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Health-Care Reform Changes Affecting Seniors

Benefits added to Medicare by the Patient Protection and Affordable Care Act include 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.

The Patient Protection and Affordable Care Act (ACA), 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 a significant portion of prescription drugs out-of-pocket after reaching a gap in your annual coverage, referred to as the "donut hole." Aside from co-pays and deductibles, Medicare generally pays for your medications up to a certain annual dollar limit, after which you have to pay more of the cost for your prescriptions. But the amount you have to pay within the coverage gap decreases each year until 2020, at which time a combination of federal subsidies and a decrease in co-payments reduces your out-of-pocket costs for medications in the gap to 25%. However, if your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain limit, you may pay a Part D income-related monthly adjustment amount (Part D-IRMAA) in addition to your monthly plan premium. This extra amount is paid directly to Medicare, not to your plan.

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

Each year, Part D and Medicare Advantage beneficiaries can make changes to their coverage from October 15 to December 7. During this period,

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you can not only join a Part D plan for the first time, but you can switch from one drug plan to another or drop your drug coverage completely.

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.

The ACA created Health Insurance Marketplaces through which you can purchase affordable health insurance coverage. The Marketplaces 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 a Marketplace 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 First Choice Option is 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.

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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