



Retirees and the New Health Care Reform Law: Frequently Asked Questions

- **How will Medicare's Part D "Doughnut Hole" be phased out?**

Later this year, Medicare will provide a \$250 rebate for seniors who fall into the big gap in prescription drug coverage known as the doughnut hole. Next year, seniors in the doughnut hole will start receiving a 50% discount for brand name drugs and the government will provide a small subsidy to help reduce the cost of generic drugs in the doughnut hole. Then, in 2013, the government will start subsidizing the purchase of brand-name drugs for seniors in the doughnut hole, picking up larger and larger portions of the cost of both brands and generics each year, until the coverage gap is finally phased out in 2020.

- **Will the new law reduce seniors' out-of-pocket costs for any medical services?**

YES. The new law will immediately eliminate senior citizen Medicare *co-payments* (currently 20%) for mammograms, colonoscopies and other preventive screening services. In 2011, it eliminates remaining co-pays and deductibles for preventive screenings. The law also introduces a **brand new Medicare benefit** -- **annual checkups** with your doctor will be covered for the first time.

- **Will seniors be hurt by the reduced subsidies to Medicare Advantage plans?**

Private Medicare Advantage (MA) plans are paid an average of 14% more than the per-senior cost under regular Medicare. Essentially, these private insurance plans receive \$1,000 in extra federal subsidies for every senior citizen they cover – an overpayment that has contributed to record profits for some insurance companies. A portion of these federal subsidies are paid out of the Part B premiums of *all* seniors, regardless of whether they're in MA plans or in regular Medicare. So, as a matter of fairness to *all* beneficiaries, the new health care law phases out the overpayments to MA plans over seven-years, restoring a level playing field with regular Medicare. The reductions in MA overpayments will help strengthen Medicare because the money will be re-invested in the program, **extending the life of Medicare's Trust Fund by more than 12 years**. And, MA plans will still qualify for bonuses if they can show they deliver high quality services.

Nevertheless, with lower payments from Medicare, some MA plans may decide to trim the extra benefits they offer. That will be an individual insurance company decision. But the law says they **cannot reduce any of the essential benefits** guaranteed under Medicare. Also, **the new law prohibits MA plans from charging higher co-pays** than regular Medicare's. In addition, beginning in 2014, at least 85% of the premiums collected by MA plans **must be spent on benefits**, rather than go toward company profits and administration. These are strong protections for seniors who participate in MA plans.

- **Will the law's \$500 billion in Medicare savings affect patient care?**

The new health care law produces \$500 billion in Medicare savings by phasing out the overpayments to MA plans and instituting changes to Medicare to make it more efficient. These changes include incentives for doctors and hospitals to coordinate a patient's care, demonstration programs that bundle payments to hospitals and rehabilitation facilities, and a number of other innovations. The new measures are designed to **encourage quality rather than the quantity of services**, in order to improve care. **All savings will go back to the Medicare program** in order to close the Part D doughnut hole, train primary care doctors and nurses and provide bonus payments to high quality Medicare service providers (i.e., doctors, hospitals, Medicare Advantage plans). **To protect beneficiaries**, a provision in the new law affirms that Medicare's *guaranteed* benefits will not be cut

(protecting participants of both regular Medicare and Medicare Advantage plans) and that all Medicare savings will be used to extend the solvency of the Medicare trust fund, reduce Medicare premiums and cost-sharing, improve or expand guaranteed Medicare benefits, or preserve access to service providers.

- **How will Medigap policies be affected?**

Generally, Medigap policies will not be affected, but the Department of Health and Human Services (HHS) will ask the National Association of Insurance Commissioners (NAIC) to revise the standards for policies classified as “C” and “F,” so that their benefit packages include nominal cost sharing.

- **Will the newly-insured overwhelm the system, making it hard to see a doctor?**

The “exchanges” – the new state-based, subsidized insurance pools for those who buy their own coverage – will not be up and running until 2014, so we still have a few years to prepare for the influx of new patients. To help in the transition, the health care law provides funds to train primary care physicians and nurses. This includes \$125 million in grants over the next three years to support new or expanded primary care residency programs at teaching health centers, as well as additional funds in the future as deemed necessary. Another program, funded at \$50 million a year from 2012 to 2015, will expand graduate nurse education training under Medicare.

- **Will the new law affect the subsidy for employers who provide retiree drug coverage?**

Employers who provide paid drug coverage to their retirees will **continue to get the subsidy they’ve received since 2003** (when AFSCME made sure it was included in the Part D law). As a result, most employers will maintain the benefits they currently offer. For *private-sector* employers, however, the *new* law does end the tax deductibility of the subsidy in 2013.

Here’s how that tax deduction works under the *old* law: The government provides a 28% subsidy for retirees’ prescription drugs, which means employers who offer drug coverage only pay 72% of the actual costs. For tax purposes, businesses can deduct both their costs AND the amount of the government subsidy. For example, if a company paid out \$100 million in retiree drug benefits, it would qualify for a \$28 million subsidy. After the subsidy, the company’s real expenses would be only \$72 million, but it could deduct the full \$100 million from its taxable income. These employers seem to be getting a windfall, which is why the practice will change in 2013. That’s when the tax deductibility of the subsidy ends. **Public-sector employers aren’t affected** by the tax change because they don’t pay federal income taxes.

- **What is an Insurance Exchange?**

The new law establishes state-based insurance “exchanges” – marketplaces where uninsured individuals and small businesses can compare and buy affordable high-quality insurance plans. A variety of private insurance options will be offered in each exchange and most participants will qualify for federal subsidies that will significantly reduce the cost of premiums. The new health care law requires states to set up insurance exchanges by 2014. Insurance that is sold in the exchanges must meet or exceed certain benefit standards.

- **Is there any assistance provided for early retirees?**

Yes. A reinsurance fund provides \$5 billion to help employers pay for the health benefits of their retirees who are 55 to 64 years of age. The program will reimburse employers or insurers for 80% of

the retiree claims in excess of \$15,000 and below \$90,000. Payments from the reinsurance program will be used to lower the cost of the plan and may be used to reduce the enrollees' share of the costs.

- **If a 55 to 64-year old retires early and his/her former employer does not provide health coverage, is there any other assistance?**

Yes. A temporary high-risk insurance pool will become available this year, providing insurance to individuals who've been denied coverage due to a pre-existing condition and have been uninsured for six months.

- **When will insurance companies be required to stop denying coverage to people with pre-existing conditions?**

The ban on denying coverage to adults due to a pre-existing goes into effect in 2014 (children in 2010). The high-risk insurance pool, described above, is a temporary program designed to help high-risk individuals until the ban takes effect. Starting In 2014, they will be able to purchase an insurance plan from their state exchange (probably with subsidized premiums), with no fear of being denied coverage due to pre-existing conditions.

- **How will the subsidies work for people who buy individual insurance coverage?**

Beginning in 2014, uninsured individuals will be *required* to purchase insurance. Most of them will buy coverage from a state exchange and most will qualify for federal income tax credits that will help make their insurance affordable. Those with incomes up to 400% of the federal poverty level (incomes up to \$43,320 for an individual and \$88,200 for a family of four) will qualify for a tax credit. The value of the credit will vary according to the taxpayer's income.

- **Is there a mandate for employers to provide coverage to their workers?**

No, there is no employer mandate in the health care law, although AFSCME would have liked one. Employers with more than 50 employees will face stiff penalties, however, if they don't offer coverage. They'll be assessed a fee of \$2,000 per full-time worker (excluding the first 30) IF one or more of their employees buys coverage in the exchange AND receives a federal subsidy to help pay for it.

- **What is insurance-plan "age rating" and is it included in the law?**

Age rating is another way of saying premiums are based on a person's age. The new health care law allows insurers to vary the cost of premiums up to a maximum 3 to 1 ratio – that means they will be able to charge older people 3 times the amount of premiums they charge young adults. That may seem outrageous, but prior to passage of the new health law, premiums for a 64-year old individual were typically 5 times higher and, in some parts of the country, 11 times higher than premiums for a 19 year old. So, the new provision, which goes into effect in 2014 (when the exchanges begin to operate), is a big improvement over past practice. Insurance companies insisted that, without the ability to charge somewhat higher premiums for their oldest customers, they would have to raise the premiums for younger people to unaffordable highs.

- **How does the new law improve the medical-loss ratio in order to protect consumers?**

The medical-loss ratio is the percent of premium charges that insurance companies spend on medical benefits, rather than profits and administrative costs. The new health care law requires that, beginning in 2011, plans for individuals and small-groups must spend 80% of premiums on patient care. Large group plans, including Medicare Advantage plans, must spend 85% of their premiums on patient care. Whereas 10 years ago many plans had medical-loss ratios over 80% or even 90%, today medical-loss ratios tend to be in the high 70s or low 80s. Insurers spend the rest of their premium money on profits,

executive pay, advertising, sales force and other types of overhead. In comparison, Medicare spends 97% of beneficiary premiums on patient care and 3% on administrative costs.

- **What is the so-called “Cadillac” tax and how does it work?**

Starting in 2018, there will be an excise tax of 40 percent imposed on insurance companies and plan administrators for high-cost health insurance plans. This means plans valued at more than \$10,200 for individual coverage and \$27,500 for family plans. The tax would be applied to the amount of the premium that’s in excess of those thresholds and would not include the cost of stand alone dental or vision benefits. The plan-cost threshold would go up each year according to the rise in the Consumer Price Index (CPI). For the year 2019 only, it would go up by the CPI increase *plus* one percentage point.

Plans that include individuals over age 55, as well as workers in high-risk occupations, will have a higher plan-cost threshold for the excise tax. For these plans, the threshold will be \$11,850 for individual coverage (an additional \$1,650) and \$30,950 for families (an additional \$3,450).

- **Is Congress covered by the new law?**

Yes. Members of Congress and their staff, who are currently covered under the Federal Employees Health Benefits Program, will be required to purchase insurance from an exchange. The new rule takes effect in 2014, the start year for the exchanges.

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