2015:
Your Guide to Health Care Reform and Medicare Changes

Be Happy. Live Healthy.
The Affordable Care Act (ACA) passed in 2010 with three main goals: provide better access to health care, improve quality and consumer protections, and lower health care costs.

For Medicare-eligible people, the ACA protects basic Medicare benefits and improves other benefits. Under the health care reform law, no guaranteed Medicare benefits are cut or eliminated.¹

Over the past four years, the following Medicare benefits have been implemented or enhanced:²⁻⁴

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<td>2010</td>
<td>• Long-term care program starts, reimbursing some costs of home and nursing home care.</td>
<td>• Medicare beneficiaries who reach the Part D coverage gap, or “donut hole,” receive a $250 rebate.</td>
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<td>2011</td>
<td>• Medicare beneficiaries in the “donut hole” receive a 50% discount on brand-name drugs.</td>
<td>• The Annual Enrollment period for seniors changes to Oct. 15 through Dec. 7 (instead of until Dec. 31).</td>
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<td>2012</td>
<td>• Seniors with Medicare can receive key preventive services for no cost.</td>
<td>• A 45-day annual disenrollment period from Jan. 1 through Feb. 14 allows seniors to drop a Medicare Advantage plan and return to Original Medicare.</td>
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<td>2013</td>
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<td>• Seniors can switch to a 5-star Medicare Advantage, Medicare Cost, or Medicare Prescription Drug Plan once from Dec. 8 through Nov. 30.</td>
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<td>2014</td>
<td>• Insurance forms are standardized to reduce error, paperwork, duplication, and administrative costs.</td>
<td>• Quality controls for hospitals and “accountable care organizations” are established.</td>
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<td>2015</td>
<td>• A 3.8% Medicare tax on couples with incomes above $250,000 and individuals with incomes above $200,000 is imposed. An estimated $210 billion will be collected from 2013-2019 to help alleviate health care costs.</td>
<td>• Insurance companies cannot deny coverage to people with pre-existing medical conditions.</td>
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<td>2018</td>
<td>• The 2015 employer mandate ensures that full-time workers at large companies have access to health benefits. Small companies are exempt from this mandate.</td>
<td>• U.S. citizens and legal residents are required to have and maintain health insurance or pay a penalty fine.</td>
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<td>2020</td>
<td>• The coverage gap, or “donut hole,” for Medicare prescription drug benefits will close.</td>
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**DONUT HOLE**

Before 2010, the basic Medicare Part D coverage worked like this:

- You paid out-of-pocket monthly Part D premiums all year.
- You paid 100% of your drug costs, until you reached the $310 deductible amount.
- After reaching the deductible, you'd pay 25% of your drug costs, while your Part D plan paid for the rest, until the total you and your plan spent on your drugs reached $2,800.
- Once you reached the limit, you hit the coverage gap, or “donut hole,” and were responsible for the full costs, 100%, of your drugs until the total spent for your drugs reached the yearly out-of-pocket limit of $4,550.

For those in the donut hole, drug costs were a serious financial challenge. The ACA helps relieve this burden. In 2014, people in the donut hole received a 52.5% discount on brand-name drugs and a 28% discount on generic drugs.

With steadily increasing discounts, the ACA hopes to close the coverage gap by 2020. By then, you will only pay 25% of the costs of your drugs in the coverage gap until you reach the yearly out-of-pocket spending limit.

Below is a chart outlining the Medicare Part D cost sharing for 2015:

### Schedule for Drug Discounts in the Coverage Gap

<table>
<thead>
<tr>
<th>Year</th>
<th>Brand-name drug discount</th>
<th>Generic drug discount</th>
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<tbody>
<tr>
<td>2014</td>
<td>52.5%</td>
<td>28%</td>
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<td>2015</td>
<td>55%</td>
<td>35%</td>
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<tr>
<td>2016</td>
<td>55%</td>
<td>42%</td>
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<tr>
<td>2017</td>
<td>60%</td>
<td>49%</td>
</tr>
<tr>
<td>2018</td>
<td>65%</td>
<td>56%</td>
</tr>
<tr>
<td>2019</td>
<td>70%</td>
<td>63%</td>
</tr>
<tr>
<td>2020</td>
<td>75%</td>
<td>75%</td>
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</table>

After that yearly spending limit, you were only responsible for a small amount, usually 5%, of the cost of your drugs.
PREVENTIVE SERVICES
Since 2011, Medicare beneficiaries receive 100% coverage for preventive services through Medicare. There’s no copay and no deductible requirements. These services enable seniors to take charge of their health and work with their doctors on a plan to stay healthy.

Your annual wellness visit and necessary screenings are covered. Benefits include:
• Abdominal aortic aneurysm screening
• Alcohol misuse screenings & counseling
• Bone mass measurements (bone density)
• Cardiovascular disease screenings
• Cardiovascular disease (behavioral therapy)
• Cervical & vaginal cancer screening
• Colorectal cancer screenings
• Depression screenings
• Diabetes screenings
• Diabetes self-management training
• Glaucoma tests
• HIV screening
• Mammograms (screening)
• Nutrition therapy services
• Obesity screenings & counseling
• One-time “Welcome to Medicare” preventive visit
• Prostate cancer screenings
• Sexually transmitted infections screening & counseling
• Shots: flu, hepatitis B, pneumococcal
• Tobacco use cessation counseling
• Yearly wellness visit

Get these important services and screenings at no cost to you! Call and make an appointment with your doctor today!

Read more about these services and screenings established by the ACA online at www.medicare.gov/coverage/preventive-and-screening-services
In the timeline of ACA changes, 2015 is all about improving quality and lowering health care costs. Beginning Jan 1, 2015, your doctor’s income will be based on the quality of care provided and not on the current fee-for-service payment model, or the quantity of care.

This means that physicians who provide overall higher value care will receive higher payments than those who provide lower quality care. This is great news for you! Doctors have increased incentive to ensure that all of your health needs are being cared for without costly, unnecessary procedures. Talk to your doctor about any changes in your health and work on a plan to stay healthy.

Star Ratings
The Centers for Medicare & Medicaid Services (CMS) use star ratings to rate a plan’s performance in the areas of preventive care, management of chronic conditions, plan responsiveness and care, member complaints and appeals, and customer service. This star rating system allows you to compare plans not only for coverage and cost but also for quality, care, and value. A plan can receive ratings between 1 (poor) and 5 (excellent) stars.

You can compare plans’ star ratings on the www.medicare.gov website. If the plan you’re interested in consistently receives low star ratings, you should review the details of the plan’s ratings more closely and consider switching to a plan with higher ratings.
Additional programs and services

The Affordable Care Act (ACA) provides better access to health care, but there are more great resources and programs you should know about. These programs work with the health care reform to give you additional options and protection for your care. Check out a few of these programs below!

**LONG-TERM CARE**

According to the U.S. Department of Health and Human Services, 70% of people turning age 65 can expect to use some form of long-term care during their lives.\(^\text{10}\) Long-term care is typically not medical care, but the range of services, support, and assistance for basic everyday tasks such as bathing, dressing, and eating.

Medicare only pays for time-limited, medically necessary skilled nursing facility care or home health care if you meet certain conditions.* But you have options. State programs and Medicaid offer long-term services that enable older adults to remain in the community as independently as possible.

**PACE**

The Program of All-Inclusive Care for the Elderly\(^\text{11}\) (PACE) is a Medicare and Medicaid program that allows people who otherwise need nursing home-level care to remain in their own homes. PACE provides a full range of services, such as coverage for prescription drugs, doctor visits, transportation, home care, check-ups, hospital stays, and even nursing home stays when necessary.

Once enrolled in PACE, the amount you pay each month won’t change no matter what care and services you need. There is never a coverage gap, so you’ll always get the care, services, and medication you need. To qualify for PACE, you must meet the following conditions:

- You are 55 years old or older.
- You live in the service area of a PACE organization.
- You are certified by the state in which you live as meeting the need for the nursing home level of care.
- You are able to live safely in the community with the help of PACE services at the time you enroll.

In Wisconsin, as of July 2014, PACE programs are available in Waukesha and Milwaukee. Check online for the availability of a PACE organization in your area, at [www.pace4you.org](http://www.pace4you.org).
ELDER ABUSE

Each year, an estimated 2.1 million older Americans are victims of elder abuse, neglect, or exploitation. For every case of elder abuse that is reported, it’s estimated that another five cases go unreported.

In July 2014, the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) announced the Elder Justice Roadmap, a framework for tackling the highest-priority challenges to elder abuse prevention and prosecution. One of the main goals is to educate everyone on the signs of elder abuse and gain public commitment to support older adults in our communities. This will enable individuals to be better supported and able to remain safe and thrive in their own homes.

For more information, check out the National Center on Elder Abuse online at ncea.acl.gov.
This brochure contains information that may help you understand some of the new rules of health care reform under the Affordable Care Act (ACA). It is intended for informational purposes only and should not be considered legal advice. The information is not specific to WPS policies, but rather intended as general educational material; actual plan details may vary. For detailed information and guidance related to the Affordable Care Act, please talk to your health insurance agent/broker or your WPS representative. In the emerging health care reform era, your agent is likely to become an even more important resource. You can also refer to www.healthcare.gov (the official website for health care reform set up by the U.S. Department of Health and Human Services), your attorney, or your accountant.