Frequently asked questions:

How will the Phasing-out of the Part D Doughnut Hole work?

There is a $250 rebate for seniors who fall into the doughnut hole in 2010. In 2011, seniors who fall into the doughnut hole will receive a 50 percent discount for *brand name drugs*. Beginning in 2013, the government will begin providing subsidies for brand-name drugs bought by seniors who hit the coverage gap. The government's share will start off small, at 2.5 percent, but will increase to 25 percent by 2020. Beginning in 2011, government subsidies will cover 7 percent of *generic drug* costs. The government will pick up additional portions each year until 2020, when federal dollars will cover 75 percent of generic drug costs. For more information, visit: http://bit.ly/aJf1Be.

***Does the bill eliminate* co-payments and deductibles for mammograms, colonoscopies and other preventive services?**

The new law eliminates co-payments for mammograms, colonoscopies and other preventive screening services. Congress previously eliminated any deductibles for mammograms or colonoscopies. The new law also eliminates deductibles for preventive screenings. This provision goes into effect in 2011.

Will seniors be hurt by the reductions in payments to Medicare Advantage plans?

Medicare Advantage (MA) plans are paid on average 14% more than traditional Medicare; thus Medicare pays these plans over $1000 more per person than traditional Medicare. This overpayment also raises Part B premiums for seniors and the disabled, including those not on MA plans, by $90 per couple a year. The new health care law phases out the overpayment of MA plans over a seven-year period; however, high quality plans will receive bonuses. In addition, the law prohibits Medicare Advantage plans from charging higher co-pays than traditional Medicare, and beginning in 2014, they must spend at least 85% of revenue on medical costs or activities that improve quality of care, rather than profit and overhead. The reduction in overpayment will extend the solvency of the Medicare Trust Fund by 9 years.

Will the $500 billion in Medicare savings impact patient care?

The new health law produces $500 billion in Medicare savings by phasing out the overpayment to MA plans and instituting changes to the Medicare program to make it more efficient. These changes include incentives that encourage doctors and hospitals to coordinating care for individuals, pilot programs that bundle payments to hospitals and rehab facilities and a number of other improvements. These new measures are designed to reward quality rather than quantity and improve patient care. The savings are slated to go back into the Medicare program, including $20 billion to close the doughnut hole, funding to train primary care providers and nurses and bonus payments to providers (i.e., doctors, hospitals, Medicare Advantage plans) that provide good quality care. In fact, a provision in the new health law reaffirms that Medicare's guaranteed

benefits will not be reduced and that any savings generated for the Medicare program will extend the solvency of the Medicare trust fund, reduce Medicare premiums and cost-sharing, and improve or expand guaranteed Medicare benefits or protect access to providers. The new law also reaffirms that benefits guaranteed to Medicare Advantage plan participants will not be reduced or eliminated.

Will there be a cut in reimbursements for imaging services, such as Catscans or MRIs?

There will be a reduction in reimbursements to physicians for the practice expense associated with these machines; however, this will not affect coverage or the availability of imaging services.

Is the extension of the exclusion to the therapy caps included in the new law?

Yes, the new law extends the process allowing exceptions to the limitations on medically necessary therapy to December 31, 2010. If the new health law had **not** been enacted, the combined therapy cap of $1860 per beneficiary for outpatient physical therapy and speech language pathology services would have remained in effect in 2010. This provision allows seniors who require medically-necessary therapy to continue to receive this treatment.

How will Supplemental Insurance or Medigap policy be affected?

For the most part, Medigap policies will not be affected. However, the Department of Health and Human Services (HHS) will request National Association of Insurance Commissioners (NAIC) to revise the standards for benefit packages classified as “C” and “F” so that these packages include nominal cost sharing that encourages the use of appropriate Part B physician services.

There is a shortage of primary care physicians, so won’t the newly-insured overwhelm the system?

The exchange will not be up and running until 2014. Also, the new law provides funding to train primary care physicians and nurses as follows: (1) a total of a$125 million over the next three years in grants to support new or expanded primary care residency programs at teaching health centers and additional funds in the future as deemed necessary to carry out such program. (2) $50 million to establish a demonstration program to increase graduate nurse education training under Medicare for each of the fiscal year 2012 through 2015.

Will the new health care law eliminate the government subsidy to employers who provide Part D coverage?

No, the new health care law only ends the tax deductibility of the subsidy. The government provides a 28% subsidy for prescription drugs, which means companies that provide this benefit only pay 72% of the costs. The new health care law requires companies to stop taking deductions for the government portion of the costs. In other words, businesses were deducting both their costs and the government subsidies for tax purposes. For example, an employer who paid out $100 million in retiree drug benefits would qualify for a $28 million subsidy. The Company’s real expenses were only $72 million in benefits, but it was able to deduct the full $100 million from its taxable income.

Although this part of the law does not take effect until 2013, accounting rules require companies to disclose this to their shareholders now. Thus, it looks like they are taking a hit. Please note that CWA bargaining unit members are protected by their collective bargaining agreements. Also, CWA has a written commitment from AT&T that there will be no changes in the retiree health care plan through 2012.

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 <u>not</u> provide health coverage, is there any other assistance?

Yes. The high-risk insurance pool, which takes effect in 2010, will provide insurance to individuals, who have been denied insurance due to a pre-existing condition, and have been uninsured for six months. Premiums for the pool will be established for a standard population and may vary no more than 4 to 1 due to age. The maximum cost-sharing will be limited to the current Health Savings Account limit ($5,950 and $11,900 family in 2010).

Why do we need a high-risk insurance pool if the law bans insurers from denying coverage to individuals due to a pre-existing condition?

The ban on denying coverage to adults due to a pre-existing goes into effect in 2014 (children in 2010); thus, the high-risk insurance pool is a temporary program created for uninsured *adults* who have been denied coverage due to a pre-existing and have been uninsured for six months. The program expires in 2014.

What is an Insurance Exchange?

An insurance exchange is a marketplace where uninsured individuals and small businesses can compare and shop for affordable high-quality insurance coverage. The new health care law requires states to set up insurance exchanges by 2014. In addition to state exchanges, the U.S. Office of Personnel Management (OPM), which administers the Federal Employees Health Benefit Plan, is required to contract with private insurers and create two multi-state plans in each exchange, including at least one that is run by a non-profit entity. Insurance that is sold on the exchange must meet a minimum level of benefits and be approved by either the states or by OPM. The exchange will allow individuals and small firms to obtain information, compare and purchase private insurance plans.

Are there tax credits to help Individuals purchase insurance?

Beginning in 2014, uninsured individuals will be required to purchase insurance on the exchange. However, tax credits will be provided for those with incomes up 400% of the federal poverty level ($43,320 for an individual and $88,200 for a family of four).

Is there an employer mandate?

No, there is no employer mandate in the bill. However, employers with more than 50 employees will be assessed a fee of $2,000 per full-time employee (excluding the first 30 employees) if they do not offer coverage and at least one of their employee receives a subsidy through the exchange.

When does the ban on pre-existing conditions take effect?

The ban on pre-existing conditions goes into effect in 2010 for children and in 2014 for adults.

What is "age rating" and when does it go into effect?

Age rating is basing premiums on age. The new health care law allows insurers to vary premiums up to a maximum of 3 to 1 ratio. Prior to passage of the new health law, premiums for a single 64 years old typically vary by 5 to 1 and, in some markets, as high 11 to1 the premium of a 19 year old. This provision goes into effect in 2014, the same year the exchange begins to operate.

What is the Medical-loss Ratio and when does it go into effect?

Medical-loss ratio is the percentage of premiums insurers spend on medical care. The new health care law requires that beginning in 2011 individual and small group plans spend 80% of premiums on patient care and that large group plans, including Medicare Advantage plans, spend 85% of their premiums on patient care. Whereas 10 years ago many plans had medical-loss ratios in the high 80s or 90s, today insurance plans have medical-loss ratios in the high 70s or low 80s. They spend the rest of the money on administrative costs, insurance executive pay and profits. In comparison, Medicare spends 97% of beneficiary premiums on patient care and 3% on administrative costs. For more information, please visit: http://bit.ly/mkcsI.

What is the "Cadillac" tax and how does it work?

The "Cadillac" tax is an excise tax of 40 percent on insurance companies and plan administrators for high-cost health insurance plans that are above the threshold of $10,200 for self-only coverage and $27,500 for family plans. The tax would apply to the amount of the premium in excess of the threshold. The threshold would be indexed at the Consumer Price Index (CPI) plus one percentage point for 2019 and CPI for years thereafter. An additional threshold amount of $1,650 for singles and $3,450 for families is available for retired individuals over the age of 55 and for plans that cover employees engaged in high risk professions. Employers with higher costs on account of the age or gender demographics of their employees when compared to the age and gender demographics nationally may adjust their thresholds even higher. This provision goes into effect in 2018, and the costs do not include stand-alone dental and vision benefits.

Is Congress covered by the new law?

Yes, Members of Congress and their Office staff will need to purchase insurance in the exchange in 2014. However, committee staffers and Leadership staffers are exempt, as are federal employees.

What constitutes a small business in the new health care law?

While the Small Business Administration has different definitions of what constitutes a small business based on the industry, for purposes of the new health care law, small business with 100 or fewer employees can participate in the exchange, and those with 25 or fewer employees and annual wages of less than $50,000 will be eligible for the subsidies.

Will the new health care law lower premiums for small businesses?

In the past, small firms have had difficulties expanding or hiring new workers because of crushing health care costs. The new health care law reduces the premiums of small businesses in 4 ways. First, the new health law will create state health insurance exchanges that pool small businesses and their employees with millions of other Americans to increase purchasing power and drive competition in the insurance market. Next, the new law will provide an estimated 3.6 million small businesses who qualify with tax credits to make coverage for their employees more affordable. Also, the new health law ends the "hidden tax" imposed on small businesses, which includes $1,000 added onto every family policy to cover the cost of care for those without insurance. Lastly, the new law will prevent arbitrary premium hikes that are imposed when one or two workers fall ill. The Congressional Budget Office estimates that these measures can reduce single policies for small businesses from 25-28%. According the Business Roundtable's own numbers, the new health law should reduce premiums by $3,000 per person. For more information, go to: http://bit.ly/25SHip.

815 16th Street, N.W., Fourth Floor North · Washington, D.C. 20006 · Tel: (202) 637-5399 · Fax: (202) 637-5398 www.retiredamericans.org