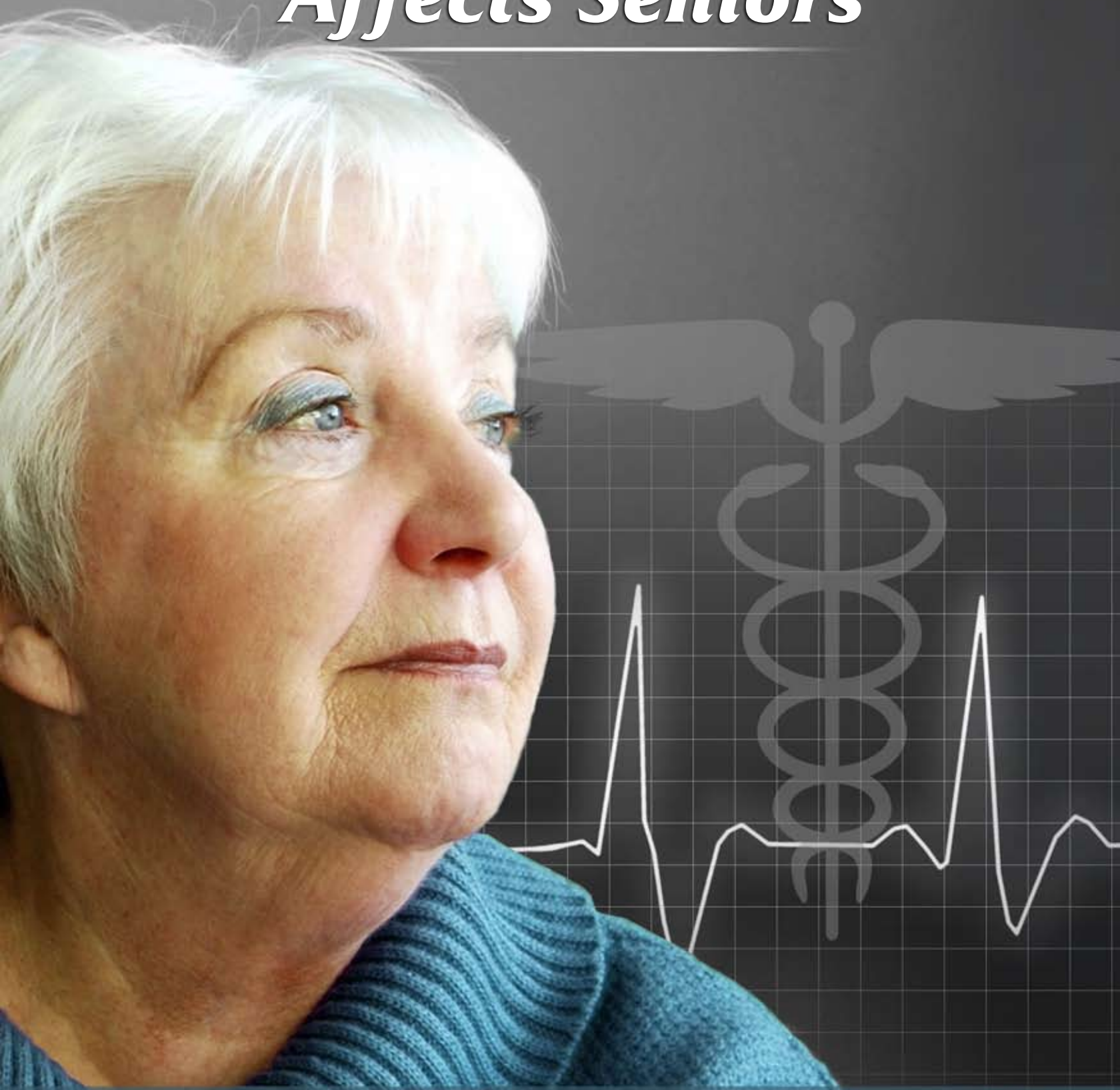
How Health Care Reform Affects Seniors



A White Paper Presented by: CSA Society of Certified Senior Advisors™

HOW HEALTH CARE REFORM AFFECTS SENIORS

A white paper presented by

The Society of Certified Senior Advisors

FOREWORD

This guide was created in order to answer some of the most often-asked questions about the new health care reform bill, titled the Patient Protection and Affordable Care Act, which was signed into law on March 23, 2010. Each year the bill is slated to roll out new provisions that affect individuals, businesses, insurance companies, health care providers, and the government. Some of the provisions may have already taken affect.

While it is possible that the bill will be modified over the years, whether by lawmakers or by the courts, it is important to understand the approaching provisions and what they mean for you. Areas where your life will be most affected may include your taxes, adjustments in your existing health care coverage, access to health care coverage, access to information, and requirements of employers.

Seniors are the focus of a few of the major portions of the health care reform bill. These include Medicare Part D drug coverage, Medicare benefits, and the Elder Justice Act. We've included the details of these issues as well as answers to commonly asked questions in order to help you better understand each issue.

We hope you find this information valuable and will share it with other seniors or professionals who work with seniors.

Ed Pittock, CSA

President and Founder
Society of Certified Senior Advisors

Note: The *How Healthcare Reform Affects Seniors* white paper is intended to provide strictly factual information about the current effects of the healthcare reform legislation for seniors. SCSA does not take a stance on healthcare reform and this white paper is only intended to help seniors interpret the vast amount of information available on this legislation.

TABLE OF CONTENTS

SUGGESTIONS FOR USING THIS WHITE PAPER

If you are a senior:

1. Use it to understand upcoming changes to health care legislation that may affect you.
2. Be sure to discuss any issues that pertain to you when working with professionals who assist you, such as your health care provider, tax preparer or financial advisor, attorney, or others.
3. Let it serve as a guide for you to keep track of the changes as they approach. Find out if the provisions will remain as stated here or if there have been efforts to amend the provisions as the time draws near for them to be implemented.
4. Use it to calculate and prepare for how the health care reform bill will affect you financially. It may be necessary for you to seek professional advice for your specific situation.

If you are a professional who works with seniors:

1. Use this guide as a resource you can give to your clients to help them understand the upcoming changes.
2. Position yourself as a source of information by including your clients on follow-up information when changes are made to the health care reform bill.
3. Use this to prepare yourself as a business owner or employee. What impacts your clients can shape your business practices.

HOW WILL MY MEDICARE BENEFITS CHANGE?

Overview

The Patient Protection and Affordable Care Act signed into law on March 23, 2010, directly affects the benefits for Medicare recipients. Substantial modifications related to Medicare benefits address expanded preventive care coverage, including proven preventive health screenings for many major conditions, such as diabetes and cervical cancer. Other expanded provisions include annual wellness visits to the doctor as well as the elimination of copayments and deductibles for those services.

Medicare Advantage

Medicare Advantage will also experience some changes. Because Medicare will start to reduce the subsidy payments made to the private insurance companies who offer Medicare Advantage, Medicare Advantage plans may change and reduce the extra benefits they offer to their members. This could include coverage for items such as eyeglasses and gym memberships. This only affects the additional benefits that Medicare Advantage beneficiaries receive on top of their Medicare standard package of benefits. Check with your Medicare Advantage insurance provider for details regarding changes to your plan.

Additional Provisions

In addition to the modifications that affect individual benefits, the health care reform bill also establishes provisions for broadening access to health care by increasing funding for community health centers and instituting a bonus system for doctors who provide quality care to Medicare patients. In areas where there is a shortage of health care providers, doctors and nurses who provide primary care will receive extra payments from Medicare.

The bill also requires skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures in order to increase the transparency of skilled nursing facilities. A new process intended to make it easier to file complaints about the quality of care in a nursing home will also be established. Standardized information on nursing facilities will also be published on a public website so Medicare enrollees can compare facilities.

Timeline for New Medicare Benefits

2010

- Expanded Medicare coverage for individuals who have developed particular health conditions as a result of living in an area that was exposed to environmental health hazards and where an emergency declaration was made as of June 17, 2009.
- Care coordination for “dual eligibles” (the low-income elderly and persons with disabilities who are enrolled in both Medicare and Medicaid) through a new office created in the Centers for Medicare and Medicaid Services, the Federal Coordinated Health Care Office.

2011

- Medicare coverage will expand to provide proven preventive health care services at no charge (e.g. annual wellness visits, mammograms, and screenings for bone density, diabetes, and cancer).
- Medicare recipients will be offered access to a health risk assessment and development of a personalized disease prevention plan. Medicare and Medicaid beneficiaries who complete a behavior modification program by following the suggestions of a health care provider will be given incentives.
- Individuals with Medicare who have been hospitalized will be assisted by the newly created Community Care Transitions Program to coordinate care and connect them to needed services upon leaving the hospital.

2011 cont.

- Income-related premiums for Medicare Part B will be frozen at the 2010 income levels until 2019. The 2010 income levels are $85,000/individual and $170,000/couple.
- Medicare Advantage plans will not be permitted to impose higher cost-sharing requirements for some Medicare covered benefits than is allowed under the traditional fee-for-service program.
- More information about nursing home inspections, complaints against facilities, and resident rights will be accessible by the public. A straightforward system to file complaints in regard to the quality of care in a nursing facility will be implemented.

2012

- Launch the Medicare Independence at Home demonstration program which tests whether chronically ill beneficiaries will benefit from coordinated primary care in their own homes.

WHAT HAPPENS TO MY MEDICARE PART D COVERAGE?

The Coverage Gap

Currently, individuals with Medicare Part D prescription drug coverage can experience a gap in their coverage, also referred to as the "donut hole". This occurs when an individual's total drug costs reach $2,830. The total drug costs are calculated by adding what the individual and the individual's insurance plan have paid. In 2007, 14% of all Medicare enrollees reached the coverage gap. After an individual and his or her insurance plan have paid a total of $2,830, the individual is responsible for the full price of all future prescriptions. If drug costs reach the "catastrophic" amount of $4,550, the individual then comes out of the gap and pays only 5% of their drug costs for the rest of the year.

New Provisions

The Patient Protection and Affordable Care Act contains provisions that are intended to assist seniors with their prescription drug costs when they reach the coverage gap. Over time the bill aims to close the donut hole completely and reduce the amount that qualifies an individual for catastrophic coverage by the year 2020. However, out-of-pocket premiums and co-payments will still exist for individuals with Medicare Part D coverage.

Additionally, an increasing number of stand-alone prescription drug plans offered by private insurance companies and Medicare Advantage plans will provide donut hole gap coverage for beneficiaries.

Furthermore, outreach efforts and enrollment assistance will be enhanced by the federal government to reach more beneficiaries eligible for the Part D low-income subsidy program.

According to an analysis by the House Committee on Energy and Commerce, the new legislation will allow the average person who reaches the coverage gap to save $700 in 2011 and $3,000 in 2020, when the gap will be essentially eliminated.

Timeline for New Medicare Part D Benefits

2010

- When Medicare beneficiaries hit the coverage gap, Medicare automatically sends them a $250 rebate check.

2011

- A 50% discount will be provided on brand-name drugs and a 7% discount on generic drugs for prescriptions filled during the coverage gap.
- Federal subsidies will begin to be phased in for generic drug costs for prescriptions filled during the Medicare Part D coverage gap. Federal subsidies are expected to reach 75% of the generic drug cost by 2020.
- Income-related premiums for Medicare Part D will be frozen at the 2010 income levels until 2019. The 2010 income levels are $85,000/individual and $170,000/couple.

2012

- Part D cost sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services will be made equal to the cost sharing for those who receive institutional care.

2013

- Federal subsidies will begin to be phased in for brand-name prescription drugs filled in the coverage gap. They are expected to reach 25% of the brand-name drug cost by 2020. (This is in addition to the 50% manufacturer brand-name drug discount already in effect.)
- The beneficiary coinsurance rate in the Medicare Part D coverage gap will be gradually phased down from 100% to 25% by 2020.

2014

- The out-of-pocket amount that qualifies an enrollee for catastrophic coverage will be reduced between 2014 and 2019.

HOW DOES THE HEALTH CARE REFORM BILL AFFECT MY TAXES?

Overview

The Patient Protection and Affordable Care Act puts into motion alterations in tax-related issues for businesses and individuals. Employers should prepare their systems well ahead of the dates of the proposed changes. Individuals also need to understand the changes that the health care reform bill brings to their personal taxes. Listed here are the major modifications in relation to taxes as they are slated to present each year.

Timeline for Tax Implications

2011

- Exclude the costs for over-the-counter drugs not prescribed by a physician from being reimbursed through a Health Reimbursement Account (HRA) or a Flexible Spending Account (FSA) and from being reimbursed on a tax-free basis through a Health Savings Account (HSA) or an Archer Medical Savings Account (MSA).
- Increase the penalty for non-health withdrawals from an HSA to 20% of the disbursed amount.

2013

- Limit the amount of contributions to an FSA for medical expenses to $2,500 per year. This will be increased annually by the cost-of-living adjustment.
- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% to 10% of adjusted gross income (AGI). This will be waived for individuals over 65 for tax years 2013 – 2016.
- Increase the Medicare payroll tax by 0.9% on earned income in excess of $200,000 for individual taxpayers and $250,000 for married couples filing jointly. Employers do not have to match this amount.
- Impose a 3.8% investment tax on unearned income for taxpayers with an adjusted gross income in excess of $200,000 for individual taxpayers and $250,000 for married couples filing jointly.
- Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014

- Tax penalties for not having insurance begin at $95 or 0.5% of income, whichever is higher, rising to $495 or 1% of income in 2015 and $750 or 2% of income thereafter, indexed for inflation after 2016. These penalties are per adult, half that amount per child, to a maximum of three times the per-adult amount per family. This penalty is capped at the national average premium for the “bronze” plan.

2017

- Itemized deduction for out-of-pocket medical expenses will be limited to expenses more than 10% of AGI for those over age 65.

2018

- An excise tax on high value or “Cadillac” plans will be imposed. This is an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. [These threshold values will be indexed to the consumer price index for urban consumers, (CPI-U) for years beginning in 2020.]

2018 cont.

- The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upward if health care costs rise more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts. (Effective January 1, 2018.)

  NOTE: It's important to note that the tax only applies to the amount over the threshold. Secondly, it doesn't take effect until 2018 and, most importantly, once you hit 65 and are on Medicare, none of these plans (since they would be supplemental) would likely have an actuarial value that would qualify a senior for the tax.

WHAT NEW ASSISTANCE IS AVAILABLE FOR LONG-TERM CARE?

Overview

The Patient Protection and Affordable Care Act that was signed into law on March 23, 2010, will include a provision for the Community Living Assistance Services and Supports program, also referred to as CLASS. The CLASS program is a voluntary insurance program for individuals to purchase nonmedical long-term services and supports if they should become functionally disabled. It is scheduled to become effective on January 1, 2011, with the Health and Human Services Secretary due to define the related benefits by October 2012. Enrollment would begin following the benefits announcement. Disbursement of CLASS benefits will not begin until 2017.

Goal of CLASS

CLASS will provide working adults who meet certain criteria with a planning opportunity for long-term care needs due to functional or cognitive limitations. A cash benefit will help offset the costs associated with such care.

How CLASS works

- It will be federally administered by the Department of Health and Human Services although the organization within the Department of Heath and Human Services that will authorize and initiate disbursement of benefits is undetermined.
- Working adults will have the option to participate and contribute premiums monthly through employer payroll deductions or directly into their account.
- Monthly premium amounts will be established by the Department of Health and Human Services Secretary.
- Premium payments will be placed in a trust fund account, called a Life Independence Account, on behalf of each individual beneficiary.
- Individuals may begin receiving benefits when they present limitations that are expected to last for an uninterrupted period of 90 days or more, as confirmed by a licensed health care practitioner.
- Individuals will receive benefits when they are unable to execute a minimum of two Activities of Daily Living, such as eating, toileting, bathing, dressing, or transferring or when they exhibit cognitive disability for which hands-on assistance or supervision is necessary, such as with Alzheimer's, multiple sclerosis, or traumatic brain injury.
- At the time benefits are recognized as necessary, beneficiaries will be paid out of the trust fund account that consists of the premiums they have paid and the interest earned on the accumulated balance in the fund. The law states that no taxpayer funds can be utilized for payment of these benefits.
- The benefit will not be subject to a lifetime or comprehensive limit.
- When the individual becomes ineligible to collect benefits because of improvement in condition or death, CLASS benefits will no longer be administered.

Who Is Eligible for CLASS?

- Adults who have paid monthly premiums for at least five years and have been employed for at least three of those years.
- Employers may choose to participate in and facilitate the CLASS payroll deduction for their employees.
- Self-employed people or those whose employers do not participate in CLASS will be provided an alternative enrollment method.
- Spouses of working adults must meet all requirements themselves.

Who Is Eligible for CLASS? cont.

- Individuals who meet the premium payment requirement and whose health condition has been confirmed by a licensed health care practitioner.
- An individual's Medicaid, Medicare, Social Security retirement, survivors, disability, and Supplemental Security Income (SSI) benefits are not affected by his or her eligibility for CLASS.

What Types of Services Are Covered Under CLASS?

- Services that support individuals in remaining independent and in a community residence
- Home health care
- Adult day care
- Assistive technology
- Modifications to the home
- Personal assistance
- Respite care
- Accessible transportation
- Homemaker services
- Assisted living facilities
- Nursing homes
- Voluntary counseling for choosing care and care providers, and for making decisions about whether to accept or refuse care

What Are the Benefits of CLASS?

- The monetary amount of the benefits will be established by the severity of limitation, disability, or impairment as determined by the Department of Health and Human Services Secretary.
- The law states that between two and six benefit-level amounts based on a functional ability scale will be put into place.
- Benefits will average not less than $50 per day.
- According to the Congressional Budget Office, benefit amounts are expected to be approximately $75 per day or over $27,000 per year.

How Are CLASS Benefits Paid to Beneficiaries?

- Benefits may be paid on a daily or weekly schedule.
- The benefit amount will be transferred from the individual's account to a debit account that is available for withdrawals by the beneficiary.
- Unused amounts may be rolled over month to month, but not year to year.

HOW ARE SENIORS PROTECTED AGAINST ABUSE UNDER HEALTH CARE REFORM?

Overview

When the Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010, it included the Elder Justice Act, a bill that had been introduced four times previously but never passed. The Elder Justice Act will provide federal funds and enact practices to support the fight against elder abuse, neglect, and exploitation.

Elder Abuse

Elder Abuse has been on the rise, according to the National Center on Elder Abuse (NCEA). A 2004 survey of data from the Adult Protective Services (APS) agencies in all 50 states, showed an increase of 19.7% in reported abuse cases from 2000. The NCEA used data from 19 states with similar reporting methods for offenses against the elderly and determined the following percentages relating to these categories of abuse:

Self-neglect	36.7%
Caregiver neglect	20.1%
Financial exploitation	15.8%
Emotional/psychological/verbal abuse	14.6%
Physical abuse	10.5%
Other	1.2%
Sexual abuse	1.0%

New Legislation

Some of the provisions of the Elder Justice Act that are included in the PPACA are:

- Requires the immediate reporting of crimes in a long-term care facility to a law enforcement agency and institutes civil monetary penalties for failure to report an incident.
- Provides penalties for long-term care facilities that retaliate against an employee who has filed a complaint against or reports a long-term care facility that violates reporting requirements.
- Authorizes $15 million for the Department of Health and Human Services to improve data collection and distribution, to create and distribute information on best practices related to adult protective services, and to administer research related to APS.
- Requires skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures, adding to the transparency of the facilities to the public.
- Creates a national program of criminal background checks for nursing home employees.
- Establishes a method of reporting complaints about the quality of care in a nursing facility. This information will be available through a website for Medicare enrollees to use when comparing facilities.

Other major provisions that are not specified here concentrate on the distribution of funds to government agencies that are serving seniors with the goal of developing and improving the practices of these agencies.

THE HEALTH CARE REFORM TIMELINE

Overview

The Patient Protection and Affordable Care Act, signed into law on March 23, 2010, will bring changes for American citizens and their relationship with health care. The provisions of the bill begin to take effect in 2010 and will roll out over time. Each year businesses and individuals will see more stipulations become law. This timeline exhibits, by year, changes for seniors, individuals, businesses, communities and states, and health care providers. It is meant to provide a broader discernment from all these perspectives.

Changes in 2010

SENIORS:

- A one-time $250 rebate to people who reach the Medicare Part D coverage gap.
- Addition of two new Medigap plans – Plans M and N.
- Care coordination for "dual eligibles" (the low-income elderly and persons with disabilities who are enrolled in both Medicare and Medicaid) through a new office created in the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.
- Expanded Medicare coverage for individuals who have developed particular health conditions as a result of living in an area that was exposed to environmental health hazards and where an emergency declaration was made as of June 17, 2009.

EVERYONE:

- People with preexisting conditions who have been uninsured for six months can get coverage through the Pre-existing Condition Insurance Plan (PCIP), also known as "high risk pools." This program will operate until January 1, 2014. At that time, all insurance plans will be required to cover individuals who have preexisting conditions.
- Individuals and/or families who enroll in new health insurance plans on or after September 23, 2010, are covered for recommended preventive services (e.g., immunizations, mammograms, colonoscopies) without being charged a deductible, co-pay, or coinsurance.
- Insurance companies are prohibited from imposing lifetime limits on health coverage.
- Insurance companies are restricted from placing annual limits on health coverage for new plans and all group plans.
- Insurance companies are prohibited from rescinding coverage because an individual becomes ill.
- An avenue of appeal for coverage determinations and claims is provided and an external review process is established.
- A website is available for consumers to compare health insurance coverage options: www.healthcare.gov
- Insurance companies are prevented from denying coverage to children 18 and under due to a preexisting condition.
- Coverage is extended for adult children until age 26 under the parent's insurance policy if they are not offered insurance at work.

BUSINESSES:

- Tax credits are offered for small businesses (less than 25 employees who earn an average yearly salary of $50,000 or less) that provide insurance benefits for their employees. A credit can be worth up to 35% of the employer's contribution to the employees' health insurance.
- Employers who provide health insurance to retirees ages 55-65, their spouses, and their dependents are provided financial assistance.

- The Food and Drug Administration (FDA) will be authorized to approve generic versions of biologic drugs and to grant manufacturers of biologic drugs exclusivity for 12 years before generics can be developed.

COMMUNITIES / STATES:

- States will receive federal matching funds to cover more individuals under Medicaid for whom funds were not previously available.
- A review process is established for reviewing health plan premium increases and justification of increases. States are required to report on trends of premium increases by insurance companies. Insurance companies that have unreasonably increased premiums may not be allowed to participate in the health insurance exchanges in 2014.
- The new Preventions and Public Health Fund will endorse proven prevention and public health programs (e.g., no smoking and combating obesity efforts).
- New financial support is offered for the construction and expansion of services at community health centers.
- A state option is created through a Medicaid state plan amendment to cover childless adults and to provide coverage for family planning services to the highest level of eligibility for pregnant women and certain low-income individuals.

HEALTH CARE PROVIDERS:

- New incentives to increase the number of primary care doctors, nurses, and physician assistants. Incentives include loan repayments and funding for scholarships for those professionals serving underserved areas.
- Increase in payments to health care providers in rural areas in an effort to attract and retain them in these underserved areas.
- New required screening procedures are put in place for health care providers who provide care to individuals with Medicare in an effort to reduce and fight fraud.
- Health plans are required to report the amount of premium dollars spent on clinical services, quality, and other costs and to provide rebates in 2011 to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for large groups and 80% for individual and small groups.

Changes in 2011

SENIORS:

- A 50% discount on Part D brand-name drugs and a 7% discount on generic drugs will be offered to people who are in the coverage gap.
- Income-related premiums for Medicare Part B will be frozen at 2010 levels through 2019. The 2010 income levels are $85,000 per individual and $170,000 per couple.
- Medicare coverage will expand to provide certain preventive services at no charge (e.g., annual wellness visits, mammograms, and screenings for bone density, diabetes, and cancer).
- Medicare recipients will be offered access to a health risk assessment and development of a personalized prevention plan. Medicare and Medicaid beneficiaries who complete a behavior modification program will be given incentives.
- Individuals with Medicare who have been hospitalized will be assisted by the Community Care Transitions Program to coordinate care to include needed services upon leaving the hospital.
- More information about nursing home inspections, complaints against facilities, and resident rights will be accessible by the public. A straightforward system to file complaints in regard to the quality of care in a nursing facility will be implemented.

EVERYONE:

- The costs for over-the-counter drugs that are not prescribed by a doctor will not be reimbursable through a Health Reimbursement Account or Flexible Spending Account. They would also be excluded from being reimbursed on a tax-free basis through a Health Savings Account or an Archer Medical Savings Account.
- Distributions from a Health Savings Account or an Archer MSA that are not used for qualified medical expenses will be subject to a tax increase to 20% of the disbursed amount.
- $11 billion for community health centers and $1.5 billion for the National Health Service Corps will be used to set up new programs to sustain school-based health centers and nurse-managed health clinics with the intent of expanding access to care over five years.
- A trauma center program to fortify emergency department and trauma center capabilities will be initiated.
- A National Prevention, Health Promotion, and Public Health Council will be created with a goal of establishing a plan to improve the nation's health as a whole.
- A national quality improvement strategy will be employed with the objective to improve the delivery of health care services, patient health outcomes, and population health.
- The new Center for Medicare and Medicaid Innovation will begin trying to determine new methods of delivering higher quality of care to patients while at the same time trying to reduce the rate of cost increases for Medicare, Medicaid, and CHIP (Children's Health Insurance Program).
- The Independent Payment Advisory Board will initiate developing and presenting proposals to Congress and the President on processes for targeting waste in the system and will recommend ways to reduce costs, improve health outcomes and increase access to high-quality care with the ultimate goal of lengthening the life of the Medicare Trust Fund.
- Disabled individuals on Medicaid will be offered home and community-based services rather than institutional care in nursing homes by their States.

BUSINESSES:

- Small employers are provided a grant for up to five years if they establish a wellness program.
- Chain restaurants (with 20 or more outlets) and vending machine foods are required to disclose the nutritional information for each item.
- A $2.5 billion annual fee will be imposed on pharmaceutical manufacturers.
- Employers are required to disclose the value of health benefits on W-2 forms.

COMMUNITIES / STATES:

- States choosing to participate in the Community First Choice Option will receive more federal funding to provide certain home- and community-based services to people with disabilities who live at home but require long-term services and support.
- States that develop, implement, and evaluate options to the current tort litigations in relation to medical malpractice will be given grants.
- Federal payments to states for Medicaid services related to health care acquired conditions will be prohibited.

HEALTH CARE PROVIDERS:

- 10% Medicare bonus increase to primary care physicians and to general surgeons who are practicing in areas where there is a shortage of health professionals (2011 – 2015).
- Changes in payment structure to Medicare Advantage plans from Medicare by setting payments to percentages of Medicare fee-for-service rates.
- Medicare Advantage will not be permitted to impose higher cost-sharing requirements for some Medicare covered benefits.

Changes in 2012

SENIORS:

- Launch of the Medicare Independence at Home demonstration program, which tests whether chronically ill beneficiaries will benefit from coordinated primary care in their own homes.
- Equal cost sharing for Medicare Part D for full-benefit dual eligible beneficiaries receiving home and community-based care services with those who receive institutional care.

EVERYONE:

- Medical records, health information, and billing records will be required to exist on a secure, confidential, and electronic standardized system with the intent of cutting costs, decreasing medical errors, and improving the quality of care.
- The Secretary of Health and Human Services will obtain and report racial, ethnic, and language data from ongoing and new federal health programs to help identify and reduce persistent health disparities.
- Community Living Assistance Services and Supports (CLASS), a voluntary long-term care insurance program meant to help individuals pay for some future long-term care service and support needs will be established. It will pay out a lifetime cash benefit if the individual paid into it for at least five years, worked at least three of the initial five years, has a qualifying disability, and meets other criteria. Employees can choose to participate, if their employer participates, through automatic payroll deduction. This program is scheduled to begin in 2012 or 2013.

BUSINESSES:

- Annual fee on pharmaceutical manufacturers will increase to $2.8 billion (2012 – 2013).

HEALTH CARE PROVIDERS:

- Medical records, health information, and billing records will be required to exist on a secure, confidential, and electronic standardized system with the intent of cutting costs, decreasing medical errors, and improving the quality of care.
- Incentives will be given to physicians who align their organizations as “Accountable Care Organizations” with the objective to better coordinate and improve patient care, prevent disease and illness, and reduce unnecessary hospital admissions. If the doctors do improve the quality of care and reduce costs to the health care system, they may retain some of the money they helped save.
- Hospitals will be required to publicly report their performance in measures relating to heart attacks, heart failure, pneumonia, surgical care, healthcare-related infections, and patients’ opinion of their care at the hospital, and financial incentives will be offered to hospitals who accomplish improvements in measured results.
- Hospitals will receive reduced Medicare payments for preventable hospital readmissions.
- A hospital value-based purchasing program in Medicare will be instituted and plans made to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Rebates will be reduced for Medicare Advantage plans.
- High-quality Medicare Advantage plans will receive bonus payments.
- Annual market basket updates for home health agencies, skilled nursing facilities, hospices, and other Medicare providers will be reduced.

Changes in 2013

SENIORS:

- Federal subsidies for brand-name prescription drugs filled in Medicare Part D coverage gap will begin. (This is in addition to the 50% manufacturer brand-name discount already in effect.)
- Medicare pilot program to appraise and develop a plan for paying a bundle payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care will be instituted.

EVERYONE:

- A $2,500 limit will be set on how much individuals can contribute to Flexible Spending Accounts. (Employers currently set the limit.)
- An excise tax of 2.3% will be imposed on any taxable medical device.
- Thresholds will be increased for the itemized deduction for unreimbursed medical expenses to 10% of adjusted gross income (from 7.5%) for regular tax purposes. The increase will be waived for individuals over 65 years and older for tax years 2013 through 2016.
- Medicare Part A tax rate will increase 0.9% for high-income taxpayers ($200,000 individual, $250,000 joint).
- A 3.8% Medicare payroll tax will be imposed on unearned income for higher-income taxpayers ($200,000 individual, $250,000 joint).

BUSINESSES:

- The tax deduction for employers who get Medicare Part D retiree drug subsidy payments will be eliminated.

COMMUNITIES / STATES:

- States will be given a one percentage point increase in the Federal Medical Assistance Percentage (FMAP) for offering Medicaid coverage of, and removing cost-sharing for, preventive services recommended by the U.S. Preventive Services Task Force and recommended immunizations.

HEALTH CARE PROVIDERS:

- Medicaid payments will increase for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.
- Disclosure of financial relationships between health entities will be required. Physicians, hospitals, pharmacists, and other providers must disclose their fiscal arrangement with manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Changes in 2014

SENIORS:

- Out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D will be reduced. Effective until 2019.

EVERYONE:

- U.S. citizens and legal residents will be required to have qualifying health coverage. For those without coverage, fines of $95 per individual up to $285 per family or 1% of taxable household income, whichever is greater, will be assessed.
- Health insurance "exchanges" will be offered for people who don't have coverage through their job. Anyone who is eligible for an exchange program but chooses not purchase it will be subject to a penalty. All health insurance exchanges must include coverage for medical care, mental health care, prescription drugs, and rehabilitation services. A standard set of benefits for "exchange" plans will be created.
- Employees who are eligible and cannot afford the health insurance coverage provided by their employer may redirect the funds that the employer would have contributed and allocate them to purchase coverage under one of the exchange plans.
- Tax credits may assist eligible individuals in paying for health insurance that is purchased through a health insurance "exchange". People with incomes between 133% and 400% of poverty qualify.
- Insurance companies can no longer place annual limits on health coverage.
- An individual cannot be denied health insurance because of a preexisting condition.
- Insurers must continue, and not limit, coverage for individuals who choose to participate in clinical trials for cancer treatments and other life-threatening diseases.
- Spouses of people on Medicaid receiving care services at home will receive the same protection for income and other resources as spouses of those on Medicaid who live in nursing homes.
- The Medicaid insurance program will be made available to more children, parents, and childless adults who have a limited income and earn less than 133% of the poverty level.

BUSINESSES:

- Annual fee on drug manufacturers will increase to $3 billion. (2014 – 2016)
- Fees will be imposed on the health insurance sector.
- Businesses with 50 or more employees that don't offer health care coverage but have at least one full-time employee who collects subsidized coverage in the health insurance exchanges will have to pay a fee per full-time employee. The first 30 employees would be exempt from the fee calculation.
- Tax credit for small businesses (less than 25 employees who earn an average yearly salary of $50,000 or less) will increase to 50% of the cost of the employee's insurance coverage.
- Employers will be permitted to offer employees wellness incentive rewards of up to 30% of health plan premiums.

COMMUNITIES / STATES:

- States will be permitted to form health care choice compacts and allow insurers to sell policies in any state participating in the compact.
- States will receive 100% federal funding (for 3 years) to support the increase in the number of individuals who become eligible for Medicaid coverage.

HEALTH CARE PROVIDERS:

- Medicare Advantage plan providers may not spend more than 15% of premium dollars on administrative costs.
- For hospital-acquired conditions, Medicare payments will be reduced by 1% (effective 2015).

Changes in 2017

SENIORS:

- Itemized deduction for out-of-pocket medical expenses will be limited to expenses more than 10% of AGI for those over age 65.

Changes in 2018

BUSINESSES:

- An excise tax on high-value or "Cadillac" plans will be imposed. This is an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage, [these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) for years beginning in 2020.]

- The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upward if health care costs rise more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts (effective January 1, 2018.)

  NOTE: It's important to note that the tax only applies to the amount over the threshold. Also, once you hit 65 and are on Medicare, none of these plans (since they would be supplemental) would likely have an actuarial value that would qualify a senior for the tax.

ANSWERS TO OTHER HEALTH CARE REFORM QUESTIONS

What would it take to repeal or make changes to the health care reform bill?

Changes can be made to the bill in a variety of ways. Lawmakers in Washington, D.C., or courts around the country may be put into a position to reconsider portions of the bill.

Lawmakers would need 60 votes in the Senate to modify the bill in its entirety. Lawmakers could attempt to cut off funding for the bill through budget reconciliation, which requires a 51-vote majority. In that case, only the parts of the legislation that are affected by budget could be impacted. Budget reconciliation to undo a major reform has never been done before.

The President can veto any legislation put in front of him that would repeal any part of health care reform. Lawmakers would then need a two-thirds majority in both chambers to override his veto.

In different states, cases concerning the bill have been, and will most likely continue to be, brought before the courts.

Citizens can do their best to abide by the changes that the health care reform bill implements, but also be aware of modifications as they are made in the coming months and year.

When does the mandate for an individual to have health insurance coverage begin?

As of 1/1/2014, all U.S. citizens and legal residents will be required to purchase health insurance.

Exceptions are granted for individuals for whom the lowest cost plan option in the health insurance exchange (the basic coverage plan) exceeds 8% of that individual's income, and for those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples). Employers will be required to include the value of insurance plans to the IRS. This method of reporting will allow the government to determine if you meet the 8% limit.

Individuals will also be exempt for these reasons as well: financial hardship, religious objections, American Indians, undocumented immigrants, individuals without coverage less than three months, and incarcerated individuals.

What is an "exchange"?

Each state, whether by its own efforts or through the federal government, will establish a health exchange where qualified individuals and businesses can choose to purchase qualified health insurance that provides an essential health benefits package as defined by the Secretary of Health and Human Services. Exchanges will be available January 1, 2014.

Seniors will have no interaction with the exchanges at all. Medicare and Medicaid are not impacted by the exchanges.

What is the fine or penalty for not having insurance?

In 2014, a penalty fee will begin to be phased in:

2014 – The greater of $95 or 1% of taxable income.
2015 – The greater of $325 or 2% of taxable income.
2016 – The greater of $695 or 2.5% percent of taxable income.

After 2016, the penalty will be increased annually by a cost-of-living adjustment.

How does the government know whether someone has insurance coverage or not?

The bill does not specifically state how the mandate for health insurance coverage will be enforced by the government. Most likely, individuals will have to provide proof when they file their taxes each year. If an individual is on Medicare or Medicaid, the government will have direct knowledge of that coverage. Employees who accept insurance coverage through their employers will have that information reported for them by their employers to the IRS.

How does the bill help someone with a preexisting condition?

The law establishes coverage through the Preexisting Condition Insurance Plan (PCIP), also known as "high risk pools." Individuals who have not had insurance for six months or more can get coverage through this plan. This program will operate until 1/1/2014 when all health insurance plans will be required by law to cover individuals who have preexisting conditions. The law currently prohibits insurance companies from denying coverage to children 18 and under due to a preexisting condition.

What is the "essential benefits" package and who determines what is offered in the package?

Beginning 1/1/2014, the Secretary of Health and Human Services will define the "essential benefits" package, which will be updated annually. The benefits will align with a typical employer plan and will include at least the following general categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

What is reported on the W-2 form as far as health insurance benefits?

Employers are required to include the total cost of group health plan benefits (not including FSA, HAS, or Archer MSA contributions or the cost of long term care and other approved benefits) on the annual W-2 forms for each employee beginning tax year 2011.

What is the definition of a "grandfathered health plan"?

The health care reform bill does not specifically define a "grandfathered health plan". The most common understanding is any group health plan that was in existence on the date of the law's enactment, which was March 23, 2010. However, if a plan is altered significantly, it is not clear at what point a plan will no longer be considered a grandfathered health plan. It is recommended that employers move carefully when adjusting their existing plans if they want to remain under the grandfathered status.

New employees (and their families) and family members of current employees who are covered by the grandfathered plan (if their enrollment was permitted under plan terms on March 23, 2010) may be included for coverage under an employer's grandfathered plan. Collective bargaining agreements are also considered grandfathered plans until the provisions of the plan are renegotiated.

How does coverage differ for grandfathered plans and new plans?

All group health plans as of March 23, 2010, regardless of grandfathered status, must include these provisions:

- Adult children up to age 26 (if the adult child is not eligible for coverage under another employer-sponsored health plan)
- Restrictions on lifetime/annual limits
- Restrictions on rescissions
- Preexisting condition exclusions
- Waiting period limited to 90-days

New plans must include these provisions (grandfathered plans are exempt):

- Recommended preventive services covered without deductible, co-pay, or coinsurance (e.g., immunizations, mammograms, colonoscopies)
- Cost-sharing limits
- A claims appeals and review process
- Coverage of clinical trials

How is my health care Flexible Spending Account (FSA) affected?

FSAs are affected in two ways:

1. Beginning January 1, 2011, over-the-counter (OTC) medications (except insulin) that are not prescribed by a physician will no longer be reimbursable through health accounts, including FSAs, Health Savings Accounts (HSAs), and Health Reimbursement Accounts (HRAs).
2. Beginning January 1, 2013, a limit on the amount that employees can contribute to FSAs will be capped at $2,500 and will no longer be at the employer's discretion.

What is the new requirement to cover dependent children up to age 26?

Group health insurance plans, including grandfathered plans, that offer members dependent coverage of children must provide coverage to adult children until their 26th birthday:

- Regardless of student or marital status…
- Even if the child is not a dependent of the parent on their federal income taxes…
- If the adult child is not eligible for coverage under another employer-sponsored health plan…

What is a voucher and how does it work?

Beginning on or after January 1, 2014:

- Employers who contribute to the cost of minimum essential coverage under the employer's plan must also provide "free choice vouchers" to "qualified" employees.
- "Qualified" employees (who choose to purchase coverage through the exchange) are those with household incomes at or below 400% of the federal poverty level ($88,200 for a family of four in 2010) and those who contribution for employer-sponsored coverage would be 8% to 9.8% of their household income.
- The value of the voucher must be equal to the amount paid by the employer for coverage under the employer plan for which the employer subsidy is the largest (as adjusted for age and enrollment category).
- Employees will be able to use these "free choice vouchers" to purchase health plan coverage from a state health exchange.
- A "qualified employee" can use the voucher as a credit against premiums required for exchange-provided coverage, and the employee may retain the excess amount if the premium is less than the voucher.
- Free choice vouchers are excluded from taxation. Employers providing free choice vouchers will not be subject to penalties for employees who receive premium credits in the exchange.

What is the pre-65 retiree reinsurance program?

Effective June 1, 2010, and ending January 1, 2014 (or when funds that the federal government allocated toward this program are depleted), employers who sponsor early retiree coverage will be reimbursed 80% of claims between $15,000 and $90,000. The purpose of the program is to encourage employers that currently offer retiree medical coverage to continue to offer it until the exchanges are initiated in 2014. Employers must apply for the program and meet certain requirements.

Individuals who are at least 55 years old, are not active workers, and are not eligible for Medicare may receive benefits through the retiree reinsurance program if their former employer chooses to participate.

CONCLUSION

As each of The Patient Protection and Affordable Care Act provisions begin to take affect, they will bring systemic change for individuals, businesses and the health care system. This guide is intended to present information that will support understanding of the new health care reform bill as it pertains to seniors.

Use this guide to keep track of approaching changes, but keep in mind that provisions may be altered by lawmakers and courts at any time. To gain more thorough knowledge of and to stay attentive to the changes made to The Patient Protection and Affordable Care Act, the following resources may be helpful:
www.kff.org
www.healthcare.gov
www.aarp.org

We hope you found this guide beneficial and that it provided you with a better understanding of The Patient Protection and Affordable Care Act. The information provided here is not a complete source regarding the health care reform bill. Please seek professional advice and counsel to determine how your specific position may be affected by the bill or to obtain the most recent information on changes to the bill.

About the Society of Certified Senior Advisors (SCSA)

SCSA is the world's largest membership organization educating and credentialing professionals who serve seniors. SCSA was founded in 1997 with the input of doctors, attorneys, gerontologists, accountants, financial planners and other experts who believed there was a need for standardized education and a credential for professionals who work with seniors.

SCSA's mission is to educate professionals to work more effectively with their senior clients. For those who work with seniors, this means understanding the key health, social and financial factors that are important to seniors—and how these factors work together. CSAs are able to integrate this into their professional practices, no matter what field they're in. They've learned how incredibly gratifying it is to help seniors achieve their goals, and the seniors they've worked with have learned how important it is to work with someone who truly understands their age-related circumstances.

For more information about SCSA, please visit www.csa.us.

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