

ANALYZING THE IMPACT OF THE NEW HEALTH CARE REFORM LEGISLATION ON OLDER AMERICANS

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After years of intensive debate, the first comprehensive health care reform bill in decades was signed into law on March 23, 2010. This Article analyzes the impact of the Patient Protection and Affordable Care Act, also known as ObamaCare, on older Americans. Professor Kaplan argues that despite the many changes the legislation makes to the American health care system, the legislation will not likely have a substantial positive effect on older Americans. This Article examines ObamaCare's changes to prescription drug coverage under Medicare Part D, the financing of long-term care, Medicare managed care plans, and employer-provided coverage for early retirees. Professor Kaplan concludes that the basic structure of health care financing for older Americans is left unchanged, but the ultimate impact of ObamaCare on older Americans is still uncertain.

After a year of intensive negotiations, Congressional hearings, White House conferences, nationwide rallies, and contentious town hall meetings, the most significant health care legislation in forty-five years was enacted. The Patient Protection and

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Affordable Care Act,¹ known informally as ObamaCare, makes changes great and small in virtually every important component of the disjointed amalgamation of financing schemes that is commonly described as the American health care “system.”

The new law’s full implications will not be known yet for many years, and much of what has been claimed about the law is sadly overblown or unduly self-congratulatory. The White House, for example, prefers to denominate the 2010 legislation “the Affordable Care Act,”² perhaps to emphasize its expansion of health insurance coverage (at least eventually), but perhaps also to de-emphasize the new law’s role in “patient protection,” where its salutary effects are not quite so apparent. On the other side of the political spectrum, the new law is demonized as a “government takeover” of one-sixth of the U.S. economy, the victory of socialized medicine, and a threat to fundamental freedoms, if not life itself.³

This Article makes no effort to resolve these competing meta-narratives, nor does it try to explicate the interaction of the new law’s multifaceted components and the delivery of health care in physicians’ offices, hospitals, nursing homes, and other health care settings. It seeks instead to analyze the most significant changes that affect older Americans and to examine the policy implications of those changes. The goal here is to consider both the enhancements that have been created and the drawbacks or caveats that are attached to those enhancements. Less heat and more light, in other words, is the objective of this Article.

For example, the projected financing of ObamaCare includes more than a half trillion dollars of cuts to Medicare,⁴ the principal

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

2. See, e.g., *Understanding the Affordable Care Act Introduction*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/introduction/index.html> (last visited Nov. 15, 2010).

3. See, e.g., Press Release, U.S. Representative Steve Buyer, House Democrats Pass Government Takeover of Nation’s Health Care System; Republicans Offered Common Sense Alternative (Nov. 7, 2009), <http://stevebuyer.house.gov/News/DocumentSingle.aspx?DocumentID=154029>.

4. See Memorandum from Richard S. Foster, Chief Actuary, Ctr. for Medicare & Medicaid Servs., Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended 2 at 4 (Apr. 22, 2010), available at <http://graphics8.nytimes.com/packages/pdf/health/oactmemo1.pdf> (Medicare cuts in 2010–2019 estimated at \$575 billion).

health care program for Americans age sixty-five years and older.⁵ To claim that cuts of this magnitude will not have any deleterious effect on the program that most older Americans utilize to pay for the bulk of their medical needs defies common sense. On the other hand, ObamaCare includes several major initiatives that actually *expand* health care benefits for American retirees and near-retirees. How any particular elder will be affected by ObamaCare, therefore, necessarily depends upon whether the increased benefits that this statute provides apply to that person's individual circumstances and whether these increased benefits offset the significant detriments that are also part of ObamaCare.

This Article will first examine the changes regarding prescription drug coverage under Medicare Part D, then the changes regarding long-term care, and then some changes pertaining to Medicare's more general coverages. This Article will not, however, consider the Elder Justice Act that was incorporated into the ObamaCare enabling legislation,⁶ because the provisions of that title deal with the phenomenon of elder abuse rather than health care as such. Similarly, this Article will not examine the various new income tax changes that accompany ObamaCare,⁷ because those changes apply to Americans of any age rather than to older Americans exclusively.

I. Prescription Drugs

One of the most significant categories of medical spending for many older adults is prescription medications.⁸ Unlike hospital charges, the cost of prescription drugs is typically an ongoing expense

5. 42 U.S.C. §§ 1395-1395aaa (2006). *See generally* LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUTSHELL* 56-97, 104-09 (5th ed. 2010) (explaining the current Medicare program).

6. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6703(a)(1)(C), 124 Stat. 119, 782-98 (2010) (to be codified in scattered sections of 42 U.S.C.).

7. *See, e.g.*, Patient Protection and Affordable Care Act, §§ 9001(a), 9004(a), 9005(a)(2), 9013(a), 9015(a)(1)(D), 124 Stat. at 847-55, 868, 870-71; *see also* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §§ 1401-1402, 124 Stat. 1029, 1059-63.

8. FED. INTERAGENCY FORUM ON AGING BELATED STATISTICS, *OLDER AMERICANS 2010; KEY INDICATORS OF WELL-BEING* 51 (2010), *available at* http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2010_Documents/Docs/OA_2010.pdf.

for much of this population.⁹ Most Medicare enrollees have at least one chronic condition,¹⁰ and such conditions generally entail a regular regimen of prescription drugs. Consequently, pharmaceutical coverage is an extremely important issue for older Americans.

Notwithstanding that medical reality, there was no coverage of outpatient prescription medications in the Medicare program during its first four decades.¹¹ Only with the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MPDIMA)¹² did general coverage of such medications become a feature of the Medicare program. Even then, however, the standard coverage was unusually constructed.

A. Origin of the Doughnut Hole

Although there is no one single Medicare Part D drug plan, the majority of the plans offered under this program include key elements of the prototype that is set forth in the enabling legislation.¹³ That prototype consists of four distinct elements as follows, using the dollar parameters established for 2010:¹⁴

9. See generally *Prescription Drugs and the Elderly: Policy Implications of Medicare Coverage*, RAND CTR. FOR THE STUDY OF AGING (1999), http://www.rand.org/pubs/research_briefs/RB5028/index1.html.

10. See Gerard F. Anderson, *Medicare and Chronic Conditions*, 353 *NEW ENG. J. MED.* 305, 305 (2005) (eighty-three percent have at least one chronic condition); see also Kenneth E. Thorpe et al., *Chronic Conditions Account for Rise in Medicare Spending from 1987 to 2006*, 29 *HEALTH AFFAIRS* 718, 723 (2010) (93.4% of Medicare beneficiaries use prescription medicines).

11. See FROLIK & KAPLAN, *supra* note 5, at 86 (stating that outpatient medications were not covered by Medicare before 2006).

12. See generally Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C. and 26 U.S.C.).

13. Elizabeth Hargrave et al., *Benefit Design and Cost Sharing*, MEDICARE PART D 2010 DATA SPOTLIGHT (Kaiser Family Found., Menlo Park, Cal.), Dec. 2009, at 1, available at <http://www.kff.org/medicare/upload/8033.pdf> (sixty percent of plans have an annual deductible); Jack Hoadley et al., *The Coverage Gap*, MEDICARE PART D 2010 DATA SPOTLIGHT (Kaiser Family Found., Menlo Park, Cal.), Nov. 2009, at 1, available at <http://www.kff.org/medicare/upload/8008.pdf> (eighty percent of plans have a coverage gap).

14. See *What is the Outlook for Medicare Part D 2010?*, Q1MEDICARE.COM, <http://www.q1medicare.com/PartD-The-2010-Medicare-Part-D-Outlook.php> (last updated Jan. 10, 2010).

- An annual deductible of \$310,¹⁵ meaning that the first \$310 of prescription drug expenses incurred during the year are the sole responsibility of the enrollee;
- A second tier of \$2520 of annual drug costs, in which the enrollee pays twenty-five percent of the cost incurred;¹⁶
- A coverage gap, known colloquially as the “doughnut hole,” consisting of the next \$3610 of annual drug costs, all of which are paid by the enrollee;¹⁷ and
- A so-called “catastrophic tier” of all remaining drug costs—namely, all annual drug expenses beyond \$6440—of which the enrollee pays only five percent of the cost incurred.¹⁸

This strange configuration has no counterpart in any other health care financing arrangement, public or private, in the United States or elsewhere. It resulted from the interaction of three unrelated political imperatives. First, Medicare’s drug plan needed a fairly low annual deductible to ensure that most participants would see some personal benefit from participating in the program. This imperative itself derived from the failed enactment of a Medicare prescription drug plan in 1988.¹⁹ That plan was repealed the very next year,²⁰ as older citizens vociferously protested its mandatory nature.²¹ As a consequence, any newly enacted Medicare drug plan had to be voluntary.²² And if plan participation had to be voluntary, it was essential that most enrollees receive some tangible benefit from their participation. Consequently, the annual deductible had to be rather minimal.

Second, the distribution of annual drug expenses follows the basic pattern for medical expenses generally—namely, the bulk of pro-

15. 42 U.S.C. § 1395w-102(b)(1) (2006).

16. 42 U.S.C. § 1395w-102(b)(2)(A), (3)(A).

17. 42 U.S.C. § 1395w-102(b)(4)(B).

18. 42 U.S.C. § 1395w-102(b)(4)(A)(i)(II).

19. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 202, 102 Stat. 683, 702–21 (repealed 1989).

20. Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, § 101(a)(1), 103 Stat. 1979.

21. See RICHARD HIMELFARB, *CATASTROPHIC POLITICS: THE RISE AND FALL OF THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988* 96 (1995).

22. See generally Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAT’L ACAD. ELDER L. ATT’YS J. 167, 170 (2005).

grammatic costs are incurred by a minority of program participants.²³ For that minority of participants, however, the incurred costs can be quite large. Accordingly, if Medicare's drug plan were to provide the greatest assistance for those enrollees who needed assistance the most, a "catastrophic" coverage level with a very low co-payment obligation was required. Thus, the prototype's final cost tier has a five percent co-payment requirement with no coverage limit.²⁴ For someone whose annual drug costs are \$20,000, to use an example, the prototype's last coverage tier pays \$12,882 of the costs incurred.²⁵

Finally, the Bush Administration determined that it was willing to commit a stipulated sum towards this new entitlement and no more.²⁶ The combination of a low annual deductible with serious benefits available after that deductible was met, an unlimited catastrophic coverage tier with a low co-payment obligation, and a fixed global budget meant that something had to give. What gave was the gap in coverage between the first tier of drug coverage and the beginning of the catastrophic coverage tier—the infamous doughnut hole.

B. Closing the Coverage Gap

Inasmuch as there was no economic, medical, or theoretical rationale for the Medicare Part D coverage gap, its elimination was an objective of senior advocacy organizations from the moment of its creation,²⁷ and ObamaCare was the vehicle for accomplishing that objective. In a word, ObamaCare "closes" the doughnut hole, though the means by which it does so may leave many older Americans disappointed. ObamaCare could have raised the annual deductible, increased an enrollee's co-payment obligation in the first coverage tier

23. See Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535, 566 (2005).

24. 42 U.S.C. § 1395w-102(c)(4)(A)(i)(II) (2006).

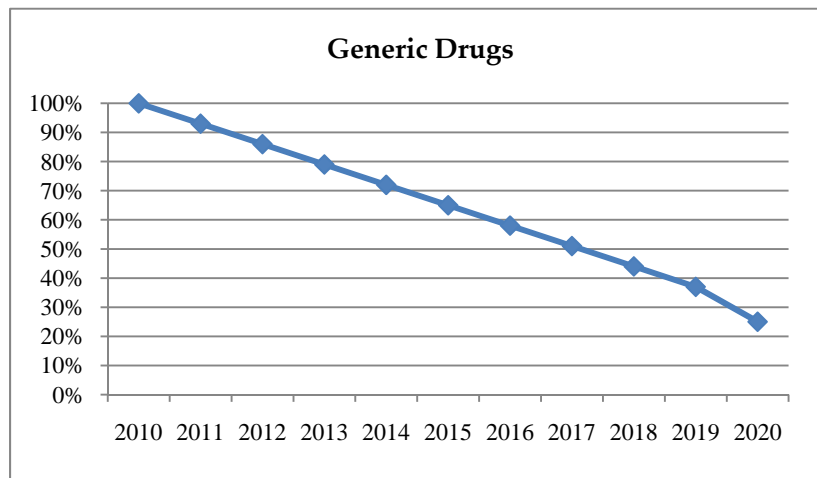
25. Drug costs of \$20,000 - last tier parameter of \$6440 = \$13,560 of covered drug costs × co-payment of 5% = \$678. Thus, Medicare pays the remaining \$12,882 of these covered drug costs.

26. See Thomas Oliver et al., *A Political History of Medicare and Prescription Drug Coverage: Missed Opportunities and Muddled Outcomes* 29 (Sept. 2, 2004) (unpublished manuscript) (on file with American Political Science Association), available at http://www.allacademic.com/meta/p_mla_apa_research_citation/0/6/1/7/6/pages61760/p61760-29.php.

27. See, e.g., *Add a Drug Coverage Option to the Original Medicare Program*, MEDICARE RIGHTS CTR., <http://www.medicarerights.org/issues-actions/add-coverage.php> (last visited Nov. 15, 2010).

above twenty-five percent, or even increased the co-payment obligation in the catastrophic coverage tier above five percent. ObamaCare adopted none of those approaches. Instead, it decreases the enrollee's cost responsibility in the doughnut hole from one hundred percent to twenty-five percent over the next ten years.²⁸ The precise schedule of decreased cost obligation depends upon whether the prescription medications are generic²⁹ or brand-name pharmaceuticals.³⁰ The applicable enrollee co-payment obligations for the next ten years can be shown graphically as follows:

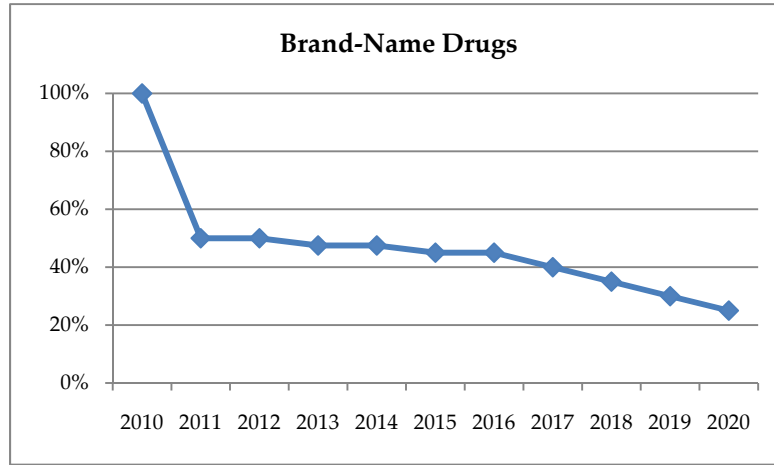
Figure 1



28. See FROLIK & KAPLAN, *supra* note 5, at 90; see also *Health Reform and Medicare: Closing the Doughnut Hole*, MEDICARE RIGHTS CTR. 1 (Apr. 2, 2010), <http://www.medicarerights.org/pdf/Closing-the-Doughnut-Hole-Chart.pdf>.

29. See Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1101(b)(3), 124 Stat. 1029, 1038 (to be codified at 42 U.S.C. § 1395w-102(b)(2)(C)(ii)).

30. See Health Care and Education Reconciliation Act, § 1101(b)(3), 124 Stat. at 1038-39 (to be codified at 42 U.S.C. § 1395w-102(b)(2)(D)(i)(I), (ii)).

Figure 2

From these graphic representations, several key points are clear. First, the doughnut hole does not completely “close.” Rather, the twenty-five percent co-payment obligation of the first coverage tier is extended through what was formerly the doughnut hole. This result is certainly a major improvement for affected enrollees, but at least \$903 at current cost levels will remain the enrollee’s responsibility,³¹ even when the drug coverage gap’s “closing” has fully phased in.

Second, the drug coverage gap’s “closing” phases in very gradually over the ten-year period. For generic drugs, the improvement is only seven percent in 2011,³² and the enrollee continues to pay the majority of the applicable costs until the year 2018. (See Figure 1). As with any governmental program, back-loaded benefits are always subject to subsequent Congressional actions that could delay or even terminate further reductions in the enrollee’s co-payment obligation.³³ The significant decline of twelve percent in an enrollee’s co-payment obligation from 2019 to 2020 is particularly vulnerable in this regard.

Third, brand-name drugs present their own peculiarities. An immediate drop of fifty percent in the enrollee’s co-payment obliga-

31. Current coverage gap of $\$3610 \times \text{co-insurance of } 25\% = \902.50 .

32. See Health Care and Education Reconciliation Act, § 1101(b)(3), 124 Stat. at 1038 (to be codified at 42 U.S.C. § 1395w-102(b)(2)(C)(ii)(I)) (gap is ninety-three percent in 2011).

33. See Kaplan, *supra* note 22, at 170.

tion takes effect in 2011,³⁴ but subsequent declines are very small and slow in coming. (See Figure 2). For example, the co-payment percentage for brand-name drugs does not decline to forty-five percent until the year 2015. Even more anomalously, generic drugs remain more expensive as a percentage of the cost paid by the enrollee until the very end of the phase-in period. That is, the enrollee's co-payment obligation for brand-name drugs is lower than the comparable percentage for generic drugs until they both reach the twenty-five percent level in 2020.

A look behind these decline patterns reveals a potential pitfall of ObamaCare. The declines in the enrollee co-payment obligation are offset in the case of generic drugs by corresponding increases in the Medicare program's payments for these drugs.³⁵ That feature has major implications for Medicare's future budgetary expenditures and possibly for Medicare Part D premiums as well. But with brand-name drugs, the immediate fifty percent decline in the enrollee's co-payment obligation is achieved by imposing "discounts" on the manufacturers of the affected pharmaceuticals.³⁶ Indeed, the Medicare program does not pay any portion of the costs of brand-name drugs in the coverage gap until the year 2013,³⁷ and even then, its proportion of such costs does not exceed ten percent until the year 2018.³⁸ In other words, the reduced burden of brand-name drugs in the coverage gap is achieved primarily by forcing substantial discounts on the manufacturers of those drugs during most of the phased-in "closing" period.

While few older Americans will shed many tears for the affected pharmaceutical companies, it remains unclear what will be the second-order implications of these major price reductions. There may be less advertising of brand-name drugs on the public airwaves, lower executive salaries at the affected firms, or less profit for the shareholders of those firms. But another possibility may be less research money being available to discover and develop the prescription drugs of the

34. *Explaining Health Care Reform: Key Changes to the Medicare Part D Drug Benefit Coverage Gap*, KAISER FAMILY FOUND. 1 (Mar. 2010), available at <http://www.kff.org/healthreform/upload/8059.pdf>.

35. *See id.*

36. *See* Health Care Education and Reconciliation Act, § 1101(b)(2), 124 Stat. at 1037 (to be codified at 42 U.S.C. § 1395w-114A(g)(4)(A)).

37. Health Care Education and Reconciliation Act, § 1101(b)(3), 124 Stat. at 1039 (to be codified at 42 U.S.C. § 1395w-102(b)(2)(D)(ii)(I)).

38. Health Care Education and Reconciliation Act, § 1101(b)(3), 124 Stat. at 1039 (to be codified at 42 U.S.C. § 1395w-102(b)(2)(D)(ii)(IV)).

future. Younger Americans, and even younger retirees, might be seriously disadvantaged if the pharmaceutical companies are less able to pursue future research opportunities. In short, the reduction in Medicare enrollees' co-payment obligations for brand-name drugs comes primarily at the expense of the creators of those drugs—a policy that preferences current program enrollees but may impose unforeseen indirect costs on future generations of Americans, including future Medicare enrollees.

C. Employer Drug Plans

One of the main reasons that the Medicare program did not include coverage of prescription drugs until the enactment of MPDIMA is that many employers provided their retirees with such coverage after retirement.³⁹ Such retiree health plans usually had annual caps on covered expenditures and utilized restricted formularies of covered medications,⁴⁰ but the costs to eligible retirees were quite reasonable, and the transition from employee coverage to retiree coverage was relatively smooth.⁴¹ Well before the enactment of MPDIMA, however, retiree health benefit arrangements were under financial scrutiny and curtailment due to higher health care costs for retirees and accounting requirements, as I explained in a co-authored article entitled *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*.⁴²

Given this trend, a key policy consideration when Medicare Part D was being developed was to ensure that employers did not use the addition of drug coverage to the Medicare program as an excuse to curtail or even terminate their existing retiree drug coverage plans.⁴³ If that happened, affected retirees would need to find some alternative means of paying for their prescription medications.⁴⁴ And if they chose to enroll in Medicare Part D, they would drive up the projected

39. See Kaplan, *supra* note 22, at 176.

40. *Id.* at 180.

41. *Id.*

42. Richard L. Kaplan, Nicholas J. Powers & Jordan Zucker, *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL'Y L. & ETHICS 287, 350–54 (2009).

43. See Patricia Barry, *Anxiety Zone: Will the New Medicare Law Encourage Employers to Drop or Keep their Retiree Drug Plans?*, AARP BULL., Feb. 2005, at 14; Frank B. McArdle et al., *Large Firms' Retiree Health Benefits Before Medicare Reform: 2003 Survey Results*, HEALTH AFFAIRS, Jan. 2004, at W4-7, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.7v1>.

44. In this context, the doughnut hole oddity in Medicare Part D's prototype plan only heightened retirees' anxiety.

cost of that new entitlement program. Consequently, policymakers sought to ensure that employers maintained their existing retiree drug plans.

To that end, MPDIMA authorized a government subsidy payment to employers who continued to provide drug coverage for their retirees.⁴⁵ The amount of this subsidy is twenty-eight percent of the affected beneficiaries' drug costs between two parameters that are adjusted annually for inflation.⁴⁶ In 2010, those parameters were \$310 and \$6300,⁴⁷ so the subsidy payment could be as much as \$1677 per beneficiary per year.⁴⁸ To obtain this subsidy payment, an eligible employer or plan sponsor must prove to the government that its plan has an actuarial value that is at least equal to Medicare Part D's prescription coverage.⁴⁹ Moreover, the subsidy payment is exempt from federal income tax in the hands of the receiving employer/plan sponsor,⁵⁰ thereby increasing its economic value.

ObamaCare does not change these specific provisions, but it does curtail a related tax benefit for affected employers and plan sponsors. Under current law, the employer/plan sponsor is allowed to deduct its cost of providing retiree drug coverage,⁵¹ as it does with any other cost of doing business.⁵² Because these same costs are the basis for a tax-free direct subsidy payment, however, ObamaCare reduces the deduction of these expenses by the amount of the tax-free subsidy payment.⁵³

For example, assume that Employer incurs eligible drug expenses of \$1000 per retiree. The government subsidy to Employer, therefore, is \$280 (\$1000 drug cost \times 28%), and Employer can deduct

45. See Kaplan, *supra* note 22, at 179.

46. 42 U.S.C. § 1395w-132(a)(3)(A) (2006).

47. See *Retiree Drug Subsidy Program: Cost Threshold and Cost Limit by Plan Year*, CTRS. MEDICARE AND MEDICAID SERVS., http://rds.cms.hhs.gov/reference_materials/threshold_limit.htm (last visited Nov. 15, 2010).

48. $\$6300 - \$310 = \$5990 \times 28\% = \1677.20 .

49. 42 U.S.C. § 1395w-132(a)(2)(A) (2006).

50. I.R.C. § 139A (2006).

51. *Id.* (second sentence).

52. I.R.C. § 162(a) (2006).

53. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9012(a), 124 Stat. 119, 868 (2010) (amending I.R.C. § 139A by striking the second sentence); STAFF OF J. COMM. ON TAXATION, 111TH CONG., TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS OF THE "RECONCILIATION ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT" 95 (Comm. Print 2010), available at <http://www.jct.gov/publications.html?func=startdown&id=3673>.

the remaining \$720 of drug expenses, but not the entire \$1000 of eligible drug expenses, as was the case before ObamaCare was enacted.

This provision takes effect for taxable years beginning after 2012,⁵⁴ but some employers have already noted its impact on future income tax liabilities.⁵⁵ Under financial accounting requirements, certain employers are mandated to disclose how this change in federal tax policy affects their financial statements, specifically the projected cost of their retiree drug coverage arrangements.⁵⁶ Clearly, this aspect of ObamaCare increases the employers' cost of maintaining their retiree drug plans. To be sure, eliminating the apparent "double-dipping" of the current law has undeniable aesthetic appeal,⁵⁷ but the inevitable result of this change is to further jeopardize the sustainability of already precarious retiree drug coverage plans. In this respect at least, ObamaCare must be seen as a negative for retirees who receive prescription drug benefits from their former employers.

Interestingly enough, one prominent employer group claims that the federal government will actually *lose* money from this statutory change.⁵⁸ Specifically, the government's "outlays will exceed tax revenue collected if as few as 24% of retirees are moved from employer-sponsored coverage to Part D."⁵⁹ In other words, retirees will lose their employer-sponsored drug benefits, and the federal government will spend more to provide replacement drug coverage for these new Medicare Part D enrollees: lose-lose.

54. Health Care Education and Reconciliation Act of 2010, Pub. L. No. 111-152, § 1407, 124 Stat. 1029, 1067 (amending Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9012(b), 124 Stat. 119, 868).

55. Steven Greenhouse, *Companies Push to Repeal Provision of Health Law*, N.Y. TIMES, Mar. 30, 2010, at B1.

56. See Paul Fronstin, *Implications of Health Reform for Retiree Health Benefits*, EBRI ISSUE BRIEF NO. 338, (Emp. Benefit Res. Inst., Washington, D.C.) Jan. 2010, at 12, available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_01-2010_No338_Ret-Hlth.pdf.

57. Cf. I.R.C. § 265(a)(1) (disallowing deduction of expenses incurred in earning income that is exempt from taxation).

58. See AM. BENEFITS COUNCIL, EMPLOYER-SPONSORED RETIREE DRUG COVERAGE COST ANALYSIS AND FEDERAL REVENUE EFFECTS OF PROPOSED TAX ON RETIREE DRUG SUBSIDIES 1 (2009), available at http://www.appwp.org/documents/hcr_partd_reveffects.pdf.

59. *Id.*

D. High-Income Beneficiaries

One final aspect of ObamaCare and prescription medications is an increased cost component for upper-income Medicare beneficiaries. Following the approach of MPDIMA that increased premiums charged to upper-income enrollees for Medicare Part B,⁶⁰ ObamaCare increases the amount that these same upper-income enrollees must pay for their drug coverage in Medicare Part D.⁶¹ This change is typically described as a reduction in the premium subsidy for upper-income beneficiaries, but the effect on those older Americans who are subject to this provision is the same—namely, an increase in the monthly costs for enrollment in a component of the Medicare program.

Unlike Medicare Part B, however, Medicare Part D plans do not have uniform prices. Every Medicare Part D plan provider establishes its own premiums, and these premiums vary from \$10 to \$120 per month (in 2010),⁶² depending upon the specific contours of the plan's benefits and the scope of its formulary. Accordingly, the increased cost, or reduced subsidy, takes the form of an additional amount that is charged to affected Medicare beneficiaries.⁶³ This additional amount is a percentage of the Medicare Part D program's "base beneficiary premium,"⁶⁴ which is adjusted every year,⁶⁵ generally upwards. The applicable percentages are determined by a given beneficiary's income as calculated for federal income tax purposes according to the following table:⁶⁶

60. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 811(a), 117 Stat. 2066, 2367 (codified at 42 U.S.C. § 1395r(i) (2006)).

61. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3308(a)(1), 124 Stat. 119, 472-73 (2010) (to be codified at 42 U.S.C. § 1395w-113(a)(7)).

62. Jack Hoadley et al., *Part D Plan Availability in 2010 and Key Changes Since 2006*, MEDICARE PART D 2010 DATA SPOTLIGHT (Kaiser Family Found., Menlo Park, Cal.), Nov. 2009, at 9, available at <http://www.kff.org/medicare/upload/7986.pdf>.

63. Patient Protection and Affordable Care Act, § 3308(a)(1), 124 Stat. at 472 (to be codified at 42 U.S.C. § 1395w-113(a)(7)(A), (B)).

64. 42 U.S.C. § 1395w-113(a)(2) (2006); Patient Protection and Affordable Care Act, § 3308(a)(1), 124 Stat. at 472 (to be codified at 42 U.S.C. § 1395w-113(a)(7)(B)(ii)).

65. 42 U.S.C. § 1395w-113(a)(2), (4)(A) (2006).

66. Derived by author based on 42 U.S.C. § 1395w-113(a)(3) and the Patient Protection and Affordable Care Act, § 3308(a)(1), 124 Stat. at 472 (adding 42 U.S.C. § 1395w-113(a)(7)).

Table 1

Annual Income	Percentage
Under \$85,000	None
\$85,001 to \$107,000	137.3
\$107,001 to \$160,000	196.1
\$160,001 to \$214,000	254.9
Over \$214,000	313.7

The full interaction of the federal income tax and Medicare's extra-charges regime is examined in the context of Medicare Part B in my article entitled *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*.⁶⁷ Nonetheless, several key implications should be noted here. First, the dollar parameters shown in the table above apply to unmarried Medicare beneficiaries.⁶⁸ For married beneficiaries, the parameters are doubled.⁶⁹ Thus, no additional charge applies to married couples whose income is less than \$170,000, and the maximum surcharge applies when a couple's income exceeds \$428,000.

Second, the dollar parameters shown in the table above are not adjusted for inflation until the year 2020.⁷⁰ In other words, the parameters shown apply for calendar years 2011 through 2019. Indexation after 2019 is provided by the new law,⁷¹ but such indexation might fall victim to some subsequent Congress's effort to reduce the budgetary impact of the Medicare program. In any case, these parameters are frozen for the next nine years at a minimum. Incidentally, Obama-Care also freezes these dollar parameters until 2020 for the Medicare Part B premium surcharge.⁷²

67. Richard L. Kaplan, *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*, J. RETIREMENT PLAN., May-June 2006, at 22.

68. 42 U.S.C. § 1395r(i)(3)(C)(i) (2006).

69. 42 U.S.C. § 1395r(i)(3)(C)(ii).

70. Patient Protection and Affordable Care Act, § 3402(4), 124 Stat. at 489 (to be codified at 42 U.S.C. § 1395r(i)(6)).

71. 42 U.S.C. § 1395r(i)(5)(A), (2006); Patient Protection and Affordable Care Act, § 3308(a)(1), 124 Stat. at 472 (adding 42 U.S.C. § 1395w-113(a)(7)).

72. Patient Protection and Affordable Care Act, § 3402(4), 124 Stat. at 489 (to be codified at 42 U.S.C. § 1395r(i)(6)).

Third, the income number used in computing this surcharge is a person's "adjusted gross income" for federal income tax purposes plus any tax-exempt interest income received.⁷³ Thus, any economic receipt that increases a person's "adjusted gross income," whether it be an unanticipated capital gain or additional income from converting a retirement plan to a Roth individual retirement account,⁷⁴ will affect that person's cost for Medicare Part D. Moreover, the applicable testing figure is from the second preceding calendar year.⁷⁵ That is, a Medicare beneficiary's income in 2010 will determine the amount of that person's Medicare Part D surcharge in 2012.

As indicated earlier, the concept of means-testing Medicare, or adjusting its benefits according to income, is not new. But ObamaCare extends this concept to Medicare Part D and significantly widens its potential scope by freezing the applicable dollar parameters for a decade. In effect, ObamaCare advances the emerging vision of Medicare as a welfare-oriented program, rather than a social insurance scheme premised on a communitarian notion of equal access to prescribed benefits.

On the other hand, relatively few Medicare beneficiaries will be affected by these new income-based provisions.⁷⁶ Moreover, the contours of this premium surcharge regime are far more generous than the comparable provisions under the federal government's Social Security program. To begin with, those parameters are much lower: \$25,000 for an unmarried Social Security recipient and \$32,000 for married couples.⁷⁷ Furthermore, Social Security's parameters create a marriage tax penalty, because the threshold of \$32,000 for married couples is less than twice the threshold for unmarried beneficiaries, namely \$50,000 ($\$25,000 \times 2$)—unlike the Medicare Part D parameters,

73. 42 U.S.C. § 1395r(i)(4)(A)(i), (ii) (2006).

74. See Kaplan, *supra* note 67, at 27; see also Richard L. Kaplan, *To Roth or Not to Roth: Analyzing the Conversion Opportunity in 2010 and Beyond*, BNA DAILY TAX REP., Sept. 22, 2009, at J-1, J-2, available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1476976.

75. 42 U.S.C. § 1395r(i)(4)(B)(i) (2006).

76. See CTR. FOR MEDICARE & MEDICAID SERV., MEDICARE AND THE NEW HEALTH CARE LAW—WHAT IT MEANS FOR YOU 4 (2010) [hereinafter MEDICARE AND THE NEW HEALTH CARE LAW], available at <http://www.medicare.gov/Publications/Pubs/pdf/11467.pdf> (two percent of Medicare beneficiaries will be affected).

77. See I.R.C. § 86(c)(1)(A), (B) (2006); see also I.R.C. § 86(c)(2)(A), (B) (secondary thresholds of \$34,000 for unmarried beneficiaries versus \$44,000 for married couples).

which are doubled for married beneficiaries. Finally, Social Security's thresholds are not adjusted for inflation and have not been increased since they were enacted in 1983.⁷⁸

Nonetheless, ObamaCare means-testing of Medicare Part D may have unintended consequences that might increase the federal government's financial obligations under this program. Specifically, the upper-income premium surcharge might cause some affected beneficiaries to drop out of the Medicare Part D program or not enroll in it initially.⁷⁹ To be sure, there are significant financial penalties that apply if they subsequently enroll in Medicare Part D,⁸⁰ but these penalties do not apply if those people do not re-enroll in the program. If wealthier Medicare beneficiaries are healthier than the average Medicare enrollee, as is often the case,⁸¹ or are not major users of prescription medications, their absence from the Medicare Part D program might increase the average incurred costs pertaining to the remaining enrollees. As a result, the cost of Medicare Part D to the federal government might be greater than it would have been with a more comprehensive enrollee pool that included upper-income beneficiaries.

II. Long-Term Care

Before ObamaCare was even contemplated, I described the funding of long-term care as "retirement planning's greatest gap."⁸² This appellation reflected the numerous restrictions that Medicare Part A applies before it pays for home health care or nursing home care.⁸³ As a result of these restrictions, the responsibility of paying for long-term care is largely an individual's obligation, shared in some cases by an individual's family but usually on a voluntary basis. Only when an older person exhausts his or her financial resources does the

78. Social Security Amendments of 1983, Pub. L. No. 98-21, § 121(a), 97 Stat. 65, 80-81 (codified at I.R.C. § 86).

79. See Kaplan, *supra* note 67, at 28 (discussing the impact of income surcharges on enrollment in Medicare Part B).

80. 42 U.S.C. § 1395w-113(b)(3)(A) (2006); see also FROLIK & KAPLAN, *supra* note 5, at 88-89.

81. See *Means-Testing of the Medicare Part B Premium*, NAT'L COMM. TO PRES. SOC. SEC. AND MEDICARE (July 2009), http://www.ncpssm.org/news/archive/vp_meanstesting/.

82. Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407, 409 (2007).

83. See *id.* at 416-21.

responsibility for paying for long-term care shift to the government via the Medicaid program.⁸⁴

After the enactment of ObamaCare, the assessment just described remains largely unchanged. The new legislation does address long-term care, however, in two separate and very distinct contexts. First, it creates a new entitlement called Community Living Assistance Services and Supports, or CLASS.⁸⁵ Second, it mandates a range of additional disclosures by long-term care facilities to facilitate better informed individual placement decisions.⁸⁶ This Part examines both of these developments.

A. The CLASS Act Program

The CLASS Act,⁸⁷ as it styles itself, is a self-funded program that is intended to help pay for the full range of long-term care services, with a special emphasis on the less expensive home and community-based alternatives to institutional care settings like assisted living facilities and nursing homes.⁸⁸ For that reason, its benefits are relatively modest—an average of at least fifty dollars per day, according to the enabling legislation.⁸⁹

1. CLASS PROGRAM BENEFITS

Fifty dollars per day will barely put a dent in the cost of skilled nursing facilities that charge, on average, \$206 per day in 2010, with substantial variation among various regions and specific facilities.⁹⁰ But this amount will cover several hours of paid home care and some community-based programs like adult day care.⁹¹ CLASS Act benefits can also be used to modify an elder's personal residence to enable that

84. *See id.* at 422–23.

85. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 8001, 124 Stat. 119, 828 (2010) (to be codified at 42 U.S.C. § 3001l).

86. Patient Protection and Affordable Care Act, § 6101(a), 124 Stat. at 699–702 (to be codified at 42 U.S.C. § 1320a-3).

87. Patient Protection and Affordable Care Act, § 8001, 124 Stat. at 828 (to be codified at 42 U.S.C. § 3001l).

88. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 828 (to be codified at 42 U.S.C. § 3001l(1), (2), (4)).

89. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 831 (to be codified at 42 U.S.C. § 3001l-2(a)(1)(D)(i)).

90. *See* GENWORTH FIN., GENWORTH 2010 COST OF CARE SURVEY 4 (2010), available at http://www.genworth.com/content/etc/medialib/genworth_v2/pdf/ltc_cost_of_care.Par.14625.File.dat/2010_Cost_of_Care_Survey_Full_Report.pdf.

91. *Id.* (median charge for adult day care is sixty dollars per day).

person to continue living at home.⁹² They can even pay a family member who provides caregiving services,⁹³ without necessarily having a formal family caregiving agreement.⁹⁴ In this sense, the CLASS Act is more flexible than long-term care insurance policies that typically have numerous restrictions on the payment of family caregivers,⁹⁵ if they cover such payments at all. CLASS Act benefits can also pay for end-of-life counseling or legal fees to create a living will or a durable power of attorney for health care—expenditures that are not customarily included within the rubric of “long-term care.”⁹⁶

On the other hand, that \$50-per-day minimum benefit is subject to several important caveats. First, the exact amount that any given CLASS program enrollee will receive depends upon that person’s level of impairment, as determined at the time he or she applies for benefits.⁹⁷ Second, the specific design of the CLASS program’s benefits has yet to be determined, and the enabling legislation simply directs that the Secretary of Health and Human Services must develop a schedule of such benefits by October 1, 2012,⁹⁸ though there are no statutory penalties for delayed implementation. Third, once a schedule of CLASS program benefits is developed, the \$50-per-day minimum is the “average” benefit to be paid on the basis of nationally predicted levels of impairment.⁹⁹ Thus, the amount of CLASS benefits for any particular enrollee might be significantly *less* than \$50-per-day, depending upon that person’s level of impairment and the nationally predicted distribution of impairment levels. In subsequent years, however, the benefit amounts are to be increased for inflation.¹⁰⁰

92. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 837 (to be codified at 42 U.S.C. § 300ll-4(c)(1)(B)).

93. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 841 (to be codified at 42 U.S.C. § 300ll-4(g)).

94. See Richard L. Kaplan, *Federal Tax Policy and Family-Provided Care for Older Adults*, 25 VA. TAX REV. 509, 526–34 (2005).

95. See *Long-Term Care Insurance: Do you need it?*, AARP, http://assets.aarp.org/external_sites/caregiving/legalInsurance/insurance.html (last visited Nov. 15, 2010).

96. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 837–38 (to be codified at 42 U.S.C. § 300ll-4(c)(1)(B) (final sentence)).

97. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 831 (to be codified at 42 U.S.C. § 300ll-2(a)(1)(D)(ii)).

98. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 832 (to be codified at 42 U.S.C. § 300ll-2(a)(3) (first sentence)).

99. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 831 (to be codified at 42 U.S.C. § 300ll-2(a)(1)(D)(i)).

100. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 837 (to be codified at 42 U.S.C. § 300ll-4(b)(1)(B)).

2. CLASS PROGRAM ENROLLMENT

The CLASS program is open to anyone, regardless of medical history or pre-existing conditions¹⁰¹—once again, unlike standard long-term care insurance. Moreover, CLASS program premiums are not adjusted for an enrollee’s medical history.¹⁰² Unlike traditional entitlement programs like Social Security and Medicare, however, no one is compelled to enroll in the CLASS program. In the first instance, employers can choose to participate or decline to participate in the CLASS program without facing any penalty for nonparticipation.¹⁰³ If an employer does decide to participate in the CLASS program, all of its employees are automatically enrolled,¹⁰⁴ but individual employees have a right to opt out of the program.¹⁰⁵ Similarly, employees of nonparticipating employers are not part of the CLASS program unless they affirmatively apply to be included.¹⁰⁶ The same mechanism applies to self-employed individuals, who are similarly excluded from the CLASS program unless they affirmatively apply for inclusion.¹⁰⁷

This combination of no medical restrictions on possible enrollment and a less-than-comprehensive pool of enrollees can lead to serious “adverse selection” problems.¹⁰⁸ That is, those employees who are healthiest and least likely to anticipate needing long-term care are most likely to not enroll in the CLASS program. As a result, the in-

101. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 834 (to be codified at 42 U.S.C. § 300ll-2(b)(3)(B)).

102. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 834 (to be codified at 42 U.S.C. § 300ll-2(b)(3)(A)).

103. See Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 834 (to be codified at 42 U.S.C. § 300ll-3(a)(1), (2)(C)).

104. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 834 (to be codified at 42 U.S.C. § 300ll-3(a)(1)).

105. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 834–35 (to be codified at 42 U.S.C. § 300ll-3(b)).

106. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 834 (to be codified at 42 U.S.C. § 300ll-3(a)(2)(C)).

107. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 834 (to be codified at 42 U.S.C. § 300ll-3(a)(2)(A)).

108. See generally MICHAEL D. TANNER, *BAD MEDICINE: A GUIDE TO THE REAL COSTS AND CONSEQUENCES OF THE NEW HEALTH CARE LAW 23–24* (2010), available at <http://www.cato.org/pubs/wtpapers/BadMedicineWP.pdf>; Letter from Am. Acad. of Actuaries, to U.S. S. Comm. on Health, Edu., Labor and Pensions, Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program 1–2, July 22, 2009, available at http://www.actuary.org/pdf/health/class_july09.pdf; Weiwen Ng, *Long-Term Services and Supports: Meeting the Needs of Elders, Families and the Workforce Through Social Insurance* 10 (Nat’l Acad. of Soc. Ins., Working Paper, 2010), available at <http://www.nasi.org/sites/default/files/research/Long%20Term%20Services%20and%20Support.pdf>.

surance concept of spreading the economic risk of incurred expenses may be difficult to effectuate.

This “adverse selection” issue is important to prospective enrollees, because the CLASS program is statutorily mandated to be self-sustaining.¹⁰⁹ That is, no general taxpayer funds are allowed to fund CLASS program benefits.¹¹⁰ If this mandate is followed, CLASS program premiums may need to be raised, perhaps substantially, over time. Such solvency-predicated premium increases are specifically authorized, in fact, by the enabling legislation.¹¹¹ As CLASS program premiums are increased, potential new enrollees may decline to enroll, and some healthier current enrollees may disenroll from the program. The resulting “death spiral” of ever-larger premium increases may ultimately doom the CLASS program,¹¹² thereby jeopardizing the expectations of participating enrollees.

3. PRIVATE INSURANCE ALTERNATIVE

Indeed, many prospective CLASS program enrollees may decide that private long-term care insurance is a more appropriate response to their long-term care cost exposure.¹¹³ I examined that issue in more

109. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 845 (to be codified at 42 U.S.C. § 300ll-7(a)).

110. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 845 (to be codified at 42 U.S.C. § 300ll-7(b)).

111. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 832 (to be codified at 42 U.S.C. § 300ll-2(b)(1)(B)(i)). Enrollees are exempt from solvency-necessitated premium increases if they are at least sixty-five years old and have been enrolled in the CLASS program at least twenty years. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 832-33 (to be codified at 42 U.S.C. § 300ll-2(b)(1)(B)(ii)(I), (II)).

112. See TANNER, *supra* note 108, at 24; see also James C. Capretta & Brian M. Riedl, *The CLASS Act: Repeal Now, or Face Permanent Taxpayer Bailout Later*, BACKGROUND, July 22, 2010, at 3-4, available at http://thf_media.s3.amazonaws.com/2010/pdf/bg2441.pdf; see also Anne Tumlinson et al., *The Circular Relationship Between Enrollment and Premiums: Effects on the CLASS Program Act*, 20 PUB. POL'Y & AGING REP., no. 2, 2010, at 28 (regarding premiums and program participation generally).

113. See generally FROLIK & KAPLAN, *supra* note 5, at 139-56 (describing the standard parameters of private long-term care insurance, the most commonly available policy options, and the federal income tax treatment of such insurance).

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detail recently in *The Journal of Retirement Planning*,¹¹⁴ and the following table summarizes much of that analysis:

Table 2

CLASS	Long-Term Care Insurance
Benefit flexibility and consumer control	Specified coverages
Unknown benefit amount	Stipulated amounts
No lifetime limit	Aggregate dollar or time limit
60-month pay-in	Selected elimination period
No insurability restrictions	Medical preconditions
Ease of application	Medical history investigation
Limited enrollment periods	Open enrollment
One-size-fits-all	Array of optional coverages and choices
Federal guarantee?	State guaranty funds
Premium stability for 20-year enrollees	No limit on premium increases
No coverage for unemployed spouse	Spousal discount
Restart allowed within 5 years	New application after 90-day lapse

4. EMPLOYMENT REQUIREMENT

The choice just posited—namely, the CLASS program or private long-term care insurance—may not be available to certain retirees because of their health history. Indeed, one study found that nearly one of every four Americans age sixty-five would be rejected for private

114. See Richard L. Kaplan, *Financing Long-Term Care After Health Care Reform*, J. RETIREMENT PLAN., July-Aug. 2010, at 7.

long-term care insurance on medical grounds.¹¹⁵ Moreover, the increasing availability of genetic testing might raise that number even higher in the future, because the Genetic Information Nondiscrimination Act of 2008¹¹⁶ does not apply to long-term care insurance.¹¹⁷ If that is the case, the affected elders will have only one option: the CLASS program.

But the CLASS program, as enacted in ObamaCare, may be of little value to most older Americans. The statute limits CLASS program benefits to those enrollees who paid CLASS premiums for at least sixty months¹¹⁸ and who were “actively employed”¹¹⁹ during at least three years of their initial CLASS program enrollment.¹²⁰ As a result, only those older Americans who can meet the “actively employed” requirement for at least three years can receive any CLASS program benefits.

On the other hand, the “actively employed” hurdle is not high. It requires only enough earnings or self-employment income to earn a “quarter of coverage” under the Social Security program.¹²¹ That amount is adjusted annually for inflation and in 2010, it was \$1120.¹²² Accordingly, older Americans who can work part-time during at least three calendar years of their initial enrollment in the CLASS program should be able to qualify for CLASS benefits. They must also be able to pay CLASS premiums as long as they remain in the program.¹²³ The ObamaCare legislation allows these premiums to be augmented to reflect an enrollee’s age (but not that person’s medical condition)¹²⁴

115. Christopher M. Murtaugh et al., *Risky Business: Long-Term Care Insurance Underwriting*, 32 INQUIRY 271, 277 (1995).

116. Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881.

117. See Kathy L. Hudson et al., *Keeping Pace with the Times – The Genetic Information Nondiscrimination Act of 2008*, 358 NEW ENG. J. MED. 2661, 2663 (2008).

118. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 8002(a)(1), 124 Stat. 119, 829 (2010) (to be codified at 42 U.S.C. § 300ll-1(6)(A)(i)).

119. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 828-29, 835 (to be codified at 42 U.S.C. § 300ll-1(2), 300ll-3(c)(3)).

120. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 829 (to be codified at 42 U.S.C. § 300ll-1(6)(A)(ii)).

121. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 829 (to be codified at 42 U.S.C. § 300ll-1(6)(A)(ii)).

122. *Table of Automatic Increases*, SOC. SEC. ADMIN., <http://www.ssa.gov/OACT/COLA/autoAdj.html> (last visited Nov. 15, 2010).

123. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 829 (to be codified at 42 U.S.C. § 300ll-1(6)(A)).

124. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 834 (to be codified at 42 U.S.C. § 300ll-2(b)(3)).

and as noted previously, those premiums may be increased further to maintain the solvency of the CLASS program.¹²⁵ As a result, being able to continue paying CLASS program premiums is not a foregone conclusion—even for persons who can meet the initial employment requirement.

5. EVALUATION

For most older Americans, the CLASS program may be unavailable despite its appealing range of potential benefits. Only if an older person is able to be “actively employed” for at least three years during his or her initial CLASS program enrollment and can continue to pay the likely ever-higher CLASS premiums will that person be able to access the program’s benefits.¹²⁶ In short, the CLASS program does very little for current retirees and other older Americans who have left the compensated workforce. Even near-retirees might find that their greatest cost exposure for long-term care—namely, nursing home expenses—is better met through the instrumentality of private long-term care insurance. Unfortunately, the outdated limits that Medicare Part A places on payment of those expenses¹²⁷ remain untouched by ObamaCare. As a result, most older Americans facing such expenses are in exactly the same situation as they were before the new law was enacted.

B. Nursing Facility Disclosures

Regarding long-term care in nursing homes, the principal contribution of ObamaCare is expanding the quantity of information about such facilities that is available to Medicare beneficiaries. Certain other initiatives promote ethics programs for nursing home employees,¹²⁸ but the main focus of ObamaCare’s nursing home initiatives is to foster better informed consumers.¹²⁹ To that end, nursing

125. Patient Protection and Affordable Care Act, § 8002(a)(1), 124 Stat. at 832 (to be codified at 42 U.S.C. § 300ll-2(b)(1)(B)(i)).

126. See Kaplan, *supra* note 114, at 12 (discussing a person’s ability to re-enroll in the CLASS program following a period of non-enrollment).

127. See Richard L. Kaplan, *Honoring Our Parents: Applying the Biblical Imperative in the Context of Long-Term Care*, 21 NOTRE DAME J.L. ETHICS & PUB. POL’Y 493, 510–13 (2007).

128. Patient Protection and Affordable Care Act, § 6102, 124 Stat. at 702–04 (to be codified at 42 U.S.C. § 1320a-7j).

129. Joshua Wiener, one of the most preeminent analysts of long-term care policy in the United States explains these initiatives as being “based on the notion that

homes must provide additional information to be included in the existing Nursing Home Compare feature that appears on Medicare's website.¹³⁰ This additional information pertains to the following:

- Ownership of the facilities and any affiliated parties;¹³¹
- Governing boards and organization structure;¹³²
- Staffing data for each facility, including how many residents live there, hours of care per day per resident, staff turnover, and their length of service;¹³³
- Summary information about the number of substantiated complaints, their type, severity, and outcomes;¹³⁴
- Adjudicated criminal violations by the nursing facility or its employees, including elder abuse violations that occur outside the nursing facility;¹³⁵ and
- Civil monetary penalties that are levied against the facility, its employees, and its contractors or other agents.¹³⁶

Some of this information is vital when considering a nursing home placement. For example, information on criminal violations relating to elder abuse and neglect speak directly to many of the fears that older Americans express when faced with the prospect of moving to a nursing facility.¹³⁷ While some of this information is available currently, it often is not sufficiently standardized to enable a prospective resident to easily evaluate potential residential facilities. On the

providing more information to consumers and regulators will motivate providers to improve quality." Joshua M. Wiener, *What Does Health Reform Mean for Long-Term Care?*, 20 PUB. POL'Y & AGING REP., no. 2, 2010, at 8, 13-14.

130. See *Nursing Home Compare*, MEDICARE.GOV, <http://www.medicare.gov> (place cursor over the "Resource Locator" link and choose "Nursing Homes" from the menu) (last visited Nov. 15, 2010).

131. Patient Protection and Affordable Care Act, § 6101(a), 124 Stat. at 700 (to be codified at 42 U.S.C. § 1320a-3(c)(2)(C)).

132. Patient Protection and Affordable Care Act, § 6101(a), 124 Stat. at 700-02 (to be codified at 42 U.S.C. § 1320a-3(c)(2)(A)(ii), (iii), (5)(D)).

133. Patient Protection and Affordable Care Act, § 6103(a), 124 Stat. at 704-05 (to be codified at 42 U.S.C. § 1395i-3(i)(1)(A)(i)).

134. Patient Protection and Affordable Care Act, § 6103(a), 124 Stat. at 704-05 (to be codified at 42 U.S.C. § 1395i-3(i)(1)(A)(iv)).

135. Patient Protection and Affordable Care Act, § 6103(a),(b), 124 Stat. at 705, 708 (to be codified at 42 U.S.C. §§ 1395i-3(i)(1)(A)(v)(II), 1396r(i)(1)(A)(v)(II)).

136. Patient Protection and Affordable Care Act, § 6103(a), 124 Stat. at 706 (to be codified at 42 U.S.C. § 1395i-3(i)(1)(A)(v)(III)).

137. See generally U.S. GEN. ACCOUNTING OFFICE, GAO-02-312, NURSING HOMES: MORE CAN BE DONE TO PROTECT RESIDENTS FROM ABUSE (2002).

other hand, the reality is that older people often have few realistic alternatives and may require a nursing home on fairly short notice. The sort of deliberate facility comparison-shopping that the new statute's requirements seem to envision is more typical of assisted living facilities than it is of nursing homes. On the other hand, the requirement that criminal violations and civil penalties must be publicly disclosed may add further bite to these sanctions, thereby enhancing their protective power.

In some cases, however, the information may lead to inappropriate interpretations. For example, the number of hours of care provided per resident depends greatly on the presenting condition of the facility's residents and the intensity of their care needs.¹³⁸ Similarly, the appropriate staffing levels in terms of training requirements depend greatly on the severity of the residents' condition. Only very knowledgeable consumers will be able to deduce the "quality of care" that a nursing facility provides on the basis of information that is to be disclosed.¹³⁹

Other requirements border on information overload. For example, a nursing home must identify every member of its governing body, including that person's title and period of service.¹⁴⁰ Similar requirements apply to a nursing home's officers, directors, trustees, and managers,¹⁴¹ as well as persons who own at least five percent of the home's real estate value.¹⁴² Mandating such disclosures is not a cost-free undertaking, and it is difficult to imagine the likely benefits to be derived by potential consumers from such disclosures that might justify the imposition of these disclosures.

138. See 42 C.F.R § 483.25 (2009).

139. See Patient Protection and Affordable Care Act, § 6103(a), 124 Stat. at 704-05 (to be codified at 42 U.S.C. § 1395i-3(i)(1)(A)(i)(I), (IV)) (requiring disclosures to include "concise explanations of how to interpret the data (such as a plain English explanation of data reflecting 'nursing home staff hours per resident day')" and "an explanation that appropriate staffing levels vary based on patient care mix").

140. Patient Protection and Affordable Care Act, § 6101(a), 124 Stat. at 700 (to be codified at 42 U.S.C. § 1320a-3(c)(2)(A)(ii)(I)).

141. Patient Protection and Affordable Care Act, § 6101(a), 124 Stat. at 700 (to be codified at 42 U.S.C. § 1320a-3(c)(2)(A)(ii)(II)).

142. Patient Protection and Affordable Care Act, § 6101(a), 124 Stat. at 700-01 (to be codified at 42 U.S.C. § 1320a-3(c)(2)(A)(ii)(III), (C)(ii), (5)(A)(ii)).

III. Other Issues

ObamaCare makes a variety of other changes that affect Medicare beneficiaries, and this Part considers some of the more significant changes.

A. Preventative Services

Even before ObamaCare was enacted, Medicare Part B began covering more preventative services, in line with U.S. health care plans generally and in an effort to minimize the need for expensive medical interventions down the road. For example, MPDIMA provided that in the first six months (later amended to the first year)¹⁴³ of a person's enrollment in Medicare Part B, that person is entitled to an "initial preventive physical examination."¹⁴⁴ The purpose of this exam is to promote health and detect diseases before they worsen. Along with various cancer screenings and tests for cardiovascular disease,¹⁴⁵ this examination includes "education, counseling, and referral" services.¹⁴⁶ In 2008, the final year of President George W. Bush's administration, this examination was expanded to include "end-of-life planning," including information about "an individual's ability to prepare an advance directive in the case that an injury or illness causes the individual to be unable to make health care decisions."¹⁴⁷

To this now-expanded examination, ObamaCare adds "annual wellness visits."¹⁴⁸ These visits include a comprehensive risk assessment and a "personalized prevention plan."¹⁴⁹ These services will consider a person's medical and family history,¹⁵⁰ various biometrics

143. Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 101(b)(3), 122 Stat. 2494, 2498 (amending 42 U.S.C. § 1395y(a)(1)(K)).

144. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 611(b), 117 Stat. 2066, 2303-04 (codified as amended at 42 U.S.C. § 1395x(ww)).

145. 42 U.S.C. § 1395x(ww)(2)(B)-(E), (J) (2006).

146. 42 U.S.C. § 1395x(ww)(1) (2006).

147. Medicare Improvements for Patients and Providers Act, § 101(b)(1)(C), 122 Stat. at 2497 (to be codified at 42 U.S.C. § 1395x(ww)(3)(A)). Don't tell Sarah Palin!

148. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4103(b), 124 Stat. 119, 553-55 (2010) (to be codified at 42 U.S.C. § 1395x(hhh)).

149. Patient Protection and Affordable Care Act, § 4103(b), 124 Stat. at 553 (to be codified at 42 U.S.C. § 1395x(hhh)(1)).

150. Patient Protection and Affordable Care Act, § 4103(b), 124 Stat. at 553 (to be codified at 42 U.S.C. § 1395x(hhh)(2)(A)).

such as body mass index and blood pressure,¹⁵¹ cognitive impairments,¹⁵² and a five-to-ten year schedule of screening tests.¹⁵³ These services, moreover, will be provided by the Medicare program at no charge to the enrollee; that is, no deductibles or co-insurance obligations will apply to wellness visits.¹⁵⁴ Such services have long been a touted component of Medicare managed care, and ObamaCare now extends them to the traditional Medicare program. They are an unalloyed improvement that should improve the health of Medicare enrollees and might even reduce Medicare's programmatic expenses down the road.

B. Medicare Managed Care

Regarding Medicare managed care, ObamaCare directs some of its most significant financial changes at Medicare Part C, the managed care component of the Medicare program.¹⁵⁵ Under MPDIMA, so-called "Medicare Advantage" plans were given extra payments and other incentives to expand their enrollment of Medicare beneficiaries.¹⁵⁶ These provisions were generally successful, and the proportion of Medicare beneficiaries who are enrolled in Medicare Advantage plans doubled to the current level of one in four.¹⁵⁷ On average, however, Medicare Advantage costs the federal government approximately fourteen percent more per beneficiary than does the traditional Medicare program.¹⁵⁸ Primarily for that reason, ObamaCare makes major budgetary cuts to Medicare Advantage plans.

151. Patient Protection and Affordable Care Act, § 4103(b), 124 Stat. at 554 (to be codified at 42 U.S.C. § 1395x(hh)(2)(C)).

152. Patient Protection and Affordable Care Act, § 4103(b), 124 Stat. at 554 (to be codified at 42 U.S.C. § 1395x(hh)(2)(D)).

153. Patient Protection and Affordable Care Act, § 4103(b), 124 Stat. at 554 (to be codified at 42 U.S.C. § 1395x(hh)(2)(E)(i)).

154. Patient Protection and Affordable Care Act, § 4103(c)(1), (3), (4), 124 Stat. at 555-56.

155. See 42 U.S.C. § 1395w-21 (2006). See generally FROLIK & KAPLAN, *supra* note 5, at 104-08.

156. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 211, 117 Stat. at 2176-80.

157. See Gold et al., *Plan Enrollment Patterns and Trends*, MEDICARE ADVANTAGE DATA SPOTLIGHT (Kaiser Family Found., Menlo Park, Cal.), June 2010, at 1, available at <http://www.kff.org/medicare/upload/8080.pdf>.

158. See OFFICE OF HEALTH REFORM, DEPT. OF HEALTH & HUMAN SERVS., HEALTH INSURANCE REFORM AND MEDICARE: MAKING MEDICARE STRONGER FOR AMERICA'S SENIORS 1, available at <http://www.healthreform.gov/reports/medicare/medicare.pdf> (last visited Nov. 15, 2010).

Most of the enacted changes are targeted to the plans themselves,¹⁵⁹ and older Americans will generally not see these changes directly. But the overall import of these changes reduces the profit potential of operating a Medicare Advantage plan. To that end, ObamaCare restructures payments to these plans and mandates certain minimum levels of expenditures for patients' medical care via "medical loss ratio[s]."¹⁶⁰ The Obama Administration often emphasizes that Medicare Advantage plans may not discontinue any "guaranteed Medicare benefits,"¹⁶¹ but many of the extra benefits that these plans currently provide to their enrollees, such as vision and dental care, will likely be scaled back or terminated outright.¹⁶² Some Medicare Advantage plans may raise premiums for their enrollees, while others may not renew their participation in the program altogether.¹⁶³ In either case, the result is likely to be higher costs, reduced benefits, and fewer options for enrollees in Medicare managed care arrangements.

What then is the impact of ObamaCare on such arrangements? To some extent, the appeal of Medicare managed care plans was already declining. One of the major attractions of such plans prior to MPDIMA was their coverage of prescription medications,¹⁶⁴ but such coverage is now available through Medicare Part D.¹⁶⁵ And the improvements to the coverage of preventative services in the traditional Medicare program, as explained above, further diminish the comparative advantage of Medicare managed care plans. On the other hand, managed care still offers the prospect of better coordinated care among various medical specialists and related health care providers,

159. See, e.g., Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102(b)-(e), 124 Stat. 1029, 1040-46 (changing applicable payment benchmarks, along with quality rating system).

160. Health Care and Education Reconciliation Act, § 1103, 124 Stat. at 1047 (adding 42 U.S.C. § 1395w-27(e)(4)) (requiring a minimum ratio of eighty-five percent).

161. See, e.g., MEDICARE AND THE NEW HEALTH CARE LAW, *supra* note 76, at 2.

162. See, e.g., Janet Adamy, *Health Law Augurs Transfer of Funds from Old to Young*, WALL ST. J., July 26, 2010, at A1 (reporting that Medicare Advantage plans "are preparing to pare dental, vision and certain prescription-drug coverage").

163. See Avery Johnson, *Private Medicare Plans Are Retrenching*, WALL ST. J., Nov. 19, 2010, at B1 (reporting that as a result of "the federal healthcare overhaul," "health insurers [will] close down certain types of plans," displacing 700,000 current enrollees).

164. See Timothy S. Jost, *Public Financing of Pain Management: Leaky Umbrellas and Ragged Safety Nets*, 26 J. L. MED. & ETHICS 240, 245-96 (1998) (describing the additional prescription drug benefits available with managed care plans).

165. 42 U.S.C. § 1395w-101.

plus an undeniable simplification of recordkeeping for the health care services consumed.¹⁶⁶

But the net result of ObamaCare is undoubtedly negative for Medicare managed care plans and the millions of beneficiaries who currently participate in these arrangements. Many of these beneficiaries may find themselves forced back into traditional Medicare,¹⁶⁷ with the corresponding need to select among an ever-changing array of Part D prescription drug plans and possibly needing to obtain private supplemental “medigap” insurance as well.¹⁶⁸ The impact on their health may be more difficult to assess, but the increase in the complexity of paying for their health care is indisputable.

C. Early Retirees

In the article *Retirees at Risk* that I referenced earlier, my co-authors and I examined the declining reliability of retiree health benefit plans and the effect of this phenomenon on retirees of all ages.¹⁶⁹ As explained in that article, the elimination of retiree health benefits has a particularly devastating impact on retirees who are too young to enroll in Medicare—namely, those under age sixty-five.¹⁷⁰ These so-called “early retirees” frequently have medical conditions that make acquiring health insurance in the individual policy market very expensive or even impossible.¹⁷¹ As a result, these newly uninsured retirees live in fear of some major health care incident that might occur prior to their reaching age sixty-five. That article analyzed various

166. See Melynda Dovel Wilcox, *Choosing a Medicare HMO*, KIPLINGER'S PERS. FIN. MAG., Aug. 1996, at 73, 74.

167. According to projections of the Chief Actuary of the Centers for Medicare and Medicaid Services, half of Medicare Advantage enrollees will lose such coverage by the year 2017. See RICHARD S. FOSTER, ESTIMATED FINANCIAL EFFECTS OF THE 'PATIENT PROTECTION AND AFFORDABLE CARE ACT,' AS AMENDED, CTRS. FOR MEDICARE AND MEDICAID SERVS., OFFICE OF THE ACTUARY 11 (2010), available at http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

For an analysis of this projection on beneficiaries of different ethnicities, income levels, and residential locations, see Robert A. Book & James C. Capretta, *Reductions in Medicare Advantage Payments: The Impact on Seniors by Region*, BACKGROUND, Sept. 14, 2010, available at: http://thf_media.s3.amazonaws.com/2010/pdf/bg2464.pdf.

168. Medigap insurance is usually unnecessary for enrollees in a Medicare managed care plan. See generally FROLIK & KAPLAN, *supra* note 5, at 97–103, 108–09.

169. See Kaplan, Powers & Zucker, *supra* note 42, at 301–32.

170. 42 U.S.C. § 1395(c)(1) (2006).

171. See Kaplan, Powers & Zucker, *supra* note 42, at 342.

options that are available to early retirees,¹⁷² and specifically addressed a then-current proposal to allow retirees as young as age fifty-five to buy into the Medicare program.¹⁷³ ObamaCare did not adopt that approach.

Instead, ObamaCare establishes a “reinsurance” program that essentially uses federal money to reimburse employers who continue to provide health care benefits to their retirees¹⁷⁴ who are age fifty-five through sixty-four.¹⁷⁵ This new financing mechanism is time-limited and disappears in 2014.¹⁷⁶ By then, the state-administered health insurance exchanges that are authorized by ObamaCare for Americans of all ages are expected to be operational.¹⁷⁷ Those exchanges, however, may not be fully responsive to the needs of early retirees and will likely offer insurance that is less comprehensive than the coverage that they had through their former employers.

In any case, the early retiree reinsurance provision is subject to several major limitations. First, it applies only to claims for health care costs incurred between \$15,000 and \$90,000,¹⁷⁸ making the maximum reimbursable claim \$75,000; however, these claim thresholds will be adjusted for inflation each year of the program.¹⁷⁹ Second, the reimbursement rate is eighty percent,¹⁸⁰ so the maximum reimbursement is \$60,000 (maximum claim of \$75,000 × 80%). These tax-free reimbursements,¹⁸¹ moreover, must be used to lower an employer’s cost of the plan or to reduce the enrollees’ premiums, deductibles, or co-payment obligations.¹⁸²

172. *Id.*

173. *Id.* at 342–54.

174. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1102(a)(1), 124 Stat. 119, 143 (2010) (to be codified at 42 U.S.C. § 18002). This program also covers the spouses and surviving spouses of retirees. *Id.*

175. Patient Protection and Affordable Care Act, § 1102(a)(2)(C), 124 Stat. at 144 (to be codified at 42 U.S.C. § 18002(a)(2)(C)).

176. Patient Protection and Affordable Care Act, § 1102(a)(1), 124 Stat. at 143 (to be codified at 42 U.S.C. § 18002(a)(1)).

177. See Patient Protection and Affordable Care Act, § 1311(b), 124 Stat. at 173–74 (to be codified at 42 U.S.C. § 18031(b)).

178. Patient Protection and Affordable Care Act, § 1102(c)(3), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18002(c)(3)).

179. Patient Protection and Affordable Care Act, § 1102(c)(3), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18002(c)(3)).

180. Patient Protection and Affordable Care Act, § 1102(c)(2), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18002(c)(2)).

181. Patient Protection and Affordable Care Act, § 1102(c)(5), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18002(c)(5)).

182. Patient Protection and Affordable Care Act, § 1102(c)(4), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18002(c)(4)).

But the most significant limitation, apart from the short duration of the program itself, is that the maximum cost to the government is set at five billion dollars.¹⁸³ That five billion dollar appropriation is the expenditure cap for the program from its inception, ninety days after enactment of ObamaCare (i.e., June 23, 2010), through its termination on January 1, 2014.¹⁸⁴ Once this sum is exhausted, no further claims will be paid, even though the state-administered health insurance exchanges that are intended to accommodate early retirees (among others) may not be ready to operate. This global cap on program expenditures effectively encourages early submission of claims,¹⁸⁵ which might actually accelerate the reimbursement fund's exhaustion. In point of fact, a recent analysis prepared by the Employee Benefit Research Institute predicted that the reinsurance fund is likely to run out of money after only two years—by the middle of 2012, if not earlier.¹⁸⁶ When that happens, early retirees will be in exactly the same situation as they were before ObamaCare became law. In short, health care coverage for early retirees under ObamaCare remains precarious.

IV. Conclusion

The ObamaCare legislation of 2010 has significant and far-reaching consequences for all Americans, especially older Americans. Persons age sixty-five and older tend to use more health care services than do their younger counterparts, and they have historically been the beneficiaries of extensive government largesse in this regard.

Medicare was created in 1965, and the new legislation makes many changes to that program. Prescription drug coverage, a relatively recent addition to the Medicare program's portfolio, is expanded for those enrollees who have major pharmaceutical expenses, although this coverage expansion requires a full decade to phase in.

183. See Patient Protection and Affordable Care Act, § 1102(e), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18002(e)).

184. Patient Protection and Affordable Care Act, § 1102(a)(1), 124 Stat. at 143 (to be codified at 42 U.S.C. § 18002(a)(1)).

185. See Patient Protection and Affordable Care Act, § 1102(e), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18002(e)) ("Such funds shall be available without fiscal year limitation.").

186. See Paul Fronstin, *The Early Retiree Reinsurance Program: \$5 Billion Will Last About Two Years*, EBRI NOTES, (Emp. Benefit Res. Inst., Washington, D.C.) July 2010, at 7, available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_07-July10.TDFs-Reins.pdf.

The critical area of long-term care is addressed by ObamaCare as well, but through a freestanding, purportedly self-funded entitlement program, apart from and not integrated into Medicare. This new entitlement, in any case, is directed towards younger workers and some near-retirees rather than current retirees, so the fundamental dilemma of how to finance extended long-term care services remains for most older Americans.

Other programmatic changes enhance the value of the basic Medicare program, moving it in a more preventative-focused direction. But the most preventative-focused component of Medicare—namely, its managed care program—is the subject of substantial cost-cutting. The impact of those cuts cannot be predicted with unassailable accuracy, but they are unlikely to be positive, and many Medicare enrollees will probably be required to make major changes in how they receive their medical attention.

More fundamentally, ObamaCare, the most exhaustively considered and far-reaching health care legislation in nearly half a century, left the basic structure of health care financing for older Americans intact. The individual components of Medicare Parts A, B, C, and D are basically unchanged. If anything, the currently fashionable approach of assuring integration of care through a “medical home” has been degraded somewhat by ObamaCare’s treatment of Medicare managed care.

On the other hand, a number of provisions in ObamaCare are designed to change the delivery of health care in important ways that remain to be delineated. The newly created Independent Medicare Advisory Board, for example, is charged with reducing the per capita growth rate of Medicare’s expenditures.¹⁸⁷ When implemented, this Board will make substantive recommendations toward this elusive goal.¹⁸⁸ At the same time, the new statute prohibits the Board from making proposals “to ration health care, raise revenues or Medicare beneficiary premiums, . . . increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.”¹⁸⁹ One is com-

187. Patient Protection and Affordable Care Act, § 3403(a)(1), 124 Stat. at 489 (to be codified at 42 U.S.C. § 1395kkk).

188. On the challenges facing this new Board, see generally Timothy S. Jost, *The Independent Payment Advisory Board*, 363 NEW ENG. J. MED. 103 (2010).

189. Patient Protection and Affordable Care Act, § 3403(a)(1), 124 Stat. at 490 (to be codified at 42 U.S.C. § 1395kkk(c)(2)(A)(ii)) (emphasis added).

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pelled to ask in this context, "What's left?" Whether the Board proposes changes that older Americans will actually see remains very much a mystery at this point. In this respect, as in many others, the ultimate impact of ObamaCare on older Americans is still uncertain.

