment:

	Part B Enrollees Using Services
Annual Wellness Visit	4,435,636
Alcohol Misuse Screening and Behavioral Counseling	60,412
Annual Depression Screening	112,398
Intensive Behavioral Therapy for Cardiovascular Disease Risk Reduction	43,704
Obesity Screening and Intensive Behavioral Therapy	34,525
Sexually Transmitted Infections (STI) Screening and Counseling	2,199,348
Tobacco Cessation Counseling	123,603

[1] All figures provided are based on analysis of fee-for-service claims data through 1/25/2013.

Prior to the Affordable Care Act, services subject to both the Part B deductible and coinsurance/copayment:

	Part B Enrollees Using Services
Bone Mass Measurement	5,148,032
Hepatitis B (HBV) Vaccination	278,528
Medical Nutrition Therapy	350,407

Prior to the Affordable Care Act, services exempt from the Part B deductible, but subject to coinsurance/copayment:

	Part B Enrollees Using Services
Abdominal Aortic Aneurysm -Ultrasound Screening	141,689
Colorectal Cancer Screening - most procedures	2,199,238
Pap Tests (that require physician interpretation)	2,115,287
Pelvic Examination	2,443,334
Screening Mammography	8,442,044

Prior to the Affordable Care Act, services exempt from both the Part B deductible and coinsurance/copayment:

	Part B Enrollees Using Services
Cardiovascular Disease Screening Blood Tests	25,569,864
Colorectal Cancer Screening - fecal occult blood tests	1,798,495
Diabetes Screening Test	3,776,570
Human Immunodeficiency Virus (HIV) Screening	66,456
Pap Tests (that do not require physician interpretation)	2,627,911
Pneumococcal Vaccination	3,882,901
Prostate-specific Antigen (PSA) Test	4,062,129
Seasonal Influenza Virus Vaccination	19,503,564

Medicare Advantage (Part C) Program

In 2012, all Medicare contracting health insurance plans (or "Medicare Advantage" plans) that serve people with Medicare offered recommended preventive services without cost-sharing. In 2012, about 10.9 million Americans were enrolled in a non-employer Medicare Advantage plan that waived cost- sharing for recommended preventive services. Assuming that in 2012, people in these plans utilized preventive services at the same rate as those in traditional Medicare, an estimated 8 million people in a non-employer Medicare Advantage plan benefited from Medicare's coverage of preventive services with no cost-sharing.

State-by-State utilization – free preventive services

	Original Medicare (Part B): Utilization of Benefit in 2012			**Medicare Advantage (Non- Employer): enrollees with access to free preventive care**
	Total Enrollees	**Enrollees Utilizing Free Preventive Services**	**Enrollees Utilizing Annual Wellness Visit**	
Nation*	**35,502,733**	**26,090,166**	**3,157,481**	**10,897,021**
Alabama	700,019	515,494	30,518	187,801
Alaska	70,431	41,371	4,093	N/A
Arizona	621,229	434,397	75,023	329,733
Arkansas	468,023	326,349	25,494	89,304
California	3,110,502	2,153,101	260,268	1,392,766
Colorado	434,943	296,093	50,023	165,071
Connecticut	443,892	343,059	75,820	117,805
Delaware	152,248	119,106	10,643	6,343
District of Columbia	67,165	45,333	4,663	2,901
Florida	2,400,748	1,823,396	259,995	1,173,159
Georgia	1,021,594	742,634	101,350	221,206
Hawaii	111,635	75,957	2,811	71,577
Idaho	172,164	113,850	16,227	71,972
Illinois	1,695,807	1,271,704	122,526	163,162

Indiana	852,808	626,050	62,925	180,745
Iowa	460,400	351,880	32,519	62,738
Kansas	393,927	284,396	27,437	48,155
Kentucky	662,442	485,843	36,599	97,688
Louisiana	536,779	381,407	19,625	171,645
Maine	233,522	168,602	32,083	35,085
Maryland	725,057	543,632	58,473	37,331
Massachusetts	875,315	686,735	166,154	167,019
Michigan	1,309,045	989,673	157,894	238,140
Minnesota	424,612	300,109	30,938	166,903
Mississippi	469,241	327,238	24,143	57,704
Missouri	798,889	584,857	58,762	223,433
Montana	152,036	100,435	16,595	26,923
Nebraska	250,225	177,050	14,104	31,409
Nevada	256,144	166,815	17,960	115,845
New Hampshire	219,562	164,065	27,366	7,392
New Jersey	1,157,252	882,282	116,412	173,961
New Mexico	236,776	151,903	15,704	75,992
New York	2,012,376	1,495,198	202,542	824,397
North Carolina	1,303,802	1,003,923	139,278	277,558
North Dakota	98,557	71,441	7,195	4,235
Ohio	1,251,167	903,150	79,387	429,802
Oklahoma	526,893	366,752	19,691	89,710
Oregon	380,291	254,595	28,542	228,406
Pennsylvania	1,396,432	1,034,635	88,807	722,127
Puerto Rico	108,232	58,993	271	434,420
Rhode Island	113,961	88,352	23,393	57,830
South Carolina	695,318	523,349	60,680	143,664
South Dakota	124,804	88,221	8,376	9,990

Tennessee	822,788	608,253	71,078	297,753
Texas	2,476,060	1,795,711	218,009	649,751
Utah	188,285	127,246	16,158	96,343
Vermont	110,317	80,464	13,112	6,391
Virginia	1,004,733	757,195	79,306	152,647
Washington	732,786	500,444	68,322	262,485
West Virginia	305,115	214,086	9,934	36,945
Wisconsin	646,046	481,835	61,903	258,349
Wyoming	81,263	48,752	5,052	3,310

* National figures include Guam, Northern Marianas, and Virgin Islands.

Premiums remain steady for people with Medicare

People with Medicare can be assured they are part of a program that strives to deliver better benefits while curbing costs. Most seniors and people with disabilities will pay the standard Medicare Part B premium of $104.90 per month in 2013, approximately $4 lower than the amount projected in early 2012. Part B benefits include certain doctors' services, outpatient care, medical supplies, and preventive services. Premiums for Part B have gone up slowly over the past five years – an average of less than 2 percent per year.

For the few people with Medicare who are affected, the 2013 Part A premium is $441, down from $451 in 2012. Approximately 1.3 percent of people with Medicare pay a premium for Medicare Part A services. Beneficiaries who do not qualify for premium-free Part A services include those who have not paid Medicare payroll taxes for 40 quarters of employment or who are not are married to a person who qualifies for premium-free Part A services. Individuals who have worked between 30 and 39 quarters of coverage are eligible to pay a reduced premium. The Part A benefit covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Using authority granted by the Affordable Care Act, CMS continues to protect people enrolled in Medicare Advantage plans from significant increases in costs or cuts in benefits. Access to supplemental benefits remains steady, and beneficiaries' average out-of-pocket spending remains constant. The average projected premium for 2013 increased by only $1.47 from last year, averaging $32.59. 2013 projected premiums are 10 percent below 2010 premiums.

Not only does access to Medicare Advantage remain strong, as 99.6 percent of Medicare beneficiaries have access to a Medicare Advantage plan in 2013, people with Medicare have access to a wide range of high-quality plan choices, with more four and five star plans than were previously available. On average, there are 28 non-employer Medicare Advantage plans to choose from in nearly every county across the country.

The average premium for prescription drug plans will remain nearly the same in 2013. Based on plans' projections, the average 2013 monthly premium for

basic prescription drug coverage is expected to be $30, while average premium for 2012 was $29.67. New tools from the health reform law and slow growth in Medicare drug spending have kept the cost of prescription drug coverage from growing.

Protecting seniors and taxpayers from Medicare fraud

Seniors and people with disabilities in Medicare are benefitting from a more secure program. The Affordable Care Act contains new tools and enhanced authority to crack down on criminals who are looking to defraud Medicare. These provisions, many of which have been in effect since 2010, are protecting seniors and taxpayers from fraudsters. As a result of those efforts, we have recovered record amounts of fraudulent payments, totaling $10.7 billion from 2009 to 2011.

In 2012, the Affordable Care Act continued to make a significant impact in the fight against fraud by:

- Increasing the federal sentencing guidelines for health care fraud offenses by 20-50 percent for crimes that involve more than $1 million in losses. The law establishes penalties for obstructing a fraud investigation and makes it easier for the government to recapture any funds acquired through fraudulent practices.
- Stopping bad actors from entering the system, by making categories of providers and suppliers who have historically posed a higher risk of fraud or abuse undergo a higher level of scrutiny than others before enrolling or re-enrolling in the Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). From March 2011 through the end of 2012, over 400,000 providers and suppliers have been subject to the new screening requirements. Almost 150,000 providers and suppliers

lost the ability to bill the Medicare program due to Affordable Care Act requirements and other proactive initiatives.

- Fostering better coordination among states, CMS, and law enforcement partners at the Office of Inspector General and Department of Justice. New rules authorize CMS to suspend Medicare payments to providers or suppliers during the investigation of a credible allegation of fraud. CMS suspended or took other administrative actions against 160 providers in three coordinated takedowns.

- Providing an additional $350 million over 10 years to ramp up anti-fraud efforts, including increasing scrutiny of claims before they are paid, investments in sophisticated data analytics, and more "feet on the street" law enforcement agents and others to fight fraud in the health care system.

- Expanded funding for Senior Medicare Patrols – groups of senior citizen volunteers who educate and empower their peers to identify, prevent and report health care fraud. Additionally, to make spotting fraud easier for seniors, CMS redesigned the statement that informs beneficiaries about their claims for Medicare services, making it clearer which information to check and how to report potential fraud.

President Obama has made fraud prevention a cabinet-level priority with the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) in 2009. This is a joint effort between HHS and DOJ to fight health care fraud by increasing coordination, intelligence sharing and training among investigators, agents, prosecutors, analysts, and policymakers. A key component of HEAT are the Medicare Strike Force teams, which are comprised of interagency teams of analysts, investigators, and prosecutors who can target emerging or migrating fraud schemes, including fraud by criminals masquerading as health care providers or suppliers. This effort received a boost in 2012 with the formation of a ground-breaking new Healthcare Fraud Prevention Partnership between HHS, DOJ and private organizations designed

to find and stop scams that cut across public and private payers. This partnership will help those on the front lines of industry anti-fraud efforts share their insights with investigators, prosecutors, policymakers, and others.

The Medicare Strike Force coordinated three major takedowns in 2012. The largest action was in May 2012, when 107 individuals, including doctors, nurses and other licensed medical professionals, were charged in seven cities for their alleged participation in Medicare fraud schemes, involving more than $452 million in alleged false billing. This coordinated takedown involved the highest amount of false Medicare billings in a single takedown in Strike Force history. HHS also suspended or took other administrative action against 52 providers, using authority under the Affordable Care Act to suspend payments until an investigation is complete.

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