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Health Care Reform and Its Impact on Seniors

Sweeping new health care reform legislation promises many changes for seniors. Here's what you need to know.

During the past spring, Congress passed and the President signed into law the Patient Protection and Affordable Care Act. The Act contains numerous provisions that affect, or will affect, seniors in our country. It is expected to cost approximately $940 billion over the next decade. To help offset the cost of health care reform, the Act imposes higher taxes, fees and reduced payments to Medicare providers. According to the Congressional Budget Office, the Act is projected to reduce the federal deficit by about $143 billion over 10 years.

The changes to the tax code include restrictions on the use of flexible spending accounts, limitations on the deductibility of medical expenses, increases in the Medicare tax on wages and a new tax on unearned income for certain taxpayers. There will also be new assessments on insurance companies and pharmaceutical companies.

Generally speaking, the Act requires most U.S. citizens and legal residents to have qualifying health insurance. Those without coverage will pay a penalty, which will be phased in over a few years. Exemptions will be granted from the penalty for reasons of financial hardship and religious reasons, among others.

So, what does this all mean for seniors and those with special needs?

The Patient Protection and Affordable Care Act—commonly referred to as "Health Care Reform"—requires most U.S. citizens and legal residents to have qualifying health insurance.

An Overview of Key Changes

The Medicare prescription drug benefit has been improved. Seniors who enter the "donut hole" receive a $250 rebate this year. The Act gradually eliminates the donut hole by 2020, when it is expected to be fully closed.

The donut hole, which first took effect a few years ago, is a coverage gap in Medicare Part D. It refers to a hole in Part D coverage that occurs once you and your prescription drug plan have spent a certain amount of money for covered drugs; from that point on, you have to pay all costs out-of-pocket up to a certain limit. In addition, for those in the donut coverage gap, the Act provides that in 2011 pharmaceutical manufacturers whose drugs are covered by Part D must provide a 50% discount for brand-name drugs. Moreover, federal subsidies are provided for generic drugs.

The Act will provide for free preventive care services, and an annual physical exam starting in 2011.

Payments to Medicare Advantage plans (Part C), the private-plan part of Medicare, will be reduced to make them on par with payments made through traditional Medicare. The excess payments to Medicare Advantage Plans have allowed these privately run plans to offer more benefits than traditional Medicare. So, if you are in one of these plans, don't be surprised if some of your optional benefits such as vision or dental coverage are reduced. It is hoped that these reductions will extend the life of the Medicare Trust Fund, which according to some estimates is on a path to run out of money in 2017 unless some combination of cost savings or tax increases are enacted.

The Act provides for free preventive care services such as mammograms, colon and breast cancer screening, and an annual physical exam for Medicare recipients starting in 2011. Thus, there will be no co-payment or deductible for an annual wellness visit, which includes the creation of a personalized prevention assessment plan. This is a shift in focus from treatment to prevention in an attempt to reduce Medicare costs in the long term. Prevention services include referrals to education and preventive counseling or community-based interventions to address risk factors.

The Act also creates an Independent Medicare Advisory Board, which will have authority to make legislative proposals containing recommendations to reduce the cost of Medicare. While there are restrictions on what the Board can propose, the recommendations of the Board will take effect if Congress does not enact an alternative proposal that achieves the same cost savings. Congress is required to re-examine the Board in 2017 and has the power to terminate it.

The Act also ties Medicare Part D premiums to income and moves more Part D and Part B beneficiaries into higher-income categories. Thus, these people will pay higher premiums due to a freeze on income thresholds. For example, the Medicare Modernization Act of 2003 changed how Medicare Part B premiums are calculated for some higher income beneficiaries. The majority of Medicare beneficiaries are

not affected. This law, which took effect in 2007, requires higher income beneficiaries to pay a higher Part B premium based on income they report to the Internal Revenue Service. The income thresholds have historically gone up based on an inflation index. The Act freezes the Medicare Part B premium threshold from 2011 through 2019, which means that more people will be paying higher Part B premiums. This continues a trend in the Medicare program to tie benefits to income. Traditionally, Medicare has not been a means-tested program, although that appears to be changing.

Changes to Long-Term Care

In addition, the Act makes some changes to the way long-term care will be delivered in America. The Act attempts to move our health care delivery system away from the current institutional bias to a more community-based system.

Under current law, many seniors are forced into nursing homes because they do not have the resources to stay at home and are not eligible for long-term care insurance due to a pre-existing condition. The Act establishes the Community First Choice Option, whereby the states are given more federal money if they set up community services for residents who would otherwise be in nursing homes. The states will be able to provide community-based services to seniors and other individuals with disabilities who are Medicaid-eligible and who require an institutional level of care. This program ends in 2016, five years after it starts.

The Act also mandates that states include spousal impoverishment protections, such as the community spouse resource allowance, in their home-based waivered Medicaid programs. Since the late 1980s, spouses of nursing home residents have been entitled to enhanced protections under law. Although the protections vary by state, generally speaking, the spouse of a nursing home resident is entitled to keep more assets and income than a spouse of someone who is receiving care at home paid for by Medicaid. This new program will apply to Medicaid waiver programs and will also end after five years. A Medicaid waiver program allows states to provide certain services to their residents yet still receive federal matching funds.

The Act also freezes the Medicare Part B premium threshold through 2019, which means more people will be paying higher Part B premiums.

A New CLASS of Benefits

The Act also establishes the Community Living Assistance Services and Supports program ("CLASS"). CLASS is akin to a national long-term care insurance plan in many respects. This was the brainchild of former Senator Edward M. Kennedy and had been in the works for several years. CLASS is intended to allow seniors and those with disabilities to maintain their independence and alleviate the burden on caregivers, while reducing the institutional bias in our health care system. Another goal is to ease the strain on the Medicaid program by attempting to get more Americans to recognize the need to plan for long-term care at an earlier age and to contribute towards the cost of that care.

CLASS is set to take effect next year, although it is unlikely to be fully implemented until the Secretary of Health and Human Services (HHS) has issued regulations, since many of its provisions are subject to interpretation such as setting the premium and benefit levels and the disability triggers for receiving benefits. It is not expected that HHS will have issued regulations until 2012; therefore, the CLASS program might not take effect until 2013.

Under the program, employees may make voluntary payroll deductions as determined by HHS, in exchange for the right to receive cash payments if they are unable to perform activities of daily living (e.g., bathroom use, dressing, transferring, eating, and bathing) or suffer from cognitive impairment. The cash benefits are to be used for the purchase of community living assistance services and supports such as a home health aide, transportation, wheelchairs, lifts, adult day care, respite care, or to pay for care in assisted living or a nursing home. Only working people are eligible. People who are retired (unless they work part-time), non-working spouses, and unemployed people are not eligible to participate. The premiums and benefits will be determined by your age, with younger people paying less. Participants will be required to pay premiums for five years, the so-called vesting period, before they can receive any cash benefits. The daily benefit has not been set but will not be less than $50, with no lifetime limit. The Congressional Budget Office assumed a daily cash benefit of $75 and a monthly premium of $123 in one of its cost estimates. The premiums are expected to remain constant, unless an increase is needed to maintain the solvency of the program. There are no underwriting requirements and those with pre-existing conditions are accepted.

One of the biggest questions regarding the implementation of CLASS is who will participate. According to some estimates only about 5% of eligible employees choose to participate in employer's private long-term care insurance benefit programs and only about 7 million Americans own private long-term care policies. Initially, the long-term care insurance industry lobbied against CLASS, fearing that it would reduce people's incentive to purchase private long-term care insurance. Others argue that it will heighten people's awareness about the need to plan for long-term care and actually increase sales of long-term care insurance since the CLASS daily cash benefit may be in the $50 to $75 range. The average cost of long-term care in the United States is significantly higher than that. In fact, in some major metropolitan areas the cost can exceed $200,000 a year. Perhaps long-term care insurance can be used to fill in some of the gaps in the CLASS program similar to the way Medigap policies fill in the gaps in Medicare.

Under the Act, CLASS is supposed to pay for itself through premiums. It cannot be subsidized by the government. During the first five years CLASS is in effect this should not be a problem since no participants will be entitled to cash benefits during this time. However, after the first five years the long-term viability of CLASS will depend upon whether enough people participate. Will enough young, healthy people contribute so that the system is not financially strained by significant payments to people who need the benefits? We won't know the answer to this question until CLASS has a track record. According to one government estimate, only 5% to 6% of those eligible to participate would actually sign up for the CLASS program.

In order to attract healthy employees, the government hopes that the CLASS regulations will provide for a streamlined sign-up process and make it easy to have the premiums deducted from people's paychecks. One way of doing this is to offer employees the opportunity to pay their premiums through payroll deductions. In that case, all employees must be automatically enrolled in the program unless they opt out similar to the way some firms administer their 401(k) plans. It is hoped that automatic enrollment will increase participation by employees, which, in turn, would strengthen the financial condition of the CLASS program.

While there are many other provisions in the voluminous Act, including those regarding insurance reforms, nursing home staffing and quality of care provisions, and elder abuse, these are some of the more salient provisions affecting seniors and those with disabilities. ■

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