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Health-Care Reform Changes Affecting Seniors

According to a report from the Centers for Medicare & Medicaid Services, The Patient Protection and Affordable Care Act (health-care legislation) will extend the Medicare Part A trust fund for an additional ten years, to 2027.

Health-care reform legislation, enacted in 2010, contains some provisions that directly affect our nation's elder population. If you're a retiree or a senior, you may be concerned about how these reforms may affect your access to health care and insurance benefits. The following is an overview of health-care reform legislation provisions you should be aware of.

Medicare spending cuts

Not surprisingly, the concerns of retirees and seniors generally center on potential cuts in Medicare benefits. At the outset, the new legislation does not affect Medicare's guaranteed benefits. However, two goals of the new health-care legislation are to slow the increasing cost of Medicare premiums paid by beneficiaries, and to ensure that Medicare will not run out of funds.

To help achieve these goals, cuts in Medicare spending will occur over a ten-year period, beginning in 2011, particularly targeting Medicare Advantage programs--Medicare benefits provided through private insurers but subsidized by the federal government. These cuts are intended to bring the cost of federal subsidies for Medicare Advantage plans in line with costs for comparable benefits for Medicare beneficiaries. If you participate in a Medicare Advantage plan, these cuts could reduce or eliminate some of the extra benefits your plan may offer, such as dental or vision care, and your premiums may increase. But Medicare Advantage plans cannot reduce primary Medicare benefits, nor can they impose deductibles and co-payments that are greater than what is allowed under the traditional Medicare program for comparable benefits.

Benefits added to Medicare

The legislation also improves some traditional Medicare benefits. For example, prior to the new legislation, traditional Medicare paid 80% of the cost for a one-time physical for new enrollees within the first 12 months of enrollment. But beginning in 2011, you will receive free annual wellness exams; preventive care tests such as screenings for high blood pressure, diabetes, and certain forms of cancer; and a personalized prevention assessment and plan to address particular health risk factors you may encounter.

Medicare Part D drug program changes

If you are a Medicare Part D beneficiary, you may be surprised to find that you have to pay for the entire cost of prescription drugs out-of-pocket after reaching a gap in your annual coverage, referred to as the "donut hole." You could pay up to an additional $3,610 out-of-pocket for medicines after reaching an initial threshold of $2,830 in total prescription drug costs (including Part D payments, beneficiary co-pays, and deductibles). But, in 2010, if you fell in the donut hole, you received a $250 rebate, and, in 2011, you receive a 50% discount on brand-name drugs. Also beginning in 2011, a reduction in co-payments for generic drugs within the donut hole will be phased in, and, beginning in 2013, a reduction in co-payments for brand-name drugs will be phased in. Essentially, by 2020, a combination of federal subsidies and a reduction in co-payments will reduce your out-of-pocket costs for medications in the gap from 100% to 25%. However, individuals with annual incomes greater than $85,000 and couples with incomes exceeding $170,000, will see their Part D premiums increase as the federal subsidy offsetting some of the cost of Medicare Part D premiums is reduced.

If you are a full-benefit dual eligible beneficiary (eligible for both Medicaid and Medicare) receiving institutional care, such as in a nursing home facility, you do not owe any co-payments for Part D-covered prescriptions. However, if you're dually eligible and receiving long-term care services at home or in a day-care community-based setting, you are subject to Part D drug co-payments. Beginning in 2012, the new legislation removes this imbalance by eliminating

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co-payments for individuals receiving services at home or in a community setting.

Also, beginning in 2011, the time period during which Part D and Medicare Advantage beneficiaries can make changes to their coverage is extended and runs from October 15 to December 7. This extension should provide more time for you to consider your options while ensuring that all changes are properly incorporated into the plan for the following year.

Coverage for those under age 65

You may be between the ages of 55 and 65 and do not have health insurance provided by your employer, or if covered, find that your cost for insurance is substantial. If you're in this predicament, the health-care legislation provides you with opportunities for affordable health insurance.

By 2014, state-based American Health Benefit Exchanges will be created, through which you can purchase affordable health insurance coverage. The Exchanges will serve as a conduit for health insurance providers to offer health plans with different benefits, co-insurance limits, and premium costs. You can then compare the costs of various plans and benefits. If you can't afford an Exchange plan, you may be eligible for a government subsidy based on income and family size.

Increased access to home-based care

Often, people with disabilities or illnesses would rather receive care at home instead of at a nursing home. The health-care reform law provides for programs and incentives for greater access to in-home care. The Community Living Assistance Services and Support program (CLASS) will be established sometime after 2011 (depending on when final regulations are published) as a voluntary insurance program, financed through payroll deductions and available to all working adults who choose to participate. This national program helps participants with functional limitations to maintain their personal and financial independence and live in the community by providing a cash benefit of at least $50 per day (after a five-year vesting period) for nonmedical services, such as home-care services, family caregiver support, and adult day-care or residential-care services. In order to qualify, you must need help with at least two activities of daily living, such as eating, bathing, or dressing.

Also in 2011, the Community First Choice Option will be available for states to add to their Medicaid programs. This option provides benefits to Medicaid-eligible individuals for community-based care instead of placement in a nursing home.

In addition, the State Balancing Incentive Program, to be established in 2011 and running through October 2015, provides increased federal funds to qualifying states that offer Medicaid benefits to disabled individuals seeking long-term care services at home, or in the community, instead of in a nursing home. In order to be eligible, a state must spend less than 50% of its total Medicaid expenditures for at-home or community-based long-term care services and supports. The state must also agree to use the additional federal funds to provide new or expanded non-institutionally-based long-term care services.

Nursing home transparency

The Independence at Home demonstration program, available in 2012, is a test program that provides Medicare beneficiaries with chronic conditions the opportunity to receive primary care services at home. This is intended to reduce costs associated with emergency room visits and hospital readmissions, and generally improve the efficiency of care.

While in-home care may be a preference, often a nursing facility is the better or only alternative. In the past, consumers had very little information available in order to compare nursing homes. The health-care legislation addresses the need for more transparency regarding nursing facilities. For example, nursing homes are required to disclose their owners, operators, and financers. The government will also collect and report information about how well a particular nursing home is staffed, including the number of hours of nursing care residents receive, staff turnover rates, and how much facilities spend on wages and benefits.

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