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How the Affordable Care Act (ACA) Affects Baby Boomers and Medicare Beneficiaries
Kaiser Family Foundation
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RAKESH SINGH: Hello and welcome to the fifth session in the webinar series for journalists covering health reform. As always, today's session is brought to you by the Foundation's Media Fellowships Program. As a reminder, you can view and listen to an archive version of today's program online along with all previous sessions.

Today's session focuses on how the Affordable Care Act Affects Baby Boomers and Medical Beneficiaries. We have two expert presenters whose full bios are available at kff.org.

Our first presenter is Karen Pollitz, a Senior Fellow at the Foundation working on health reform and private insurance issues. Our second presenter is Juliette Cubanski, an Associate Director of the Foundation's Program on Medicare Policy.

After the brief presentations, you'll be able to ask questions via the chat function on the webinar platform or via phone by first pressing 1 and then 4. Now, without further delay, let me turn it over to Karen Pollitz for her presentation.

KAREN POLLITZ: Thanks Rakesh and hello everyone. Thanks for joining us. I'm going to start by offering a little clarification. When we say baby boomer generation today, when I say it, I'm really focusing on people aged 55 to 64.

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Sometimes, this age group is described as the near elderly but some of us who are now a member of this age group objected to that label. We like baby boomers better. In fact, the boomer generation includes people as young as 49 and as old as 67 but for the first part of today's presentation, I'll be focusing on people who are in the last decade before Medicare eligibility and so still largely relying on private health insurance coverage. This age group is about 38 million people or about 12-percent of the population and as a group, they've got some characteristics that are worth mentioning.

In particular, labor force participation starts to decline after age 55. About 36-percent of boomers report that they are no longer in the labor force compared to less than 20-percent of younger adults. Boomers start to leave the labor force early for a variety of reasons. Those who have done well financially might decide they can retire early. In addition, people may quit working or reduce the hours that they work if their health declines. Health status does decline as we age. The incidence of many chronic conditions such as heart disease, cancer and diabetes increases as we reach our 50s and our 60s. Of course, leaving the labor force has implications for health insurance. For those of you who followed our earlier webinars, you know that most Americans under age 65 get their health insurance through work through employer-sponsored health plans.

What are the health insurance options for boomers if they leave the labor force early before the age of 65? Retiree health benefits are one source of coverage for the boomers but as it turns out, not very many of them. Retiree health coverage has been on the decline for the last 25 years. Most employers do not offer retiree health benefits at all. Those that do tend to be very large firms and public sector government employers. Only about 25-percent of retirees younger than the age of 65 are offered health benefits by their former employers. The affordability of retiree health coverage can change over time as employers look for ways to cut cost. According to the Employee Benefit Research Institute, three-quarters of employers who offer retiree health benefits reported increasing the share of premiums that retirees had to pay from 2011 to 2012 and a third indicated that they had increased cost sharing for their retiree health benefit plans.

Now, I know a lot of reporters have written about people who are offered employer-sponsored health benefits and how that affects their ability to apply for non-group health plans and subsidies in the new exchanges. I just wanted to point out that the rule is different for employer-sponsored retiree health benefits. Boomers should know that eligibility for a retiree health plan offered by a former employer does not disqualify a person from being eligible to shop for coverage on

the exchange or the marketplace or from applying for income-related subsidies. When you first retire and leave your job, if you're offered the choice of retiree health benefits, you can compare that coverage and cost to what is offered on the exchange and pick the deal that is better for you. Boomers who are already retired during this open season can also choose to drop their retiree health coverage and choose exchange coverage and subsidies if that is the better deal for them. Again, that is different than the rule for employer-sponsored coverage offered to active employees.

I have mentioned the non-group market and now, we're going to talk about that. Boomers like any other age group rely on non-group health insurance when they don't have access to job-based health benefits and when they don't qualify for a public program, for example, because they're not yet old enough to enroll in Medicare.

Boomers rely disproportionately on the non-group market. Our survey indicates that about 30-percent of non-group market participants today are aged 55 to 64, and today, this can be a difficult market in which to find coverage particularly for people at this age. Today, the non-group market is medically underwritten. That means people can be turned down or charged more because of their health status and

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that is especially significant for people in this age group who tend to experience more chronic conditions.

Boomers who are in perfect health won't be turned down and may find affordable premiums when they first buy individual health insurance. However, if they need to hold onto that coverage for four or five years and something happens, their health declines, they may see their rates climb at renewal and, because they’re no longer in perfect health, they won't be able to shop around and switch to more affordable coverage.

Even for people in perfect health, premiums are also adjusted by age. Today, many insurers in the non-group market backload their age rating, making only modest adjustments at the early ages -- people in their 30s pay just a little bit more than people in their 20s -- but then applying larger adjustments at the back end so that people in their 60s pay a lot more than people in their 50s.

Today, people in their early 60s can easily pay four to six times what people in their early 20s would be charged for the same coverage. For example, if you want to go online, go to any insurance website today and look at the premiums that they’re charging for policies this year entering different ages for applicants. I looked on eHealthInsurance.com where you can sort policies according to what’s most often sold and found, for example, a Chicago policy offered to 64-year-olds for $300

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a month. That same policy would cost $63 a month for a 21-year-old. That's an age climb of 4.81 and you can see lots of other examples.

The non-group market is also characterized by limited benefits particularly mental health, prescription drugs, rehab after an accident, or a serious illness. These benefits may not be covered or may be limited under non-group policies. This market is also characterized by high cost sharing. Annual deductibles of $7,500 or $10,000 a year per person are not uncommon because that's what it takes to make premiums affordable. For people aged 55 to 64 who have such policies today and who do become seriously ill, the shortcomings of this market can have devastating financial consequences. Finally, this market is unsubsidized so whatever premiums people are paying, they're paying on their own.

The Affordable Care Act will transform the non-group market in ways that will be very important for this generation. Medical underwriting stops in 2014. All policies will be offered on a guaranteed issue basis and premiums will be set according to modified community rating, meaning people can no longer be charged more because of their health status or their health history either at issue or at renewal.

Age rating will also be limited under the ACA. Premiums for people in their early 60s cannot be more than

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three times premiums charged to people in their early 20s. Starting next year, all non-group plans must cover 10 categories of essential health benefits and cost-sharing limits will apply in all plans. Insurers can't require people to pay more than $6,350 a year in deductibles, copays and all other forms of cost sharing combined.

Finally, there will be premium subsidies for those whose income are between the poverty level which is about $11,500 for a single person and about $15,500 for a couple, between that level and four times poverty or about $46,000 for a single person and $62,000 for a couple. The subsidies are on a sliding scale, and they limit what a person has to pay for a benchmark silver plan, a mid-range plan. They limit what people have to pay to no more than a percentage of their income. If your income is near poverty, the formula limits what you would have to pay for that benchmark plans in no more than 2-percent of your income, and at four times poverty, the most you’re required to pay is 9.5-percent of income.

Just one last point about the subsidies that will be different for boomers compared to younger adults. As the name implies, a sliding scale subsidy fades away gradually but the interaction of age rating and the subsidy formula can result in an abrupt cost cliff for boomers just as they pass four times the poverty level and the subsidy stops.

As this chart shows, let me see if I can do this, by the time income reaches four times poverty, the cost of an age-rated premium for the benchmark plan for a young person which is just over $2,500 dollars is much less than the required 9.5-percent of income. It's only 5.5-percent of income so a 21-year-old making four times poverty just pays the full premium and if they earn a little bit more to 401-percent of poverty, they just pay the same premium.

By contrast, for a 64-year-old, the same benchmark plan costs three times as much or just over $7,600. With the ACA premium subsidies, if that 64-year-old earns four times poverty, she isn't required to pay more than 9.5-percent of her income or about $4,366 for that plan. The federal government pays the rest, essentially covering the cost of most of the age rating for her. If her income increases just a little bit to 401-percent of poverty, there is no more subsidy and she would have to pay the entire premium which would take more than 16-percent of her income.

The cliff is even more pronounced for couples. At four times poverty, a married couple would pay 9.5-percent of their income or $5,900 for the benchmark silver plan on average in the US but if they earn just a few hundred dollars more, their cost would jump up to over $15,000 or 25-percent of their income.

Now, this isn’t necessarily going to be a prevalent problem. According to the census, most baby boomers have incomes below four times the poverty level and when income goes higher than that, people generally are eligible for employer-sponsored health coverage. Their income is higher because they’re still working. However, for those who do need non-group coverage, the cost of the silver plan could be unaffordable at least under the ACA standard, well in excess of 8-percent of income. People in this circumstance might shop for bronze or catastrophic plans which will be somewhat cheaper and if they end up not covered, because they can't afford it, they won't owe a tax penalty.

Finally, I would just point out that boomers who have income around four times the poverty level and who need to be in the non-group market will probably want to consult their accountants or their tax advisers on any options that they might have to adjust their income down to four times the poverty level. For example, if they are retired, they might want to reduce their distributions from their 401(k), or if they’re self-employed, perhaps limit their working hours to earn a little bit less because for people who are right on the cusp of four times poverty, lowering your income by a few hundred dollars could save thousands of dollars in health

insurance premiums, and they're going to need to keep an eye on that until they turn 65 and can enroll in Medicare.

That is a good place for me to stop and turn the webinar over to Juliette.

JULIETTE CUBANSKI: Thank you, Karen. I am Juliette Cubanski. I'm an Associate Director of the Program on Medicare Policy here at Kaiser. While a lot of the focus around the new health insurance marketplace is related to what it means for non-elderly people without health insurance or inadequate insurance, there have also been questions about what the new marketplace means for the 52 million people who are ages 65 and older or who have permanent disabilities who also have Medicare. The short answer is nothing but more specifically, here are some answers to five key questions about the marketplaces and people with Medicare.

First thing to know, people with Medicare can and should keep it. They do not need to sign up for marketplace plans and in fact, insurers are not allowed to sell marketplace plans to people they know have Medicare. Moreover, the tax penalty does not apply to people on Medicare because Medicare coverage satisfies the requirement in the Affordable Care Act that people have health insurance coverage or pay a penalty if they go without. People on Medicare are not eligible for premium tax credits since these tax credits can only be used to

purchase marketplace plans and are not available to people on Medicare.

The state and federally run marketplaces are a destination for purchasing private health insurance coverage only. They are not a place for people on Medicare to purchase Medicare Advantage plans, Part D plans or Medigap plans. Medicare beneficiaries can compare their plan options and enroll in a plan if they choose to do so through Medicare's plan finder website or by calling 1-800-MEDICARE or going directly through a Medicare or Medigap plan.

Finally, Medicare's open enrollment period has not changed. There is some overlap with the first open enrollment period for the marketplaces but the Medicare enrollment period runs from October 15th to December 7th.

Although the new health insurance marketplaces were not designed with Medicare beneficiaries in mind, the Affordable Care Act did bring about some changes to the Medicare program. One of the most important changes that millions of people on Medicare will benefit from is the closing of the Medicare Part D donut hole. Just to remind you all of what the donut hole is or was, this is the gap in the Medicare prescription drug benefit where enrollees were responsible for 100-percent of their drug costs until they qualified for catastrophic coverage. The Affordable Care Act is closing this coverage gap

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by gradually reducing beneficiary cost sharing to 25-percent of drug costs in the gap by the year 2020.

In 2014, people on Medicare who are enrolled in Part D plans will pay 47.5-percent of their brand name drug costs and 72-percent of their generic drug costs for prescriptions that they fill when they're in the coverage gap. This gap will begin after an enrollee's total drug cost reaches $2,850, and the gap will end after an enrollee has spent a total of $4,550 out of pocket in 2014.

As of this past September, HHS estimates that more than 6.5 million people with Medicare have saved over $7 billion on prescription drugs as a result of this provision.

In addition to increasing the generosity of the drug benefit, the Affordable Care Act included other improvements in Medicare benefits including better coverage of preventive services by providing for a new annual wellness visit and by eliminating cost sharing for preventive services that are rated A or B by the US Preventive Services Task Force.

Another major focus of the Affordable Care Act relates to delivery system reforms. The law established some new administrative structures and set in motion many programs, pilots and demonstrations that are all intended to improve the quality and efficiency of care for people on Medicare while reducing Medicare program spending. Many of these new ideas

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are emanating from the new Center for Medicare and Medicaid Innovation within the centers for Medicare and Medicaid services. The Innovation Center is authorized to test, evaluate and expand successful payment models that both reduce program spending while also maintaining or improving the quality of care that beneficiaries receive.

Several of these new initiatives are currently underway including accountable care organizations, bundled payments and medical homes. Other efforts to improve care coordination specifically for people dually eligible for both Medicare and Medicaid are also being undertaken. One of the major efforts here is the financial alignment initiative in which CMS and the states are testing ways to better coordinate services and benefits for the Medicare-Medicaid enrollee population.

The Affordable Care Act also included new revenues and Medicare savings that help improve the program's financial outlook. In terms of new revenues, the law expanded income relating of Medicare premiums whereby higher-income people on Medicare pay a higher premium for Part B and Part D. In this context, higher income means individuals with incomes greater than $85,000 and married couples with incomes greater than $170,000. The Affordable Care Act fixed these income thresholds at their current levels through 2019 for Part B premiums. Previously, these thresholds were indexed to

increase each year with inflation. The law added a new income-related premium for the Part D drug benefit. Additional new revenue for Medicare is coming in the form of higher Medicare payroll taxes. The ACA increased the payroll tax by 0.9-percent for higher-income taxpayers on earnings over $200,000 for individuals and $250,000 for married couples.

In terms of savings, a couple of provisions in the ACA are estimated to account for significant Medicare spending reductions over the coming decade. One is that payments to Medicare Advantage plans are gradually being reduced to align more closely with costs under traditional Medicare. Meanwhile, new quality-based bonus payments are being provided to Medicare Advantage plans with higher star ratings.

The second big savings provision is that payments for hospitals and medical providers but not physicians are being reduced by way of a so-called productivity adjustment which will automatically reduce Medicare's annual provider payment update.

The Affordable Care Act also authorized the establishment of a new entity called the Independent Payment Advisory Board which is a 15-member panel charged with recommending Medicare program changes if program spending growth exceeds certain targets but as of yet, no board members have been appointed.

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I want to end by taking a quick bigger picture look at Medicare spending trends and projections since this subject has played a starring role in recent federal deficit and debt reduction discussions. The previous and current trend lines for projected Medicare spending that you see here diverge partly but not entirely due to provisions in the Affordable Care Act. According to a recent analysis by the Congressional Budget Office, some combination of slower growth in Medicare provider payments along with changes in beneficiary age and health status and likely also changes in the delivery of care to beneficiaries have played a role on the recent slowdown of Medicare spending growth.

Questions have been raised about the long-run sustainability of the provider payment adjustments that are called for by the Affordable Care Act, and the lower projections of Medicare spending that you see here assume large cuts in the physician fees on the order of about 25-percent this coming January that will occur due to the physician payment formula known as the Sustainable Growth Rate which was not addressed by the Affordable Care Act. If Congress acts to defer these reductions as they've done on numerous occasions in the past, then Medicare spending will exceed the current projections shown here.

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On the other hand, as I mentioned earlier, the Affordable Care Act did promote the development of many delivery system reforms that are or were untested and while these provisions were not estimated to produce major savings in the law when it passed, if implementation of these policies actually does produce savings then Medicare could experience slower program growth than is currently projected.

I will stop there and turn the webinar back to Rakesh.

RAKESH SINGH: Thank you. Now is your opportunity to ask questions and answers of our experts. I'm going to ask the operator to review the ways to ask questions. You can chat via the webinar platform but you can also queue up by phone.

OPERATOR: Thank you. Ladies and gentlemen, if you'd like to register a question, please press the 1 followed by the 4 on your telephone. You will hear three tone prompts to acknowledge your request. If your question has been answered and you would like to withdraw your registration, please press the 1 followed by the 3. If you'd like to ask a question using the web, please use the chat feature located in the lower left corner of your screen. Our first question comes from the line of Ronald Schwartz with *Remington* from Rhode Island. Please go ahead.

RONALD SCHWARTZ: I am from the *Remington Report*. The question I have is is there anything in the Affordable Care Act

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that relates to the Medigap insurance policies as far as regulation goes? I realize that there was a lot of discussion on how the law affects conventional insurance or even insurance that I guess somebody would purchase before they are 65. One of the problems I see with Medigap insurance is that the prices keep going up and at some point, those premiums equal what you would pay in an open market if you had no Medicare. I'm talking about not just the Medigap but also if you combine that with the Medicare Part D, the drug plan, then you're up maybe over $400 a month. Of course, you're getting the best Medigap policy but I'm sure those are going to be going up with any copayments that are increased such as if a home health copayment is added. Any answer to that as far as the Medigap policies?

JULIETTE CUBANSKI: This is Juliette. No, the Medigap market was not addressed by the Affordable Care Act. You may be familiar with some of the recent proposals to place some restrictions on supplemental coverage including Medigap policies that are being proposed as part of some of the deficit reduction proposal but the issue that you address in terms of the cost of Medigap policies or other Medicare plan premiums were not addressed in the Affordable Care Act.

RONALD SCHWARTZ: Could I have a follow-up? You mentioned that current thinking I guess in Congress is an act

or legislation dealing with Medigap policies. One of them would have a tax on these policies. I don't quite understand what the rationale would be behind that.

JULIETTE CUBANSKI: Well, the rationale behind these policies generally, again this is Juliette, the rationale is that the people who have Medigap policies use more services and cost more to the Medicare program than people without supplemental coverage. The idea would be to restrict the generosity of the so-called first-dollar Medigap policies so that people who have these policies bear more of the financial responsibility for the services that they use.

The premium surcharge is a way of making these people pay a little bit more to make up for the fact that they are using more services than people who don't have supplemental coverage. One of the concerns, of course, is that many of these people buy Medigap policies because they do need services and the Medigap policies provide them with peace of mind in terms of a financial protection that they receive as part of having the policy but this is an ongoing discussion and I don't know what the prospect for these proposals are currently.

RONALD SCHWARTZ: Okay, thanks.

JULIETTE CUBANSKI: You're welcome.

OPERATOR: Ladies and gentlemen, as a reminder, to register a question on the phone, press the 1 followed by the 4 on your keypad.

RAKESH SINGH: I think we're going to take some chat questions now. The first question is from Steve Jordan of the *Omaha World-Herald*. Will the ACA take the money from Medicare and have the effect of reducing Medicare benefits? I know that this was often discussed during debates when the legislation was in Congress. Karen or Juliette, either one of you wants to tackle that?

JULIETTE CUBANSKI: This is Juliette. There is no mechanism for taking savings from Medicare and reducing Medicare benefits as a result. If anything, the Affordable Care Act as I mentioned in my slides had the effect of improving Medicare benefits. I know there has been some concern about the payment reductions for Medicare Advantage plans and the potential impact that that might have on coverage and the availability of Medicare Advantage plans but there is no sense that we're seeing now as a problem. I don't know if one of my colleagues wants to add to that answer.

PATRICIA NEUMAN: This is Tricia Neuman. The Medicare Advantage plans today are able to offer additional benefits but they are required in any case to provide Medicare covered benefit. Even with payments to plans being constrained by the

Affordable Care Act, plans may make changes but they would have to continue to provide all Medicare-covered benefits even if they save extra benefits that they may also provide.

RAKESH SINGH: Related question about financing, Marcia Mercer [misspelled?] asks how might ACA cuts in payments to hospitals under hospital quality control measures affect hospital care Medicare beneficiaries receive?

JULIETTE CUBANSKI: This is Juliette. I don't actually have an answer to that question. I think there is certainly some concern that some hospitals may be less able than other hospitals to absorb these payment reductions but I also know that the Medicare Payment Advisory Commission has looked at hospitals in terms of their ability to absorb payment reductions and I think the evidence suggests that there is some level of greater efficiency that can be gained and that these productivity adjustments might move many hospitals more in that direction but I really do think the verdict is out on the ultimate effects that these provider payment adjustments will have in terms of beneficiary access to care and hospital's ability to deliver quality care to people on Medicare.

RAKESH SINGH: A quick follow-up from Steve Jordan. There will or could be a reduction in Medicare Advantage benefits is his question regarding impact on Medicare benefits from the ACA.

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PATRICIA NEUMAN: This is Tricia Neuman. There may be a change in benefits offered by Medicare Advantage plans from one year to the next. Medicare Advantage plans are still required to offer Medicare-covered benefits but they may make other changes for which they have greater flexibility. For example, plans may make changes if they offer an eyeglass benefit which some do. They may decide to change that benefit, reduce the generosity of that benefit, but they are required to continue to provide Medicare-covered benefits.

RAKESH SINGH: Next chat question, William Gibson, what special impact do you foresee on a state like Florida, a retirement haven with large numbers of people who are retired or nearing retirement age?

KAREN POLLITZ: Sure, this is Karen. I don't live in Florida so I don't know. It may be that there is a greater concentration of these boomer residents who are now looking at the healthcare marketplace, at their plans or at their subsidy options; more residents of Florida who are in this situation compared to other states but the rules generally are the same from state to state. The subsidy eligibility is the same and so forth. I'm not sure if I can come up with anything else that would be specific to Florida off the top of my head.

RAKESH SINGH: I will tell you a related retirement question from Jim Fuquay. How does a person retiring next year

declare their income purposes of the subsidy? What would you enter when filling out an application on the exchange?

KAREN POLLITZ: This is Karen. That's a good question. When people are applying for coverage now for 2014 and applying for subsidies, they will need to estimate what their income will be in 2014. Their subsidies will be based on their 2014 income. If they've already retired, probably a good place to start would be whatever their current monthly income is and then just annualize that for 2014 if they already know for example. If they're drawing early Social Security benefits or if they're taking a distribution from their 401k, they could just see what they're doing in November and December and then just multiply that to come up with a good estimate for their 2014 income. Should their income change during the year, that will be less likely once you retired and locked into an income stream but you never know. You may be getting some investment income, for example, and the market would change. Should your income change during the year, you can go back to the exchange at any time and report that change in your income. If you haven't been receiving subsidies and your income drops, if you're already enrolled in an exchange plan, at that point, you can apply for subsidies going forward. If you've already been receiving subsidies and your income goes up, you can report the change to the marketplace. I'm sorry I keep saying exchange

but they're called marketplaces now, and you can dial back your subsidies going forward for the remainder of the year so that you don't end up taking more than what you should take on the basis of your annual income.

People should do their best I think to project what their income will be for 2014 and then just know that if they do take subsidies, they will need to file a tax return for 2014 in the spring of 2015. They'll have to report what their actual income was and compare that to the subsidy level that they were actually eligible for and if they didn't take enough, they can get an additional tax refund at that point so they can collect the rest when they file their tax return. If they collected too much, they would have to pay it back, a portion of it, or if their income has crossed that threshold that I talked about, four times poverty level, they might have to pay all of it back.

RAKESH SINGH: We have a general question that I'm going to throw out to the presenters to think about as we enter some more specific questions. Michael Tummale [misspelled?] is asking do you have any anecdotes of a boomer who has been affected by the PPACA, and I'm going to let you think about that and discuss it. I'll bring it up later but I'll switch to some specific scenarios that are being asked about.

Robert Powell asks is it possible that high-income earners who are on Medicare be subject to both the higher payroll half and the surtax?

JULIETTE CUBANSKI: This is Juliette. The payroll tax on earnings is the additional 0.9-percent on earnings over $200,000 paid by workers, I assume by surtax the questioner is referring to the income-related premiums for Medicare Part B and Part D which applies to individuals with incomes over $85,000. Yes, it's possible for somebody to pay both the additional payroll tax and the income-related premium.

One thing I would note if somebody is still actively working and they qualify for Medicare and they have coverage through their employer, they can defer enrollment in Medicare Part B and Medicare Part D until they no longer have the offer of coverage from their employer or they retire, and at that point, they would then sign up for Medicare Part B and Part D and start paying those premiums. For somebody who's actively working aged 65 and older and has a group policy through their employer, they don't need to sign up for Part B until they no longer have that employer coverage so they wouldn't be hit with the income-related premium and then at that point, they might not have earnings that are high enough to qualify for the additional payroll tax or the income-related premium. The scenario is possible but it's only about 5-percent of people on

Medicare now who are paying the income-related premium so it's still a relatively small share of people on Medicare who are at that higher-income level.

RAKESH SINGH: Again, feel free to chat your questions to us or queue up on the phone by pressing 1 and then 4. Our next question is from Robert Smith for Karen. Do you have an estimate of how many boomers may take the income cliff dilemma you outlined in your presentation?

KAREN POLLITZ: Hi Robert. It's Karen. No, actually I can't estimate the number of people. Well, it won't be most people by any stretch of the imagination. Most people in this age group according to the census do have incomes below four times poverty, and again, it is generally the case I think at all ages for people who have income above four times poverty. Most often, that's because they're working and earning a good salary and good salary jobs generally also come with group health benefits. It would be a small minority of the baby boomer generation but I couldn't give you a number. Sorry.

RAKESH SINGH: We have a question referring back to some of the discussion previously. Jen Pure [misspelled?] used the healthcare calculator for a family of six. This is a reminder that the foundation has a healthcare premium and subsidy calculator available online where you can estimate what

you will have to pay for a second lowest cost silver plan based on what state you're living in, zip code.

Jen Pure says that I did the healthcare calculator for a family of six. The consequent cost was $28,000 but with a tax subsidy if the income is between 100- and 400-percent of poverty scale. She is asking does that mean a family needs to pay $28,000 first and wait for the end of the year to get the tax refund?

KAREN POLLITZ: This is Karen. No. When people are eligible for premium tax credits, they can elect to receive that in advance. They can take all of it in advance. They would go through a similar calculator with the exchange. They'd be told the dollar amount of subsidy that they're eligible for. If they want, they can take one-twelfth of that each month and request it be paid directly to their health plan and then the health plan will only bill them for the balance of the premium. At the other end, they can wait until the end of the year if they can afford to pay the whole premium upfront now. I think a lot of people won't be able to but maybe they could and then just collect the tax subsidy on their tax return when they file at the end of the year. Or they can do a mix. They could maybe take half of it upfront and collect the other half at year end when they file. There's total flexibility and how much you want to claim in advance.

RAKESH SINGH: I'm going to go back to the more general anecdote question that I mentioned earlier. Michael Tummale asked do you have any anecdotes of a boomer who has been affected by the PPACA which is the acronym for the Affordable Care Act, the full name, and I just throw it out to the experts who presented and also some of our other experts in the room. I'm sure you've heard about specific stories. Are there other scenarios that you want to bring up that you think have been bubbling up for this population?

KAREN POLLITZ: This is Karen. Actually, there was a story that came up that I first heard about a couple of weeks ago that aired on one of the network new channels and then it got a lot of replay in other coverage. It was a woman who's about my age. She was in her mid-50. I think she lived in Florida, and she received a notice from her health plan that it was going to be discontinued at the end of this year. She was only paying about 50 bucks a month for that health insurance, and she was distraught to find that the new policy that they suggested she might want to buy was going to cost something like $500 a month and she was very distressed. She thought she had a great health plan. She described it as having only a $50 copay for services. When I and others started looking this plan up, we realized it wasn't even a health insurance. She didn't have a $50 copay. She had a $50 benefit. That's all

the plan would pay. Anytime she went to the doctor or had any kind of procedure, it would pay $50 and that's it. She owed the rest. That's why it was that inexpensive and in fact, it wasn't a very good deal at all to pay $50 a month. For a plan that had a $50 benefit is actually a really bad deal. This woman was essentially uninsured but she didn't know that she was and when other reporters started calling her and asking her more details about her plan, she put it all together and realized, oh my goodness. I've been in this precarious place all along. I thought I had health insurance and now I realize I don't and at this age, if something happened to me, that would be it. I could lose my house and that would be the end of everything. She also then went online and looked at the subsidy calculator and figured out, because she only earned about $30,000 a year, that she wasn't going to pay anywhere near $500 a month for coverage because she qualified for a premium tax credit.

I think boomers are not unique in finding health insurance coverage complicated and may inadvertently be stepping into coverage in the non-group market that is really very inadequate. Not even health insurance in her case. It doesn't even meet the definition of health insurance under federal law currently and who will be surprised to find that the law will work better for them, that they will get much more

comprehensive protection at a cost that they can afford because the tax credits will help cover the premiums. That's one example and I think there are probably as many examples as there are people. But it is definitely difficult -- just in the press calls that I've been taking the last month -- I think this is a very tricky thing to cover. There are a lot of details that are important to really try to track down when you're hearing about plans that are changing and just going on the information that the individual reports is the case may not be the full and accurate story. So it really is important to try to track these details down and see what's going on.

It's difficult with HealthCare.gov not working so well now to then make the transition to see what else might be available to people and what it might cost. I hear it's getting better and you certainly can use our subsidy calculator on the KFF website which is based on the filed rates of all the plans in all the rating areas to get a pretty good approximation of these levels of assistance that people might be eligible for.

RAKESH SINGH: Related to the scenario now where there is some trouble with the website, does either of our presenters have some other resources that this population, both the baby boomers and Medicare beneficiaries, can turn to get their questions answered?

KAREN POLLITZ: Well, I'll start. We'll go in chronological order. This is Karen. The website I understand is getting better but still a little balky and can take some time. This will vary by state. I think some of the state websites for the marketplace are terrific. Boy, Kentucky is a great place to live these days. They've got a beautiful website, and it works great. It is worthwhile to go online to your own state website or to HealthCare.gov and to try to go through the process. If you do run into trouble, there are assisters in every state. Right on the homepage of HealthCare.gov, one button works great. It will take you right to the assisters and you can just plug in your zip code and it will give you the name and contact information of all the assisters within a designated radius of where you live. It's worthwhile to try to get an appointment to meet with one of these experts. There's also a call center. Every exchange has to have a call center and you can call and try to get your questions answered by phone.

You can begin to shop a little bit on your own for plans. HealthCare.gov will also list all of the plans that are available in your zip code. You'll still then though need to get more information on them. If you haven't gone through the normal process, you're going to have to then research each one. If it's a Blue Cross plan, go to the BlueCross website. If

it’s an Aetna plan, go to the Aetna website, go look it up and see what it offers. You’ll be able to see the posted price knowing that that’s the real price. It’s not going to vary and get higher if you have a preexisting condition but it might get lower if you are eligible for the premium tax credit subsidy. A lot of people are going to be eligible for those subsidies so I really think it is worthwhile to reach out to a navigator or an assister to try to walk through this process.

If you want to try on your own until you can get through on the website, you can do this outside research but just be prepared you’re going to have to sit at the computer for an afternoon to really gather all these information piece by piece.

JULIETTE CUBANSKI: This is Juliette. As far as resources that people on Medicare can turn to for assistance with questions that they might have, Medicare offers some official materials. The Medicare & You handbook that is delivered to every person on Medicare during the open enrollment period has answers to many questions about basic Medicare benefits and what’s covered and cost and plan choices that Medicare beneficiaries confront. The Medicare.gov website has a plan finder that helps walk people through the options that are available in their area. With regard to the Part D drug plan, a person on Medicare can actually type in the list

of drugs that they take and the pharmacy that they prefer to visit to fill their prescriptions and can actually get a list of plans in their area ordered by lowest to highest total annual cost and helps people compare their other plan options including Medicare Advantage plans. This information is also available by calling the 1-800-MEDICARE hotline.

The other important resource for people on Medicare to know about is that every state has a state health insurance assistance program which is specifically designed to help people on Medicare understand their health insurance choices and can help them actually make decisions about their Medicare coverage, whether they want to go into traditional Medicare or sign up for a Medicare Advantage plan, whether they want to sign up for a Part D plan, and can also help with their Medigap plan choices.

Then, there are the local area agencies on aging as well as community events at pharmacies and in other places for people to get help with understanding their Medicare choices. I think it's really important for people to know that there is some fraudulent activity taking place, that people on Medicare may be getting information from fraudulent actors getting them to sign up for plans that they don't need in terms of marketplace coverage or certain coverage that might duplicate what they already have under Medicare. I think for people who

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aren't sure about whether something is official or not, probably the best thing to do is go to one of the official Medicare sources, be it the website or the 1-800-MEDICARE number or seek assistance from the state health insurance programs. We have a list of those on our website, through our "Talking About Medicare" consumer resource, and a list of the state health insurance assistance programs, they're also known as SHIPs, is also available on the www.Medicare.gov website.

RAKESH SINGH: We have a couple of call questions so I'll hand you over to the operator.

OPERATOR: Thank you. Our first question is a follow-up from the line of Ronald Schwartz with *Remington Report* from Rhode Island. Please go ahead.

RONALD SCHWARTZ: Yes. Juliette, you had mentioned that in the Affordable Care Act, there are a number of provisions to conduct research on productivity and cost issues in our healthcare system. My question relates to quality. Is there much effort made to examine the quality of healthcare when desirable productivity is achieved? I suppose one of the examples many of us deal with is if you go to the hospital and say in the ER, chances that you'll see a doctor may be 50/50 or maybe less. I mean the hospital has obviously become more productive. It's been able to have physician assistants and whatever assume these functions that the doctor would have but

what's the impact on quality? Is there any measure of that? I know the emphasis is on reducing cost.

CRISTINA BOCCUTI: This is Cristina Boccuti from Kaiser Family Foundation, and I'm looking into some of the programs from the ACA that are studying ways to reduce spending without affecting the quality or improving quality. With all of these studies which are often called demonstration project or other initiative, there are always included quality thresholds or studies on quality. There is often disagreement about what measures to be used and which are most effective but I have not seen programs that are investigating ways to cut cost without including monitoring of quality within them. I think you asked a bit about other clinical providers other than physicians and I think that that is not part of the demonstration so much but there are clinicians that can bill Medicare when they see Medicare patients which include nurse practitioners and physician assistants.

RONALD SCHWARTZ: Yes. I'm familiar with that.

CRISTINA BOCCUTI: With the quality increases that we were talking about before, in many cases, the providers that are participating in these studies and demonstrations need to find ways to improve quality and that is being measured and documented.

RONALD SCHWARTZ: For example, if a physician sees a patient, they know that they can only spend like 10 minutes with that person today whereas before maybe they spend 20 minutes. It goes down as a plus today because if they're becoming more productive, one wonders where the quality is really judged in cases like that.

CRISTINA BOCCUTI: I see what you're saying. I wanted to make sure that it's clear that Medicare doesn't place time constraints on the amount of time physicians can spend with their patients. These are decisions that the clinician makes about spending that time. Medicare pays for the visits and there are even modifiers that Medicare allows for if the physician determines that he or she needs some extra time. There are some kinds of modifiers but the payment like it is for many fee-for-service providers is for the visit and the amount of time can depend based on the complexity of that visit and then that complexity requires a different billing code. If it's a very complex patient and the physician determines that he or she needs to spend more time, we can bill for complex patient but there are no time constraints.

RAKESH SINGH: Let's move on to the next call question.

OPERATOR: Our next question comes from the line of Jennie Phipps with Bankrate.com from Michigan. Please go ahead.

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JENNIE L. PHIPPS: Hi. Can somebody explain to me what happens to the people who are in states that didn't expand Medicaid, those people who are either not eligible for Medicaid because they're not, in a lot of cases women with children, and they earn—they're the working poor—they earn more than 100-percent of the poverty level but less than 135-percent? How does the subsidy work for them? I mean most of them don't even pay much in the way of taxes so subsidies don't make much sense.

KAREN POLLITZ: This is Karen. The subsidies in the marketplace are for people earning at least the poverty level and up to four times the poverty level. The person you described would be eligible for subsidies. They are indeed administered by the tax system but you don't have to owe taxes in order to pay them. They are refundable tax credits. Even if you don't know anything in taxes, you will have to file a return just to true up everything at the end of the year with the IRS but the IRS will send that money out. Once the marketplace determines that you're eligible, that your income is 100-percent of the poverty level, you will owe no more than 2-percent of that income. If you're a single person, that's going to work out to a premium of about $20 a month that you would have to pay regardless of what your benchmark plan cost whether you're 20 or whether you're 60. That's all you'll have

to pay and then the marketplace will ask the IRS to send the rest of that money to the health plan every month. You'll be billed for your share and you'll just go ahead from there. At the end of the year, you will be required to file a return so that may be new for low income people who aren't used to filing. They don't have a filing requirement. They'll have to file a return just so that they finished up all the paperwork and the IRS knows that they were there and acknowledges that they received this subsidy, matches that information up with what the exchange tells them so that we all know where the money went, where it's supposed to go but they won't owe any taxes. They'll get money back.

JENNIE L. PHIPPS: Those people are making less from the poverty level but not eligible for Medicaid?

KAREN POLLITZ: They're in trouble. Yes, right. People who make less than the poverty level are not eligible for subsidies because again the subsidies start at income of the poverty level and go up from there. If people who earn less than poverty live in a state that hasn't expanded Medicaid, there isn't anything new for them—

JENNIE L. PHIPPS: Who still don't have insurance.

KAREN POLLITZ: Right. They don't have insurance. They won't owe a penalty. There's no penalty for people in that situation but no, they still don't have insurance and

that's why advocates in many states are pushing hard to try to convince state leaders to elect the Medicaid expansion. This was intended to cover about half of the uninsured when the law was passed, and it is turning out to be a problem for very low income people in states that have not elected the Medicaid expansion yet.

RAKESH SINGH: We're going to wrap up after addressing a couple quick questions. One, to access the marketplace, do you have to provide a Social Security number?

KAREN POLLITZ: This is Karen. To make an application to the marketplace, yes. You have to provide a Social Security number. A number of state marketplaces have created what they're calling a window-shopping feature so that you can go online and view all your health plan choices and just begin to get an idea of what's out there before you go to the actual application. HealthCare.gov, which is the marketplace site for the federally-operated marketplaces which is about two-thirds of the states, also has a window-shopping feature although it's not very detailed.

To look at the plans, there is some ability to do that without providing any personally identifiable information. You do have to put in the zip code so you can see what the plans are in your area but to actually apply for a subsidy and actually even to apply to buy on the exchange, you have to

demonstrate that you are eligible to buy on the exchange. People who are not citizens and not legally residing in the United States are not even eligible to buy on the exchange even unsubsidized coverage so to verify your identity and your legal residency, you will be asked for contact information and your Social Security number and then if you proceed to apply for the subsidy for the premium tax credit and cost-sharing subsidy, you'll also be required to submit information about your income for 2014.

RAKESH SINGH: We're going to wrap up with this question from Marcia Mercer. Please address claims that the ACA limits care for people 75 and older such as cancer treatments.

JULIETTE CUBANSKI: This is Juliette. The short answer to that is that is a false claim. There's no restriction on care for people on Medicare.

RAKESH SINGH: Alright. Well, thank you everyone for participating in our webinar today. This is again the fifth in the series. We will have an archived version available with the transcript in the near future and stay tuned for future sessions. Again, please e-mail us some of your ideas or topics you'd like to hear about and we wish you all a good day in the meantime. Thank you.

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