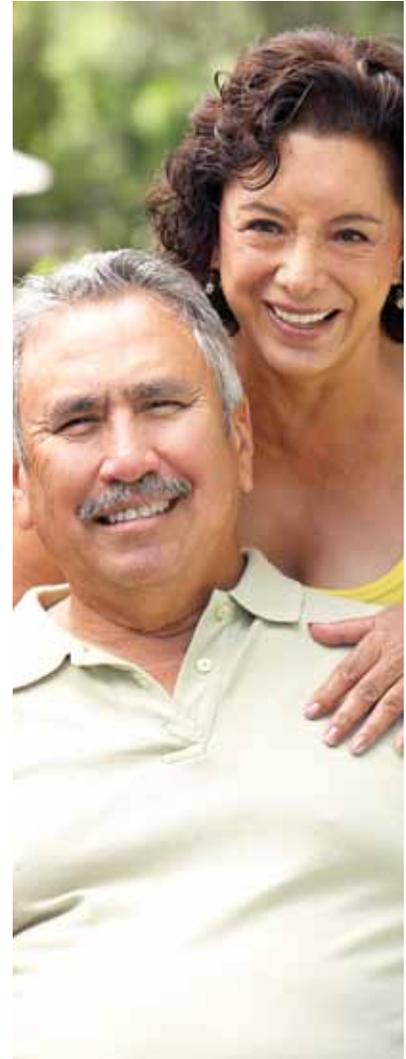


5 Proposed *Changes* to Medicare:

What You Need to Know



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Today, nearly 47 million Americans—including nearly 1 million Wisconsin residents¹—depend on Medicare to help them pay for health care. But Medicare is facing long-term financial challenges.

The problem is simple. Medicare, which is funded by payroll taxes, health premiums, and other sources, is spending more than it takes in.² And costs are expected to rise as the population ages and the costs of care continue to outpace inflation.³

Policymakers in Washington and other stakeholders are approaching the problem from every angle, and several have proposed changes that would alter the program significantly. These proposals include everything from raising Medicare premiums to changing the cost-sharing requirements for Medicare-approved services. Some proposals could take effect almost immediately. Others would change the program slowly over a number of years.

Read on to find out about some of the proposed changes to Medicare that people are talking about today.

¹Kaiser Family Foundation, <http://www.statehealthfacts.org/profileind.jsp?rep=70&cat=6&rgn=51>.

²Martin Crutsinger, "Medicare Paying Out More Than It Takes In." *USA Today*, May 12, 2009. Available at: http://www.usatoday.com/money/economy/2009-05-12-social-security-medicare_N.htm.

³Jeanne Sahadi. "America's Debt Crisis: The Ugly Math of Medicare." *CNN Money*, April 8, 2011. Available at: http://money.cnn.com/2011/04/07/news/economy/medicare_reform/index.htm.

Proposed changes to Medicare include:

1. Increase the age for Medicare eligibility.

Medicare eligibility begins at age 65 for most people without disabilities. Some proposals suggest raising the Medicare eligibility age to 67, and others to as high as 70.⁴ This age increase would phase in slowly over the next several years and not affect current beneficiaries.

Raising the age for Medicare eligibility would reduce Medicare spending modestly, but require 65- and 66-year-olds to find another source of health insurance—such as an employer-based plan, a government plan such as Medicaid, or an individual plan from a private insurance company.

⁴Medicare Rights Center, *Painting a Grim Picture: Deficit-Reduction Proposals That Hurt People with Medicare*, 2011. Available at: <http://www.medicarerights.org/pdf/Deficit-Reduction-Proposal-Fact-Sheet.pdf>.

POSITIVE CHANGES HAPPENING NOW

While the future of Medicare is uncertain, enrollees can look forward to some positive changes today:

- **Expanded preventive care.** The Affordable Care Act (ACA) provides Medicare enrollees expanded coverage for preventive-care benefits, including a variety of screening tests and a fully covered physical exam through the “Welcome to Medicare” program if the exam is scheduled within the first 12 months of signing up for Medicare Part B. Enrollees are also entitled to a personalized intervention plan and an annual wellness visit with no cost sharing.
- **A smaller Part D “donut hole.”** Last year’s 50% discount on brand-name prescription drugs in the donut hole still applies. But this fall (plan year 2013), the donut hole will shrink further as coverage for generic drugs increases by 7% and coverage for prescription drugs rises 2.5%.
- **A focus on quality.** Starting in October 2012, the ACA will promote quality health care for Medicare enrollees by linking hospital payment to quality outcomes. Better-performing hospitals will receive higher reimbursements than lower-performing hospitals.

2. Change Medicare Part A and Part B cost-sharing requirements.

Today, Medicare Part A (hospital insurance) and Part B (doctor insurance) are structured to have different copays and deductibles. In 2012, for example, Part A has a deductible of \$1,156 for inpatient hospital stays and no copay for the first 60 days. Meanwhile, Part B has an annual deductible of \$140, after which beneficiaries are responsible for paying 20% of their costs (coinsurance).

Proposals on the table would redesign Part A and Part B cost sharing so that both share a single deductible (some suggest \$550) and one coinsurance (20%).⁵ In addition, some proposals would place a limit on out-of-pocket costs each year, with higher limits for higher-income beneficiaries. Currently, there is no annual out-of-pocket limit for Part A and Part B costs.

⁵Kaiser Family Foundation, *Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals*, 2011. Available at: <http://www.kff.org/medicare/upload/8124.pdf>.

3. Increase Medicare cost sharing for certain services.

Several proposals under discussion would create new cost-sharing responsibilities for Medicare beneficiaries who receive home health care, care at a skilled nursing facility, and laboratory services such as blood tests and other diagnostics.



One proposal under consideration would charge a copay of \$100 for home health care requiring five or more visits.⁶ This proposal would also charge enrollees a copay for the first 20 days of care in a skilled nursing facility. Several proposals would create a 20% copay for laboratory services such as blood tests and other diagnostics.

Barring federal changes to the benefits offered by Medicare supplement plans, Medicare beneficiaries would likely be able to find some protection from these additional costs by purchasing a supplemental plan.

⁶American Association of Retired Persons, *The Future of Medicare: 15 Proposals You Should Know About*, June 2012. Available at: <http://www.aarp.org/health/medicare-insurance/info-05-2012/future-of-medicare-proposals.1.html>.

4. Offer premium-support options.

Since its start in 1965, Medicare has been a federal government program. But since the 1980s, policymakers and commissions have proposed offering “premium-support” options provided by private health insurance companies.



Under one such proposal, starting in 2023, new Medicare enrollees would receive a fixed amount of money each year (called “premium support” and sometimes referred to as a “voucher”) with which to buy coverage either through traditional Medicare or from private health insurance companies that would compete with Medicare to provide the same basic benefits.⁷ (Previously enrolled beneficiaries would not be affected.) Each year, private insurers and Medicare would submit bids to the government to provide this coverage as affordably as possible. Enrollees would receive a premium-support subsidy equal to the second most affordable plan. The amount of the subsidy would depend in part on the age, income, and health of the beneficiary. Poorer beneficiaries and those in lesser health would receive a greater subsidy than healthier and wealthier people.

If an enrollee were to select a plan that costs more than the subsidy, he or she would be responsible for paying the difference out of pocket. Enrollees who select the least-expensive plan would receive a rebate to be placed in a tax-free health savings account and used to pay for future medical expenses.

⁷Kaiser Family Foundation, *Comparison of Medicare Premium Support Proposals*, 2012. Available at: <http://www.kff.org/medicare/upload/8284.pdf>.

5. Fix or replace Medicare’s physician payment formula.

In 1997, Congress established the “sustainable growth rate” (SGR) formula to help keep Medicare spending on doctors’ payments from growing faster than the nation’s gross domestic product. The formula places limits on the amount of money that doctors who treat Medicare patients can be paid.

For the past several years, the SGR has specified—and Congress has rejected—a reduction in doctors’ fees. Because many doctors who treat Medicare patients already complain about low Medicare reimbursements, many fear that further cuts will cause more and more doctors to refuse to take Medicare patients (resulting in limited access and longer waits for appointments), and may deter would-be doctors from entering the medical profession altogether.

Some proposals suggest placing a freeze on physician payments for 2013 and cutting payments by 1% in 2014.⁸ Other proposals suggest reforming the SGR formula or repealing and replacing it with other means of controlling health care costs.

⁸Kaiser Family Foundation, *Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals*, 2011. Available at: <http://www.kff.org/medicare/upload/8124.pdf>.

What Can You Do?

As our representatives in Washington work to find a balance between controlling the nation's spending and protecting the health and financial security of Medicare beneficiaries, very little is certain. But this we do know: Medicare is going to change. Nobody can say just how or when, but now is the time to pay attention.

The outcome of this debate has the potential to affect you, your family, and every American. It is important that you stay informed and involved. Communicate with your elected representatives and let your voice be heard. You have earned the right to be a part of the discussion that will decide the future of Medicare.



And Speaking of Change . . .

While policymakers in Washington debate the future, you still need to focus on today. The following tips will help you choose wisely and make changes to your current coverage, if need be, to ensure you're protecting your health and retirement savings the very best you can.

1. **You are free to make changes to your Medicare supplement plan at any time.**

Medicare's Annual Enrollment Period has no bearing on your Medicare supplement choices, so you don't have to wait to get the coverage that's right for you.

2. **Read your Annual Notice of Change.**

Because Medicare plans change every year, it's essential to ensure that your current plan still meets your needs. The Annual Notice of Change (ANOC), although it is a lengthy document, is particularly important to read. You should receive this document by Sept. 30. The first section immediately following the cover letter will list the changes to your plan, such as changes in the premium, copays, formulary (for Medicare Advantage and Part D plans), tiers and restrictions, and will compare the benefits in 2013 with those in 2012. With these changes in mind, do some comparison shopping to see if your current plan makes the most financial sense for you.

3. **Make coverage decisions with long-term value and benefits in mind.**

So many people make the mistake of signing up for the lowest-cost plan available, only to be disappointed later, either by high out-of-pocket costs or high rate increases after that initial low rate. What's worse, many end up stuck in inadequate plans because, if their health begins to decline, they are no longer eligible to change to a high-quality Medicare supplement plan that will take care of their medical needs. So look for a plan that will give you the protection you need, both today and many years from now.

The Wisconsin Board on Aging and Long Term Care offers the following advice:

*"Give yourself plenty of time to gather all the information you need to make informed choices in a timeframe that you are comfortable with. Also remember the old adage, **if it sounds too good to be true, it probably is.**"⁹*

4. **Ask an agent for advice.**

As with any important decision, it's best to get help from the experts. Contact an experienced health insurance agent to discuss your situation and get valuable advice so you're well equipped to choose the best coverage for your needs.

⁹The Wisconsin Board on Aging and Long Term Care, 2006. Important Medicare and Part D changes are coming in October [Press Release].

Medicare Questions?

The following agencies are reliable sources for Medicare information.

Centers for Medicare & Medicaid Services (CMS)

Resources and tools to help you learn about Medicare, compare health plans, find doctors and hospitals, and more.

1-800-MEDICARE (1-800-633-4227)

www.medicare.gov

Social Security Administration

To apply for Medicare benefits:

1-800-772-1213

1-800-325-0778 (TTY)

www.ssa.gov

Medicare Rights Center

For help understanding your rights and benefits, navigating the Medicare system, and making the most of your options.

1-800-333-4114

www.medicarerights.org

Wisconsin Office of the Commissioner of Insurance

For help with purchasing insurance, comparing policies that supplement Medicare, making decisions on planning and paying for long-term care, and more.

1-800-236-8517

www.oci.wi.gov