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THE AFFORDABLE CARE ACT AND MEDICARE

*How the Law Is Changing the Program
and the Challenges That Remain*

Karen Davis, Stuart Guterman, and Farhan Bandeali

June 2015





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ABSTRACT

This second report in the series *Medicare at 50 Years* describes how the Affordable Care Act is strengthening the program for current and future beneficiaries and outlines the major challenges that policymakers have yet to confront. By starting to move Medicare away from fee-for-service payment and holding health care providers more accountable for both the quality and total cost of care, certain ACA reforms—most notably the new Center for Medicare and Medicaid Innovation—have the potential to reshape not just the Medicare program but the entire U.S. health care system, the authors say. But the rapid influx of new beneficiaries as the postwar generation retires will necessitate further changes to Medicare, as total program outlays will likely outpace growth in the economy. Another challenge is Medicare’s complex and fragmented benefit package, which as currently configured is inadequate for meeting the financial and health care needs of future beneficiaries.

This report is the second in a series that traces the evolution of Medicare and its major accomplishments over the past 50 years; examines the Affordable Care Act’s reforms to Medicare and the challenges facing policymakers going forward; and lays out policy options to ensure Medicare’s viability and effectiveness for future beneficiaries.

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EXECUTIVE SUMMARY

The aims of the Affordable Care Act (ACA) were to increase health insurance coverage for those under age 65, improve the performance of the health care delivery system, and slow cost growth. Less recognized are the provisions of the law that seek to strengthen the Medicare program.

The ACA addresses gaps in Medicare preventive and prescription drug benefits. It initiates ambitious testing of new payment methods to improve the value of care received by beneficiaries and, indirectly, all Americans. And it substantially extends the solvency of the Medicare Health Insurance Trust Fund by slowing the growth of future Medicare outlays.

By moving Medicare away from fee-for-service payment and by holding health care providers accountable for both the quality and total cost of care, certain ACA reforms have the potential to reshape not just the Medicare program but the entire U.S. health care system. For example, the law's creation of the Center for Medicare and Medicaid Innovation (CMMI) will enable Medicare to test innovative models of provider payment and service delivery and expand those that demonstrate promise to improve beneficiary outcomes and patient experiences of care or lower cost. The projects initiated by the CMMI are just now beginning to produce results; significant work remains to identify and spread successful payment innovations.

The ACA also makes important changes to the Medicare Advantage (MA) program, through which enrollees can choose to receive their Medicare benefits from private plans. Payment rates to MA plans are to be constrained until those plans are on a par with traditional Medicare, though financial rewards are available for plans achieving high performance ratings. These changes are intended to provide incentives for MA plans to improve quality and patients' health care experiences and encourage beneficiaries to choose plans with higher quality and lower cost.

While these new policies strengthen Medicare, they were not intended to address some of the serious challenges facing Medicare in the future. Without additional changes, the retirement of the post-World War II generation will cause total Medicare outlays to outpace growth in the economy, claim an increasing share of the federal budget, and exceed the revenues currently dedicated to the Medicare program.

As currently configured, Medicare benefits do not adequately address the financial and health care needs of future beneficiaries—particularly the poorest and sickest among them. Traditional Medicare's benefit design reflects the fragmented nature of health care delivery, with separate hospital, physician, and prescription drug benefits adding to the complexity, administrative cost, and difficulty of coordinating care. The predominantly fee-for-service provider payment system used by traditional Medicare, and by most MA plans, provides no incentive to eliminate duplicative or ineffective care, coordinate care, or substitute lower-cost care alternatives—and in effect penalizes providers who do so. This mismatch between benefits and needs will be an increasing source of concern

as families struggle with out-of-pocket costs, serious health conditions, and inadequate options for caring for family members with physical and cognitive functional impairments.

While the ACA's reforms hold significant potential to make Medicare more viable and successful in the future, Medicare's long-term fiscal solvency, complexity, and gaps in coverage remain unaddressed. As millions of Americans age into Medicare, federal budgetary pressures will inevitably focus attention on more fundamental reform of the program.

THE AFFORDABLE CARE ACT AND MEDICARE: HOW THE LAW IS CHANGING THE PROGRAM AND THE CHALLENGES THAT REMAIN

INTRODUCTION

When President Obama signed the Affordable Care Act (ACA) into law on March 23, 2010, his signature initiated the most significant overhaul of the U.S. health care system since the introduction of Medicare. While the ACA was intended primarily to extend health coverage to the uninsured and to make care more affordable, it also contained provisions designed to improve the health and health care of Medicare beneficiaries, lead the change toward paying health care providers based on quality rather than quantity of care, and shore up the long-term financial health of Medicare.¹

The ACA strengthens Medicare in a number of important ways. It:

- Improves coverage and care for beneficiaries by addressing gaps in preventive care and prescription drug benefits and strengthening chronic care management.
- Stimulates health care providers to innovate by emphasizing quality over quantity of care.
- Strengthens the structure and viability of the program by slowing the growth of future Medicare outlays and extending the solvency of the Medicare Health Insurance Trust Fund.

This report discusses the gains created by the ACA as well as the problems that remain to be addressed. Forthcoming papers in the *Medicare at 50 Years* series examine in greater detail some of the critical challenges Medicare faces and present potential policy options.

IMPROVING COVERAGE AND CARE FOR BENEFICIARIES

The ACA includes provisions that directly improve benefits for all Medicare beneficiaries.² It adds preventive services without cost-sharing and improves Medicare prescription drug coverage. More broadly, the ACA emphasizes the importance of primary care in boosting the health of beneficiaries and in achieving cost savings through greater care coordination.

The ACA requires coverage without cost-sharing for all preventive services such as flu shots, tobacco cessation counseling, and screening for cancer, diabetes, and other chronic diseases. In addition, it adds coverage for an annual wellness visit to the previous one-time Welcome to Medicare visit. During 2013, an estimated 37 million Medicare beneficiaries received free preventive services. This not only improved access to such services but also increased the affordability of expensive screening such as colonoscopies.³

The Medicare Modernization Act of 2003 made coverage available for prescription drugs through private drug plans, but there was a gap in coverage once covered costs exceeded a threshold—the so-called “doughnut hole,” which required the beneficiary to pay the full covered cost until a much higher catastrophic coverage threshold was reached. The ACA reduces prescription drug

prices for those who fall in the coverage gap and phases out the doughnut hole by 2020. In 2014, Medicare beneficiaries in the doughnut hole received a 52.5 percent discount on brand-name drugs and a 28 percent discount on generic drugs; as of July 2014, more than 8 million Medicare beneficiaries had saved over \$11.5 billion since 2010 as a result of the ACA's prescription drug provisions.⁴

Easy access to basic medical care is key to both better patient outcomes and lower cost. Yet the U.S. health care system disproportionately rewards specialized care, contributing to a decline in the number of newly trained physicians electing primary care practice. The ACA provides a 10 percent boost in Medicare payments to primary care providers (and general surgeons) for five years (2011–15), and also raised Medicaid primary care services payment rates up to Medicare levels for two years (2013–14).⁵ Additionally, to address the shortage in the primary care workforce, the ACA creates new incentives such as funding for scholarships and loan repayments to expand the number of doctors, nurses, and physician assistants serving in underserved areas.

The ACA strengthens chronic care management by providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition. The Community-based Care Transitions Program (CCTP) is a new ACA initiative that funds community-based organizations to provide transition services to help reduce 30-day readmission rates.⁶ The organizations are paid on a per-eligible-discharge basis per 180-day period. The ACA also includes provisions for coordinating Medicare and Medicaid benefits for dual eligibles covered by both programs. The ACA created the CMS Medicare–Medicaid Coordination Office to fully integrate both care and payments for the dual-eligible population. Through more coordinated efforts, the dual-eligible population, which currently makes up the most expensive segment of the beneficiary population, could receive higher quality care at a cost savings.

Medicare does not cover long-term care. While the ACA initially included a Community Living Assistance and Supportive Services (CLASS) program with daily payments for long-term care services and supports in the home or in nursing facilities,⁷ that provision was subsequently repealed because the voluntary premium funding with only a five-year vesting period was viewed as fiscally unviable. The ACA does provide states the opportunity to support community-based long-term services administered through Medicaid to keep beneficiaries at home or in the community for as long as possible. The ACA also extends funding for the Money Follows the Person program, which tries to reverse trends in institutionalization by boosting access to long-term services and supports at home, by five years.⁸

STIMULATING HEALTH CARE PROVIDERS TO INNOVATE

The fee-for-service provider payment system used by traditional Medicare and by many other payers has been subject to increasing criticism in recent years.⁹ It has not rewarded providers who deliver better patient outcomes or care experiences. It has imposed no penalty for duplicative or ineffective care, encouraging overutilization. In the case of Medicare, it has controlled prices but not expenditures, especially for physician services, which have continued to increase in volume over time.¹⁰ The

ACA includes significant provisions that encourage movement away from fee-for-service payment and improvement in the quality of care provided to Medicare beneficiaries.

The Center for Medicare and Medicaid Innovation

Perhaps the ACA's most important Medicare reform initiative is the CMMI, also known as the Innovation Center. With \$10 billion in funding over 10 years, this new agency is tasked with developing, assessing, and disseminating innovations that contribute to improved outcomes, better patient care experiences, and lower costs, with authority for the Secretary of Health and Human Services (HHS) to spread successful innovations throughout the Medicare program.

These demonstrations and pilots are intended to lay the foundation for fundamental provider payment reform under Medicare by identifying and testing promising models of payment and health care delivery to replace fee-for-service payment. Among the most prominent innovations being tested are:

- A Comprehensive Primary Care Initiative, testing a blended payment method of fee-for-service, a per-Medicare-beneficiary-per-month payment for care management, and bonuses for quality performance.
- A Bundled Payments for Care Improvement initiative that provides an all-inclusive bundled payments for hospital, physician, and/or postacute care services for a specified condition and period of time for select hospital procedures and conditions.
- Variations on the accountable care organization (ACO) model, under which a group of providers takes responsibility for the total cost of care of beneficiaries who receive the plurality of their primary care from physicians in the organization. Those organizations receive a share of the Medicare savings they generate if they perform well on measures of quality and patient experience. Although most ACOs do not take risk for excess growth in Medicare spending for their patients, the objective is to move toward that type of arrangement over time.

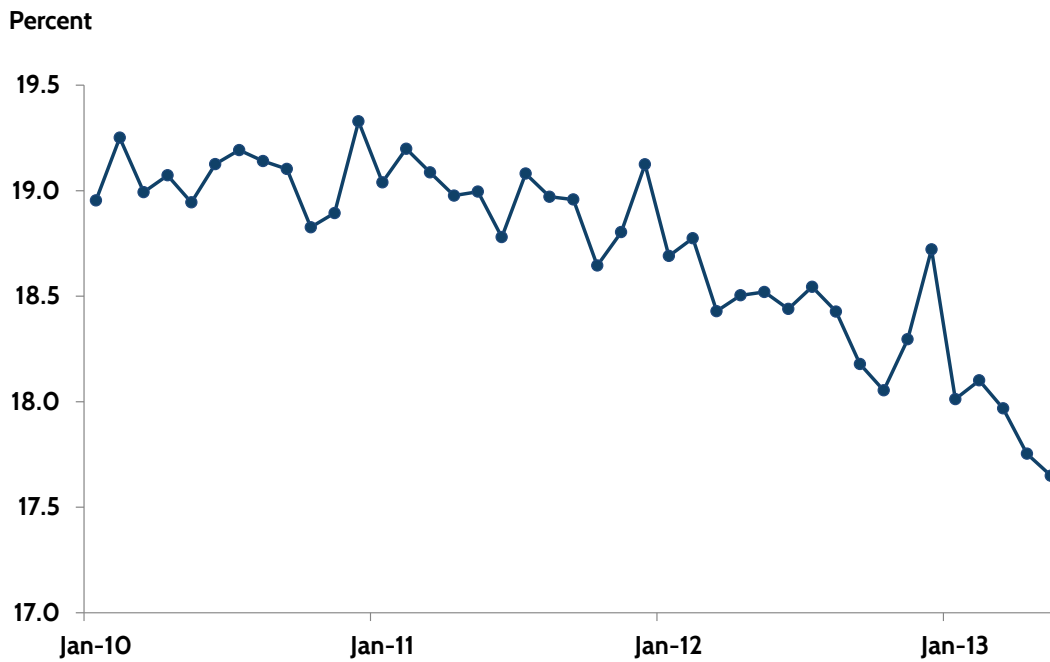
To date, ACOs in the Medicare Shared Savings Program and in the Pioneer ACO pilot have demonstrated improvements in quality with modest cost savings.¹¹ A similar effort in the private sector by the Massachusetts Blue Cross Blue Shield plan has found 8.6 percent savings over a four-year time frame.¹²

Incentives to Encourage Quality and Value

The ACA created penalties designed to reduce hospital readmissions and hospital-acquired conditions (such as bed sores, falls, infections, and surgical complications). The hospital readmissions reduction program established a risk-adjusted methodology, endorsed by the National Quality Forum, to calculate benchmark levels of readmission rates for various health conditions including heart attacks, heart failure, pneumonia, and chronic obstructive pulmonary disease (COPD).¹³ If the readmission ratio for each condition is in excess of the national average given each hospital's risk profile, the hospital is penalized with a reduction in their Medicare payment. Early evidence

indicates progress in reducing hospital readmissions—between January 2010 and January 2013, the readmission rate fell from almost 19 percent to just over 17.5 percent (Exhibit 1).

Exhibit 1. All-Cause, 30-Day Hospital Readmission Rate Steadily Declines



Source: Patrick Conway; Office of Information Products and Data Analytics, Centers for Medicare and Medicaid Services.

The ACA includes a Value-Based Purchasing program that provides extra payments to hospitals and other providers that have higher clinical quality and patient experiences of care.¹⁴ CMS has markedly expanded its public reporting of provider quality performance, making comparative data more readily available to beneficiaries, the public, and providers. In doing so, CMS hopes to help improve the responsiveness, quality, effectiveness, and efficiency of the health system for all Americans. The enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) in April 2015 accelerates that process and increases coordination among multiple value-based purchasing initiatives now in place with a new Merit-Based Incentive Payment System (MIPS).¹⁵

STRENGTHENING THE STRUCTURE AND VIABILITY OF MEDICARE

Perhaps the most controversial aspect of the ACA was how to finance improved coverage for the uninsured and underinsured. While the “carrots” of improved coverage and benefits are typically popular with those who stand to benefit, the “sticks” of funding improved coverage through reductions in spending for current programs or increased taxes always face opposition. The final legislation more than met the requirement that any added federal budget costs must be covered either by reductions in current federal outlays or by increased revenues. At the time, the 10-year net cost of

the insurance coverage provisions was estimated by the Congressional Budget Office (CBO) at \$788 billion over the period 2010 to 2019, financed with \$492 billion in reduced direct government spending primarily in the Medicare program and \$420 billion in new revenue, for a net reduction to the federal deficit of \$124 billion over 10 years.¹⁶

Specifically, savings included \$186 billion in reductions to the annual updates of Medicare provider payment rates; \$118 billion from reduced governmental subsidies for MA plans; \$43 billion in reduced payments to hospitals serving a disproportionate share of low-income patients under both Medicare and Medicaid (to reflect the reduced amount of uncompensated care they would provide as many of the uninsured obtained coverage); and several other smaller provisions. The ACA also contained provisions to improve delivery system performance to enhance Medicare's effectiveness, but these were "scored" by the CBO as achieving only minor savings (for example, \$5 billion over 10 years from ACOs and \$7 billion from reduced hospital readmissions). Revenues included fees on device manufacturers, pharmaceutical companies, and health insurers, plus increased payroll taxes on high-income Medicare beneficiaries dedicated to the Medicare Hospital Insurance Trust Fund (\$87 billion).

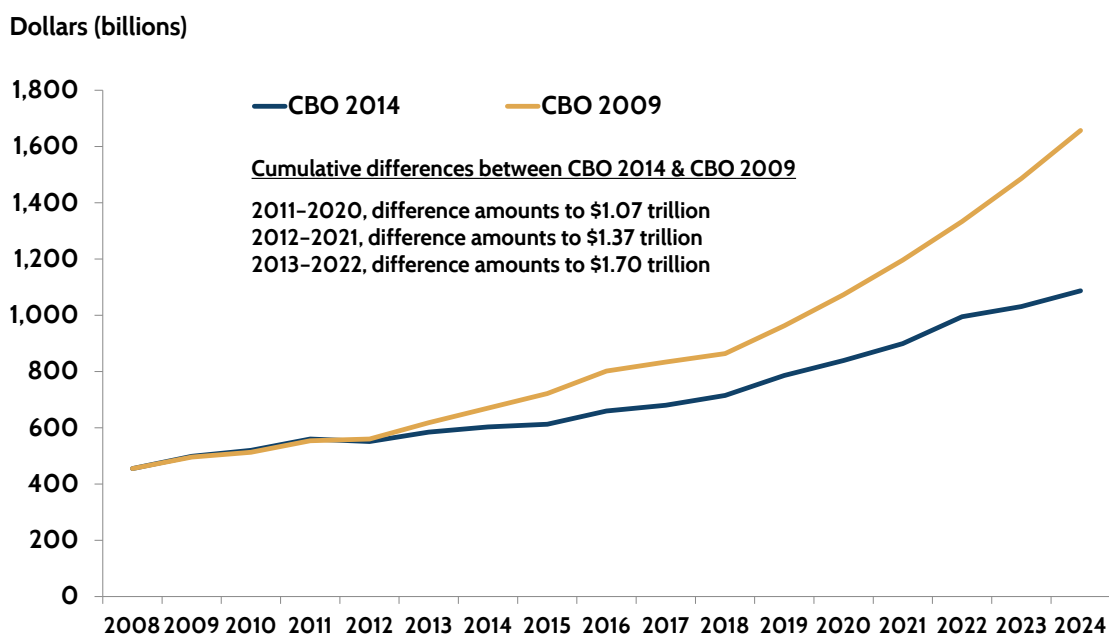
Downward Revisions to Projected Growth in Medicare Expenditures

Five years after enactment of the ACA, perhaps the most remarkable finding is that Medicare outlays have grown much more slowly than predicted. In each year since 2009, the Congressional Budget Office has lowered its projection of Medicare outlays over the following 10 years.¹⁷ The cumulative effect is stunning: projected Medicare spending from 2011 to 2020 is \$1 trillion lower than the CBO estimated prior to the ACA's enactment (Exhibit 2). This contrasts with the less than \$400 billion in savings from the Medicare provisions of the ACA originally projected by the CBO. In fact, the slowdown in spending under Medicare would have been more than sufficient to finance the entire cost of the ACA as originally estimated (which itself has been subsequently reduced given the Supreme Court decision allowing states to opt out of participation in Medicaid expansion and the slower than anticipated enrollment of the uninsured in insurance exchanges).

Controversy continues over how much of this slowdown in Medicare expenditure growth can be attributed to the ACA, how much was an overestimate of baseline spending resulting from an understandable failure to anticipate the full impact of the Great Recession, and how much was related to fundamental restructuring of the health care industry that predated ACA enactment. Undoubtedly, all three explanations played a role, and their effects most likely overlap. Further research will be required to shed more light on the issue.

At the time of the ACA's enactment, some experts suggested that the CBO estimates of Medicare savings were overly conservative, giving insufficient weight to the payment and delivery system reforms included in the ACA.¹⁸ For example, an analysis of Medicare savings in the ACA released by The Commonwealth Fund estimated 10-year Medicare savings at \$686 billion over the period 2011 to 2020, more than one-third greater than the savings estimated by the CBO.¹⁹

Exhibit 2. Ten-Year Medicare Spending Projections Reduced by \$1 Trillion

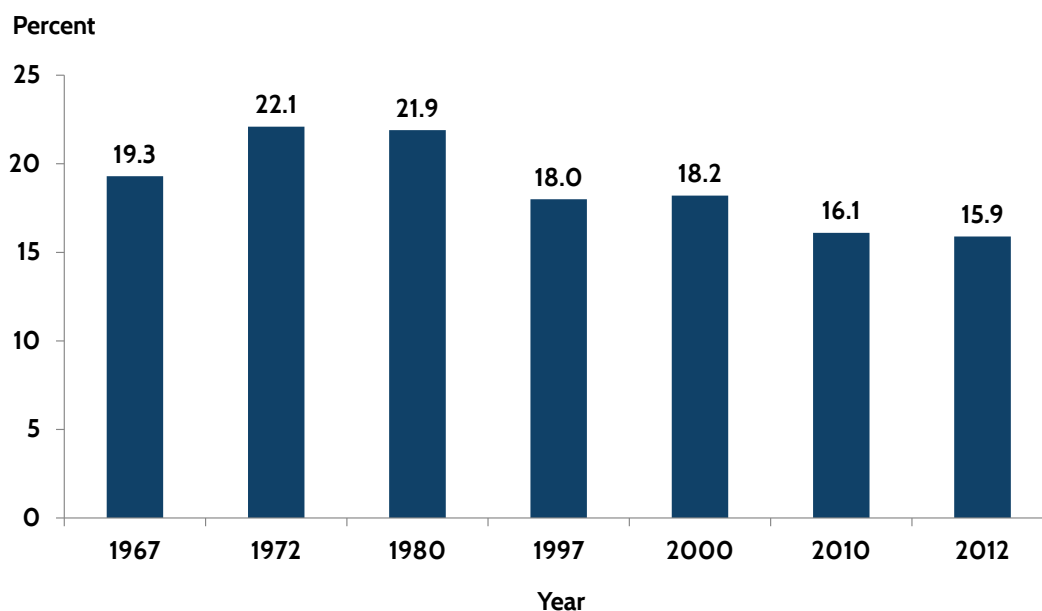


Source: Karen Davis and Jeromie Ballreich, Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health, based on annual Congressional Budget Office (CBO) reports.

There is also some indication that increases in overall health care spending, including Medicare, began slowing down after 2005—a trend not obvious to CBO estimators in 2009–10, given lags in data availability—contributing to an overestimate of baseline Medicare spending. Experts have suggested that this slowdown could be a consequence of efforts that predated the ACA to improve patient safety and quality, or a number of leading prescription drugs going off patent protection, or the effect of Medicare prescription drug coverage on reduced hospitalization of Medicare beneficiaries. Most likely it was the result of a combination of these and other factors.²⁰

Certainly, throughout the decade following the release of the Institute of Medicine report *To Err is Human* in 1999, hospitals in particular mounted efforts to improve patient safety and reduce medical errors.^{21,22} The addition of prescription drugs to Medicare coverage in 2006 may have facilitated management of chronic conditions, reducing hospitalizations for conditions that are sensitive to primary care and medication adherence. Whatever the reason, annual hospitalization rates of those age 65 and older declined from 18.2 percent in 2000 to 16.1 percent in 2010, contributing to reduced Medicare outlays and slowing the overall trend in spending (Exhibit 3). Research will continue to explore the underlying causes of the trends in Medicare and total health care spending over the years predating and following enactment of the ACA. At this point, however, it seems clear that the changes set in motion by the ACA contributed to slowing the growth in Medicare outlays—and, in doing so, enhanced the financial viability of the program.

Exhibit 3. Decline in Annual Hospitalization Rate, Age 65 and Older, Helps to Slow Spending



Note: Although the recent decline in hospital admissions for people age 65 and older is partly the result of an increase in the proportion of younger beneficiaries (ages 65–69), who have lower rates of hospitalization, hospitalization rates have in fact fallen for each age group in Medicare.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, family core and sample adult questionnaires, 2013.

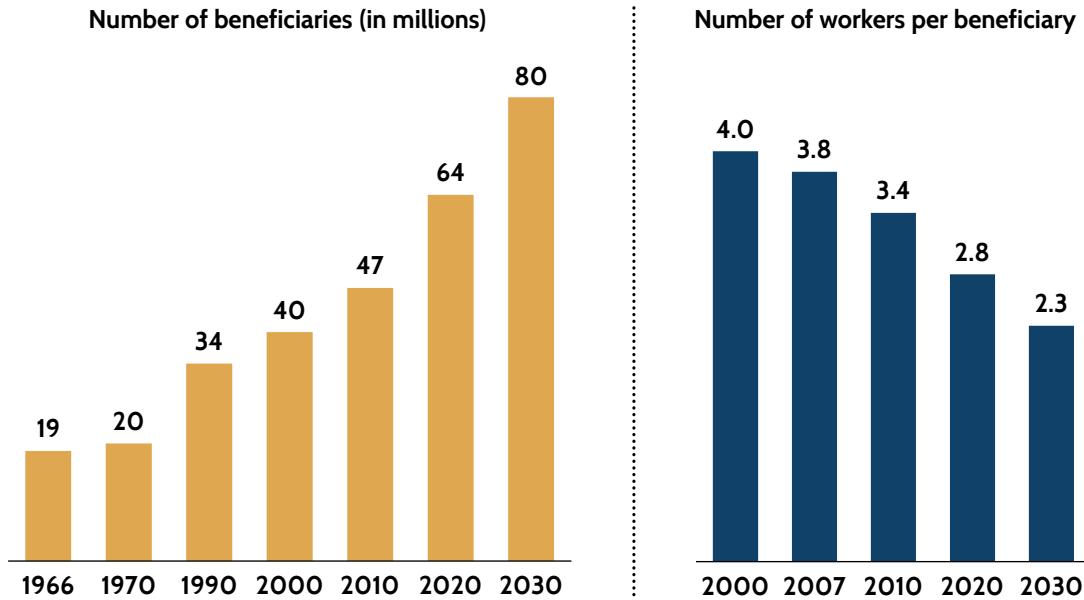
Solvency of the Medicare Hospital Insurance Trust Fund

The Medicare Hospital Insurance Trust Fund, which pays for hospital and other facility-based services used by Medicare beneficiaries, is financed by an earmarked payroll tax of 1.45 percent on both employers and workers. Historically, outlays from the Trust Fund have increased faster than employee wages and therefore payroll tax revenues. And with the boom in population following World War II and the drop in fertility rates in the 1960s, the elderly population is projected to grow markedly faster than the working-age population for the next two decades (Exhibit 4). As more people draw benefits and relatively fewer people pay into the system, the gap between revenues and expenditures inevitably widens over time.

The date at which reserves in the Hospital Insurance Trust Fund are projected to be depleted is referred to as the “insolvency date.” Although in practice Congress has acted to modify revenues or expenditures to prevent predicted insolvency over time, and would undoubtedly dedicate additional revenues to the Trust Fund if necessary, the insolvency date has served to focus periodic political attention and corrective action (Exhibit 5).

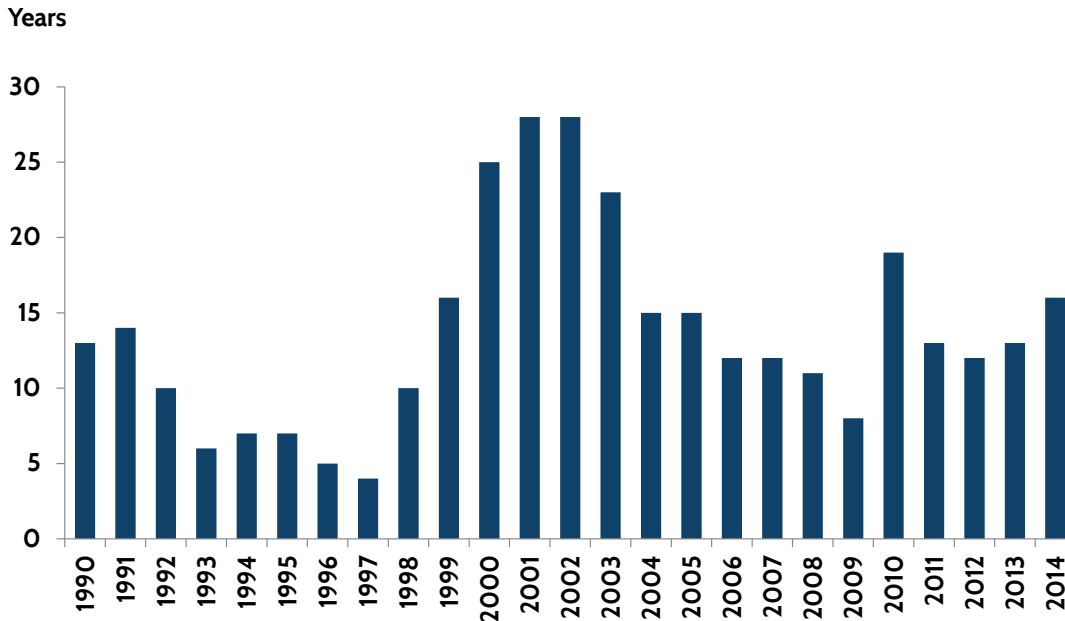
Prior to enactment of the ACA, the Medicare Trustees projected that the Hospital Insurance Trust Fund would be depleted by 2017.²³ Immediately following enactment, the Trust Fund’s solvency was extended by 12 years, to 2029.²⁴ Currently, the projected insolvency date is 2030—13 years later than at the time the ACA was enacted.²⁵ Rather than undermining the Medicare program, the ACA has strengthened its financing, reducing, at least for the near-term, pressure to cut

Exhibit 4. Federal Budgetary and Trust Fund Solvency Concerns as the U.S. Population Ages



Source: 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Exhibit 5. Medicare Hospital Insurance Trust Fund: Years Remaining Until Projected Insolvency, 1990–2014



Source: P. A. Davis, "Medicare: Insolvency Projections," Congressional Research Service Report RS20946, Sept. 19, 2014.

benefits, shift costs to beneficiaries, tighten provider payment rates, or raise taxes to ensure the adequacy of financing. The fundamental imbalance in Medicare financing, however, remains unaddressed.

Independent Payment Advisory Board

The ACA authorized an Independent Payment Advisory Board to make provider payment recommendations aimed at holding Medicare expenditures to a given rate of growth relative to the economy over time. These recommendations would become binding if Congress does not substitute alternative mechanisms for achieving the same expenditure growth target in a timely fashion. The Board also would make recommendations on how to slow health spending across the public and private sectors. The CBO estimated the board would generate \$16 billion in savings over 2010–19, mostly in the out-years. This provision, however, has been politically controversial and has not been implemented to date.

Moving from Volume to Value

The ACA's provisions have signaled the direction for the future for Medicare provider payment reform. Traditional Medicare is moving to adopt new value-related alternative payment methods that encourage providers to be accountable for the quality and cost of care they deliver to beneficiaries. The Secretary of HHS has set a goal that 85 percent of all traditional Medicare payments will be tied to quality or value by the end of 2016, and 90 percent by the end of 2018.²⁶ A recent scorecard on Medicare payment reform found that, as of the end of 2013, that figure was 42 percent.²⁷ While progress has been made, considerable work remains to be done.

CHALLENGES REMAINING FOR MEDICARE

With its payment, quality, and delivery system reforms, the ACA is reshaping the Medicare program and addressing the need for improved performance throughout the entire health care system. The U.S. outspends other countries per capita on health care, yet lags on important dimensions of performance including access to care and health outcomes.²⁸ Innovative payment and delivery systems, along with other potent tools such as health information technology, comparative provider performance data, outcomes research, and a stronger primary care foundation, can generate significant savings and improved performance. Still, an array of remaining challenges will determine Medicare's course as it enters its second 50 years; several of these will be addressed in more detail in future papers in this series.

Provider Payment Reform

The recent enactment of the MACRA legislation modifying Medicare's physician payment system will accelerate the move toward paying for value.²⁹ Physicians participating in innovative alternative-payment methods such as accountable care organizations, bundled payment, or patient-centered

medical homes will be eligible for 5 percent bonuses, and additional funding will be provided for value-based payments. The commitment by the Secretary of HHS that alternative payment models will constitute 50 percent of Medicare outlays by the end of 2018 indicates a push toward Medicare payment reform. Under the ACA, the Secretary has the authority to spread innovative payment methods tested by the CMMI that are found to either improve quality or lower cost without harming the other. But challenges remain in accomplishing the goals the Secretary has set out.

Improving Benefits for Low-Income Beneficiaries and Those with Complex Care Needs

Low- and modest-income beneficiaries are experiencing increasing financial difficulties in meeting uncovered costs.³⁰ As Medicare beneficiaries grow older and experience complex care needs, Medicare will have to identify innovative ways to help more beneficiaries continue to live at home and in the community as they face physical and cognitive impairments and need more personal care. Most challenging will be how to finance long-term care services and supports needed for a growing aging population.

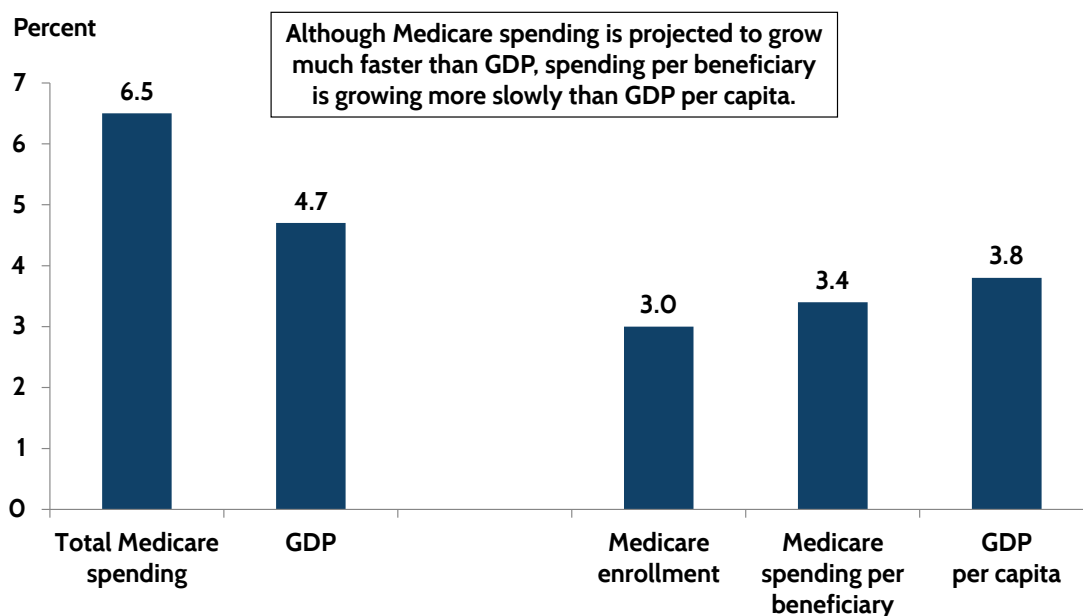
Medicare Program Complexity

While Medicare has been an innovative leader in methods of paying health care providers, its basic benefit structure is largely unchanged. The fragmentation of coverage into separate parts for hospital (Part A), physician (Part B), and prescription drugs (Part D) adds to administrative cost, complexity, and confusion for beneficiaries, and hinders coordination of care. Further, the high Part A deductible and absence of a ceiling on out-of-pocket costs leads most beneficiaries to supplement traditional Medicare with private coverage (from retiree plans or through individual purchase) or Medicaid. To obtain a single comprehensive integrated benefit package, Medicare beneficiaries must enroll in private MA plans that have higher administrative costs and more limited provider networks.³¹

Medicare Program Cost and Financing

The ACA bought time for policy officials to grapple with the best strategies for bringing Medicare revenue sources and expenditures into line. The Hospital Insurance Trust Fund's revenues will cover expenditures until 2030, and Part B and D rely on general revenue financing. Medicare expenditures per beneficiary are projected to grow more slowly than the gross domestic product per capita (Exhibit 6). However, total Medicare expenditures will place an increasing draw on general revenues and strain on the federal budget, and eventually the payroll tax revenues that support Part A will be inadequate. It also remains to be seen whether the slowdown in health care costs will continue, experience further improvement, or begin to rise again as a result of increased access to care for the previously uninsured, aging of the population, or technological change. All of these factors, and how they are addressed, have implications for Medicare's fiscal viability.

Exhibit 6. Projected Annual Growth Rates for Total Medicare Spending, GDP, Medicare Enrollment, Spending per Beneficiary, and GDP per Capita, 2013–2023



Note: GDP refers to gross domestic product.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditure Projections, 2013–2023.

Role of Private Plans

The appropriate role of private plans in the Medicare program continues to be the subject of intense debate. Medicare beneficiaries have a choice of traditional Medicare and private MA plans, in what effectively is a nationwide health insurance exchange. How best to balance the roles of the public traditional Medicare program and the private MA plans is an ongoing question. Historically, Medicare payment policy has advantaged private plans, preventing the program from realizing the anticipated gains these plans offer in flexibility and efficiency.³² As the ACA provisions to phase out those overpayments to MA plans are implemented, increased efficiencies may result from at least some of those plans.³³ Proposals to promote more direct price competition between traditional Medicare and Medicare Advantage plans also are getting attention.³⁴ How these issues are sorted out will be key to determining how beneficiaries receive their coverage and how Medicare—and beneficiary—dollars flow in the future.³⁵

CONCLUSION

In its 50 years, Medicare has successfully accomplished its two key goals—to ensure access to health care for its elderly and disabled beneficiaries and to protect them against the financial hardship of health care costs—and done so more effectively and efficiently than other sources of health insurance. Even with its coverage gaps and fragmentation of benefits, Medicare continues to be a positive force in shaping the U.S. health system.

The Affordable Care Act holds significant promise to improve Medicare’s performance, strengthening it for a more viable and successful future. Challenges related to cost, complexity, and gaps in coverage remain, and their solutions will require collaborative and creative thinking. Subsequent papers in the *Medicare at 50 Years* series will explore these challenges, and policy options for addressing them, in greater detail.

NOTES

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- ³ Centers for Medicare and Medicaid Services, “7.9 Million People with Medicare Have Saved over \$9.9 Billion on Prescription Drugs,” press release (Washington, D.C.: CMS, March 21, 2014), available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-03-21.html>.
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