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Overview of the Patient Protection and Affordable Care Act

By Robert R. Pohls

I. Introduction

On March 23, 2010, President Barack Obama signed the *Patient Protection and Affordable Care Act* (Affordable Care Act). The measure became law when, on March 30, 2000, he also signed the *Health Care and Education Reconciliation Act of 2010* which had been passed by both the House and the Senate. By many accounts, the resulting law is one of the most sweeping and far-reaching national reform acts since the *Civil Rights Act of 1964*. Indeed, it promises to reform the national health care system in a variety of ways that will impact virtually every member of American society -- personally, financially and/or professionally.

When consolidated with the *Health Care and Education Reconciliation Act of 2010*, the *Affordable Care Act* consumes 954 pages text which implement an ambitious piece of legislation with several objectives. In certain ways, those objectives seem inconsistent with one another. For example, the *Affordable Care Act* seeks to improve the quality of health care while, at the same time, lowering the costs of delivering it. It also seeks to make health care available to more people while, at the same time, ensuring that the government-run programs through which many Americans gain access to it are more financially secure.

Toward those ends, the *Affordable Care Act* calls for numerous insurance reforms and changes in the Medicare and Medicaid programs. It also invests in and creates standards for new care environments. In addition, it changes tax laws by giving certain credits, closing certain loopholes, and imposing new taxes and fees.

While many of the changes mandated by the *Affordable Care Act* are new, others are not. Rather, many of the *Affordable Care Act*'s provisions serve to give life to old ideas and programs that were considered (if not tried) in the past, and some serve only to expand the scope of existing programs. Collectively, though, they promise to re-shape the American health care system – and the way for which Americans pay for their health care – in significant ways.

II. Changes to Private Insurance

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status. Young adults will be allowed to remain on their parent's health insurance up to age 26.

Health insurers will be prohibited from rescinding coverage, except in cases of fraud.

Health insurers also will be prohibited from charging people more based on their health status and gender. Instead, health plan premiums will be allowed to vary based on geographic

area, age (by a 3 to 1 ratio), tobacco use (by a 1.5 to 1 ratio), and the number of family members. In addition, any increases in health plan premiums will be subject to review.

When less than 85 percent of a large group's premium dollars (80 percent for individual and small groups) are used for benefits, health insurers will be required to provide consumer rebates.

All new health plans also will be required to provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage. Nonetheless, health insurers will be prohibited from imposing lifetime limits on coverage, and waiting periods for coverage will be limited to 90 days.

Existing individual and employer-sponsored insurance plans will be allowed to remain essentially the same, except that they are prohibited from rescinding coverage, will be required to extend dependent coverage to age 26, must eliminate annual and lifetime limits on coverage, and must eliminate waiting periods for coverage of greater than 90 days.

III. Health Benefit Exchanges

A temporary national high-risk pool will be established to provide health coverage to individuals with pre-existing medical conditions. That pool will be funded by payments from health insurers in the individual and group markets, but will cease to exist in 2014, when states will create *Health Benefit Exchanges* where individuals and small employers can purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

Small businesses with up to 100 employees can purchase coverage through the exchanges. However, access to the exchanges will be limited to U.S. citizens and legal immigrants.

There will not be a public plan option in the exchanges. Rather, the *Office of Personnel Management* will contract with private insurers to offer at least two multi-state plans in each exchange, including at least one offered by a non-profit entity. In addition, funds will be made available to establish non-profit, member-run health insurance Co-Ops in each state.

Plans in the exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.

Premium subsidies will be provided to families with incomes between 100-400% of the poverty level ($29,327 to $88,200 for a family of four in 2009) to help them purchase insurance through the exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income (for those up to 133% of the poverty level) and 9.5 % of income (for those between 300-400% of the poverty level). Cost-sharing subsidies will also be available to people with incomes between 100-400% of the poverty level to limit out-of-pocket spending.

IV. Employer Requirements

Although there is no employer mandate, employers with 50 or more employees will be assessed a fee of $2,000 per full-time employee (in excess of 30 employees) if they do not offer coverage and if they have at least one employee who receives a premium credit through an exchange. Employers with more than 50 employees that offer coverage but have at least one employee who receives a premium credit through an exchange will be required to pay the lesser of $3,000 for each employee who receives a premium credit or $2,000 for each full-time employee (in excess of 30 employees).

Large employers that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage. In addition, employers that offer coverage will be required to provide a voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 8-9.8% of income to enable them to enroll in a plan in an exchange. Employers that offer a free choice voucher will not be subject to the penalties described above.

V. The Individual Mandate

With some exceptions, all individuals will be required to have health insurance. Those who do not have coverage will be required to pay an annual financial penalty of the greater of $695 per person (up to a maximum of $2,085 per family) or 2.5% of household income. Exceptions will be given for financial hardship and religious objections; to American Indians; to people who have been uninsured for less than three months; to those for whom the lowest cost health plan exceeds 8% of income; and if the individual has income below the tax filing threshold ($9,350 for an individual and $18,700 for a married couple in 2009).

VI. Changes to Medicare and Medicare-Advantage Plans

Medicare beneficiaries will no longer have to pay for Medicare-approved preventive care services. Beginning in 2011, Medicare also will pay for an annual wellness visit, as well as screenings for bone density, diabetes and certain cancers. In addition, Medicare beneficiaries will be able to work with their doctors on a personalized prevention plan to stay as healthy as possible.

When total drug costs exceed a certain amount ($2,830 in 2010), Medicare beneficiaries with Part D coverage fall into the "*doughnut hole*" – a circumstance that requires them to pay the full price for drugs until their total costs are high enough to qualify for catastrophic coverage ($4,550 in 2010). After reaching that level, a Medicare beneficiary is responsible for just 5% of prescription drug costs for the remainder of the year. To help reduce those out-of-pocket costs, Medicare beneficiaries who reach the *doughnut hole* in 2010 will automatically receive a one-time rebate check of $250. In 2011, Medicare beneficiaries will get a 50% discount on brand name drugs and a 7% discount on generic prescription drugs while in the *doughnut hole*. The *doughnut hole* also will gradually narrow until it disappears (in 2020).

Beginning in 2011, pharmaceutical manufacturers will be required to provide a 50% discount on brand-name prescriptions filled when a Medicare beneficiary is in the *doughnut hole*. Federal subsidies for prescriptions of generic drugs also will be phased in.

Primary care doctors and nurses who treat people with Medicare will get 10% bonus payments for providing quality care. In areas with doctor shortages, Medicare will give extra payments to physicians and nurses who provide primary care.

People with a Medicare Advantage plan for 2010 will continue with the same plan through the end of 2010. Thereafter, they will have a choice between either a Medicare Advantage plan or "original" Medicare.

The *Medicare Payment Advisory Commission* (MedPAC) has estimated that Medicare paid Medicare Advantage plans 14 percent (or an average of $1,000 per person) more for health services than was paid under original Medicare, without any measured difference in health outcomes. Much of the cost associated with those overpayments is thought to have been passed on to the 77 percent of senior citizens who are not enrolled in a Medicare Advantage plan in the form of increased premiums.

Starting in 2011, Medicare Advantage plans cannot charge more than Original Medicare for certain services, including chemotherapy administration, renal dialysis, and skilled nursing care. Beginning in 2012, though, Medicare also will start to reduce the subsidies historically paid to the private companies that offer Medicare Advantage plans so that payments will be more comparable with Original Medicare.

Plans may differ in how they respond to the lower subsidies. For example, some plans may drop extra services such as eyeglasses and gym memberships. Other plans may raise their premiums and co-payments. Some may even decide to leave the Medicare program altogether. In October 2010, then, each person in a Medicare-Advantage plan will receive a notice that identifies any that will be made to the plan for 2011. Other information will be available on a new website: *Medicare Options Compare* (www.medicare.gov/MPPF/).

The *Centers for Medicare & Medicaid Services* (CMS) will separately develop a rating system for Medicare Advantage plans. Starting in 2012, plans to which CMS gives at least four out of five stars will receive bonus payments for providing better quality care. However, those plans are required to use some of the bonus money to give extra benefits and rebates to people participating in the plans.

To ensure that Medicare more accurately accounts for productivity, the Affordable Care Act seeks to promote providers' efficiency while maintaining high quality of care. To that end, Medicare Advantage plans will be prohibited (as of 2014) from spending more than 15 cents of each premium dollar on administrative expenses.

VII. Expansion of Medicaid

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) based on modified adjusted gross income.

This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a limitation of the program that prohibits most adults without dependent children from enrolling in the program today. As under current law, undocumented immigrants will not be eligible for Medicaid. Eligibility for Medicaid and the *Children's Health Insurance*

Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level who do not have access to employer-sponsored insurance will obtain coverage through the newly created state health insurance exchanges.

The federal government will fully fund the costs of those who become newly eligible for Medicaid for years 2014 through 2016, 95% of the costs for 2017, 94% of the costs for 2018, 93% of the costs for 2019, and 90% of the costs for 2020 and subsequent years. States that have already expanded adult eligibility to 100% of the poverty level will receive a phased-in increase in the *Federal Medical Assistance Percentage* (FMAP) used in determining the amount of Federal matching funds for certain state expenditures for non-pregnant childless adults.

Through a *Community First Choice Opion*, states will be allowed to offer community-based attendant support services to certain people with disabilities through Medicaid, rather than institutional care. A S*tate Balancing Incentive Program* will provide enhanced federal matching payments to increase non-instutionally based long term care services.

Medicaid payments to primary care doctors for primary care services will be increased to 100% of Medicare payment rates in 2013 and 2014. They also will be fully funded by the federal government.

VIII. Fighting Waste, Fraud and Abuse

The *Affordable Care Act* provides CMS with $350 million in new resources for anti-fraud activities, as well as significant flexibility with respect to how those resources may be used.

CMS will have new tools for screening providers as they enter Medicare and periodically re-screening them. Those tools include criminal background checks, on-site visits, and the imposition of probationary periods with enhanced review of claims submitted to Medicare. Certain providers and suppliers also can be required to post surety bonds, depending on the volume of their billings to Medicare and their level of risk.

CMS also will be given authority to combat fraud in targeted geographic areas, provider types and services that involve higher levels of risk or over-utilization. New technologies will be made available to help CMS monitor and address those issues. CMS may use data analysis to identify areas for which pre-payment review will be required. Depending on the threat, it also may suspend payments on the basis of credible allegations of fraud.

In order to receive home health care or durable medical equipment (DME), a patient will be required to have a face-to-face encounter with their physician (or another professional). Providers who refer a patient for home health of DME must enroll in Medicare. The *Affordable Care Act* also accelerates CMS's requirement of competitive bidding for DME.

Toward the end of protecting beneficiaries from harm and ensuring that entities which commit wrongs are held accountable, information about nursing home ownership will be made more transparent. Likewise, to prevent inappropriate relationships which could compromise patient care, there will be new transparency requirements for the relationships between pharmaceutical companies and both physicians and pharmacy benefit managers.

All providers will be required to have compliance plans to ensure that they are following Medicare's requirements.

IX. Improving the Quality of Care

In 2013, CMS will expand payments for value to reward better care for five of the most prevalent conditions. Payments to physicians also will become more closely linked to value by a *physician value-based system* and a *value-modifier* that rewards physicians who deliver better care. Similar programs will be initiated for other Medicare providers, such as skilled nursing facilities, home health care providers, hospice care, rehabilitation hospitals and ambulatory surgery centers.

A *hospital readmissions reduction program* will reward hospitals that are successful in reducing avoidable readmissions. It also will impose payment penalties on facilities with the highest rates of hospital acquired conditions (*e.g.*, bedsores, injuries from falls, and complications from extended use of catheters).

A new *bundled payment system* will combine payments for dialysis related services and supplies provided to patients with end stage renal disease.

The *Affordable Care Act* also establishes a non-profit *Patient-Centered Outcomes Research Institute* to research the effectiveness of health treatments and strategies and to identify national priorities.

X. Reforming the Health Care Delivery System

The *Affordable Care Act* seeks to promote team-based health care through *Accountable Care Organizations* (ACO's) which create delivery systems that encourage and support teams of physicians, hospitals and other health care providers to collaboratively manage and coordinate care for Medicare beneficiaries. ACO's will receive share of any savings they achieve from reducing duplicative services, improving productivity, minimizing paperwork or otherwise improving cost-efficiency.

Beginning in 2012, an *Independent Payment Advisory Board* (IPAB) will monitor the Medicare program's fiscal health and recommend changes in payment policies to contain growth in costs. The IPAB will submit recommendations to Congress every year. Unless Congress takes other steps to reduce expenditures, the IPAB's proposals on how to improve care and control costs will be binding when cost-projections exceed certain targets.

To promote the development of new models for payment and delivery, the *Affordable Care Act* also provides $10 billion to establish a *Center for Medicare and Medicaid Innovation*.

To increase and enhance the capacity of the workforce to meet patients' health care needs, the *Affordable Care Act* will expand and improve low-interest student loan programs, scholarships and loan repayments for health students and professionals. Funding also will be provided to strengthen build and expand community health centers, to establish *Teaching Health Centers* to provide payments for primary care residency programs in community-based ambulatory patient care centers, and to support school-based health centers and nurse-

managed health clinics. In addition, a new trauma center program seeks to strengthen emergency department and trauma center capacity.

A *Workforce Advisory Committee* will develop a national strategy for aligning the federal health care workforce's resources with the nation's needs. In addition, a *Regular Corps* and a *Ready Reserve Corps* will be commissioned to serve in times of national emergency.

XI. Public Option for Financing Long Term Care

The *Affordable Care Act* incorporates portions of a piece of legislation previously supported by Ted Kennedy, the *Community Living Assistance Services and Supports* (or "CLASS") *Act*, which will establish a voluntary national insurance program to provide cash benefits for participants who meet certain eligibility criteria and have a qualifying disability that limits their day-to-day living. The benefits can help pay for non-medical services and supports such as home modification, assistive technology, transportation, and personal care. They also can be applied to the costs of assisted living or nursing home care.

XII. Tort Reform Demonstration Programs

The *Affordable Care Act* provides for five-year grants to states for the purpose of developing, implementing and evaluating possible models of tort reform.

XIII. Tax Changes

The *Congressional Budget Office* (CBO) estimates that the *Affordable Care Act* will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years. According to CBO, by 2019, the legislation will result in 24 million people obtaining coverage in the newly created state health insurance exchanges, including some who previously purchased coverage on their own in the individual market. In addition, 16 million more people are expected to enroll in Medicaid and the Children's Health Insurance Program. The associated costs are expected to be financed through a combination of savings from Medicaid and Medicare and new taxes and fees, including an excise tax on high-cost insurance.

Some of those tax changes seek to encourage healthy behaviors. For example, a new 10% excise tax will be imposed on indoor tanning services provided after June 30, 2010.

Other tax changes seek to promote the continuation of employer-sponsored health coverage. For example, employers with 10 or fewer workers and average annual wages of less than $25,000 can receive a tax credit (up to 35% of health premium costs) each year through 2013. The credit is not available to companies with more than 25 employees or with average annual wages of $50,000 or more. When the health benefit exchanges become effective (in 2014), small companies that meet the same criteria and sign up with one of the exchanges can receive a credit of up to 50% of their costs. That credit disappears after 2015.

In light of other ways in which the *Affordable Care Act* addresses the costs of providing prescription drug coverage under Medicare Part D, the deduction that employers currently take for providing that coverage to their retirees will be eliminated in 2013, but only to the extent that the federal government subsidizes the coverage.

Certain tax changes seem designed to promote individual responsibility for financing the costs of health care coverage. To that end, the 7.5% floor on itemized deductions for medical expenses will be raised in 2013 to 10% for taxpayers under age 65. In 2016, that change will be applied to all taxpayers.

In 2014, a new tax also will be imposed on individuals without health coverage. Sometimes referred to as the "*Individual Mandate*," the new tax will be phased in over three years: in 2014, it will be the greater of $95 or 1% of income; in 2016, it will be the greater of $695 or 2.5% of gross income. A refundable tax credit will concurrently be given to people with household incomes between 100% and 400% of the federal poverty level.

Some tax changes appear designed solely to increase tax revenue. Beginning in 2011, for example, funds from flexible spending accounts, health reimbursement arrangements and HSA's can no longer be used to pay for over-the-counter medications. The penalty for nonqualified distributions from HSA's also will be doubled (to 20%). Beginning in 2013, the amount that employees can contribute to HSA's will be capped at $2,500 a year.

Still other tax changes appear to be designed to shift much of the cost of financing health care to those earning higher incomes. Starting in 2013, for example, a Medicare surtax of 0.9% will be applied to wages in excess of $200,000 for single taxpayers (over $250,000 for married couples). A Medicare tax also will be applied to the investment income of high earners (3.8% levy of unearned income or the amount by which adjusted gross income exceeds the threshold amounts, whichever is less). Beginning in 2018, an excise tax of 40% will be imposed on high-cost health plans, applicable to those portions which exceed $10,200 for individuals ($27,500 for families).

XIV. Pending Legal Challenges

As final Congressional approval neared for the *Affordable Care Act*, its opponents shifted from parliamentary and procedural opposition to legal challenges of the law's constitutionality. For example, the Virginia General Assembly passed the *Virginia Health Care Freedom Act* to prohibit any individual from being required to purchase health insurance, and the Virginia Attorney General filed a lawsuit (*Commonwealth v. Sebelius*) challenging the Constitutionality of the insurance requirement.

On August 2, 2010, the District Court denied the Justice Department's motion to dismiss that lawsuit, explaining that the case raises Constitutional issues -- mainly whether Congress has the right under the Commerce Clause to regulate and tax a person's decision not to participate in interstate commerce – which will need to await resolution after a hearing on the merits. Although lengthy appeals are anticipated, the trial of that case currently is set to begin on October 18, 2010.

Together with the States of South Carolina, Nebraska, Texas, Utah, Louisiana, Alabama, Michigan, Colorado, Pennsylvania, Washington, Idaho and South Dakota, the State of Florida separately filed a lawsuit to repeal the *Affordable Care Act*. Like the Commonwealth of Virginia's case, it primarily challenges those portions of the *Affordable Care Act* which require that individuals either purchase health insurance or pay a penalty. By June 2010, at least 20 states had some role in support of this legal challenge. The *National Federation of Independent Business* and two individuals also have joined the lawsuit as additional plaintiffs. As of this

writing, the Eastern District of Michigan had yet to rule on the plaintiffs' motion for a preliminary injunction against any enforcement of those provisions.

Importantly, the consolidated version of the *Affordable Care Act* has no severability provision. For that reason, any lawsuit that successfully invalidates any part of it could unwind the entire piece of legislation.

XV. Conclusion

The *Affordable Care Act* is a landmark piece of legislation that will reform the American health care system in numerous ways. To some, it represents a culmination of past legislative efforts and implements a number of policies which promise to bring about changes that will make quality health care more available to and more affordable for everyone. To others, it represents a further expansion of the government's role in American society.

Only time will tell if the *Affordable Care Act* can achieve its stated objectives. In the interim, some will likely fare better, while others may fare worse. Further changes in the American health care system – through the legislative process, the judicial system, the insurance industry or other sources -- therefore are a virtual certainty. In the end, then, the *Affordable Care Act* may mark only the latest chapter in an important political debate that already has consumed one century – and may yet consume another.

About the Author

Robert R. Pohls is the Managing Attorney of *Pohls & Associates,* a California law firm that he founded in 1999 to represent life, health, disability and long term care insurance companies in bad faith, ERISA and other complex forms of litigation. A litigator by trade, Mr. Pohls has earned a national reputation for his distinctive ability to achieve favorable outcomes in disputes that involve challenging facts and/or novel legal questions. However, he is equally skilled at helping his insurance clients manage difficult claims and, when possible, avoid litigation altogether. In addition, Mr. Pohls regularly assists his insurance clients when they must respond to regulatory inquiries.

Mr. Pohls is an active Member of *DRI*'s Life, Health & Disability Committee. He also is a Member of the *Association of Life Insurance Counsel*, a Member of the *Northern California Life Insurance Association*, an Associate Member of the *Association of California Life & Health Insurance Companies*, and a former Chair of the *ABA*'s Health & Disability Insurance Law Committee.

Mr. Pohls graduated from *Bucknell University* in 1984, earning a Bachelor of Arts Degree in Political Science. In 1987, he received a *Juris Doctor* degree from *King Hall School of Law* at the *University of California, Davis*.

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Appendix 1: Implementation Schedule for Insurance Reforms

2010 Insurance Reforms

• Provides dependent coverage for adult children up to age 26 for all individual and group policies. Requires all plans in the individual market and new employer plans that provide dependent coverage for children to continue to make that coverage available up to age 26; for existing employer plans, this applies only to young people not offered their own employer-provided coverage.

• Creates a temporary reinsurance program for employers providing health insurance coverage to retirees between age 55 and 64 (ie., who are not eligible for Medicare). This provision ends when Exchanges are operational (January 1, 2014).

• Establishes a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. Provides eligible individuals access to coverage that does not impose any coverage exclusions for pre-existing health conditions. This provision ends when Exchanges are operational (January 1, 2014).

• Prohibits individual and group health plans from placing lifetime limits on the dollar value of coverage and, until 2014, plans may only impose annual limits on coverage as determined by the Secretary. Prohibits pre-existing condition exclusions for children and prohibits insurers from rescinding coverage except in cases of fraud.

• Requires qualified health plans to provide first dollar coverage for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.

• Requires all new individual and group health plans to implement an effective internal and external appeals process for coverage and claim determinations.

• Requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011).

• Provides grants to assist states in reviewing increases in health plan premiums and requires plans to justify increases. Requires states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases.

2011 Insurance Reforms

• Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

• Requires health insurers to provide consumer rebates when less than 80 percent (individual and small group) or 85 percent (large group) of premium dollars are used for benefits.

2013 Insurance Reforms

• Creates the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013).

• Simplifies health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014).

2014 Insurance Reforms

• Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.

• Provides refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400% of the Federal Poverty Level to purchase insurance through the Exchanges.

• Permits states to create a Basic Health Plan for uninsured individuals with incomes between 133-200% of the Federal Poverty Level who otherwise would be eligible to receive premium subsidies in the Exchange.

• Requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for bortions beyond those permitted by federal law.

• Prohibits all employer plans and new individual plans from imposing annual limits on the amount of coverage an individual may receive.

• Requires guaranteed issue and renewability and, subject to limitations, allows for rating variation based only on age, premium rating area, family composition, and tobacco use in the individual and the small group market and the Exchanges.

• Limits deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.

• Reduces the out-of-pocket limits for those with incomes up to 400% of the Federal Poverty Level.

• Limits any waiting periods for coverage to 90 days.

• Creates an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the 2010 HSA limits, and is not more extensive than the typical employer plan.

• Requires qualified health plans to meet new operating standards and reporting requirements.

• Creates a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.

• Provides a choice of coverage through a multi-state plan that will be available from nationwide health plans supervised by the Office of Personnel Management.

• Allows states the option of merging the individual and small group markets.

Insurance Reforms (2015 and Beyond)

• Allows states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (Compacts may not take effect before January 1, 2016).

Appendix 2: Implementation Schedule for Medicare Reforms

2010 Medicare Reforms

• Provides a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020. The coverage gap currently falls between $2,700 and $6,154 in total drug costs.

• Expands Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result.

• Reduces annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units.

• Extends Medicare payment protections for small rural hospitals, including hospital outpatient services, lab services, and facilities that have low-volume of Medicare patients but play an important role in their communities.

• Bans new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limits the growth of certain grandfathered physician-owned hospitals.

• Creates a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to improve care coordination for dual eligibles.

2011 Medicare Reforms

• Freezes (at 2010 levels) the income threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduces the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.

• Establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries.

• Provides Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.

• Provides a 10% Medicare bonus payment to primary care physicians and general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015).

• Provides Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan; Provides incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.

2012 Medicare Reforms

• Makes Part D cost-sharing for full-benefit and dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care.

• Reduces annual market basket updates for home health agencies, skilled nursing facilities, hospices, and other Medicare providers.

• Establishes a hospital value-based purchasing program in Medicare and develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.

• Creates the Medicare Independence at Home demonstration program.

• Reforms physician payment models for providers organized as accountable care organizations (ACOs) that voluntarily meet quality and efficiency thresholds.

• Reduces Medicare payments that would otherwise be made to hospitals by specified percentages to account for preventable excess hospital readmissions.

• Provides bonus payments to high–quality Medicare Advantage plans.

• Reduces rebates for Medicare Advantage plans.

• Eliminates cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waives the Medicare deductible for colorectal cancer screening tests. Creates incentives for state Medicaid programs to cover evidence-based preventive services with no cost-sharing. Requires coverage of tobacco cessation services for pregnant women. Authorizes the Secretary to modify or eliminate Medicare coverage of preventive services based on recommendations of the U.S. Preventive Services Task Force.

• Prohibits Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.

• Restructures payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service rates.

• Requires pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begins phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.

• Adjusts the Medicare Graduate Medical Education policy to allow unused training slots to be redistributed for the purpose of increasing primary care training at other sites. Nursing training programs also are expanded to increase the size of the nursing workforce.

• Creates a new Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals.

2013 Medicare Reforms

• Begins federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25% in 2020, in addition to the 50% manufacturer brand-name discount).

• Establishes a national Medicare pilot program to encourage collaboration among hospitals, doctors and post-acute care providers to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

2014 Medicare Reforms

• Reduces the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019).

• Requires Medicare Advantage plans to have medical loss ratios no lower than 85%.

• Reduces Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided.

• Establishes an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate.

Medicare Reforms (2015 and Beyond)

• Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015).

• Creates a value-based physician payment program to promote increased quality of care for Medicare beneficiaries.

• Establishes an Independent Payment Advisory Board to develop and submit proposals to Congress and the private sector which are aimed at extending the solvency of Medicare, lowering health care costs, promoting quality and efficiency, improving health outcomes for patients, and expanding access to evidence-based care.

Appendix 3: Implementation Schedule for Medicaid Reforms

2010 Medicaid Reforms

• Creates a state option to cover parents and childless adults up to 133 percent of the Federal Poverty Level through a Medicaid state plan amendment.

• Creates a state option to provide Medicaid coverage for family planning services up to the highest level of eligibility for pregnant women to certain low-income individuals through a Medicaid state plan amendment.

• Creates a new option for states to provide Children's Health Insurance Program (CHIP) coverage to children of state employees eligible for health benefits if certain conditions are met.

• Increases the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.

• Provides funding for and expands the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).

• Requires the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.

2011 Medicaid Reforms

• Creates a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provides states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion.

• Creates the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long term care services.

• Establishes the Community First Choice Option to allow states to offer community-based attendant support services to certain people with disabilities through Medicaid, rather than institutional care.

• Prohibits federal payments to states for Medicaid services related to health care acquired conditions.

2012 Medicaid Reforms

• Creates new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through

2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

2013 Medicaid Reforms

• Increases Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100%; Provides federal funding for the incremental costs to states of meeting that requirement.

• Provides states that offer Medicaid coverage of preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the federal medical assistance percentage (FMAP) and removes cost-sharing for these services.

2014 Medicaid Reforms

• Expands Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% of the Federal Poverty Level based on modified adjusted gross income (MAGI) and provides enhanced federal matching for new eligibles.

• Reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments.

• Increases spending caps for the territories.

Appendix 4: Implementation Schedule for Health Care Delivery Reforms

2010 Health Care Delivery Reforms

• Establishes a non-profit Patient-Centered Outcomes Research Institute to identify national priorities and provide research to compare the effectiveness of health treatments and strategies.

• Expands and improves low-interest student loan programs, scholarships, and loan repayments for health students and professionals to increase and enhance the capacity of the workforce to meet patients' health care needs.

• Requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system.

• Establishes a Workforce Advisory Committee to develop a national strategy for aligning federal health care workforce resources with national needs.

• Establishes a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.

• Creates an interagency council to promote healthy policies at the federal level and establishes a prevention and public health investment fund to provide for national investment in prevention and public health programs.

• Provides additional resources to HHS to develop a national quality strategy and support quality measure development and endorsement for the Medicare, Medicaid and CHIP quality improvement programs.

• Authorizes the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

• Reauthorizes and amends the Indian Health Care Improvement Act.

2011 Health Care Delivery Reforms

• Develops a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.

• Establishes the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.

• Provides grants for up to five years to small employers that establish wellness programs.

• Awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

• Improves access to care by increasing funding by $11 billion for community health centers and by $1.5 billion for the National Health Service Corps over five years; Establishes new programs to support school-based health centers and nurse-managed health clinics.

• Establishes the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.

• Establishes a new trauma center program to strengthen emergency department and trauma center capacity.

• Provides funds to build new and expand existing community health centers.

• Establishes Teaching Health Centers to provide payments for primary care residency programs in community-based ambulatory patient care centers.

• Expands funding for scholarships and loan repayments for primary care practitioners working in underserved areas.

• Requires chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

2012 Health Care Delivery Reforms

• Establishes a value-based purchasing program to promote enhanced quality outcomes for acute care hospitals. Requires the Secretary to submit a plan to Congress on how to move home health and nursing home providers into a value-based purchasing payment system.

• Directs CMS to track hospital readmission rates for certain high-volume or high-cost conditions; Uses new financial incentives to encourage hospitals to reduce preventable readmissions, improve care for beneficiaries and control unnecessary health care spending.

• Requires collection and reporting of enhanced data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

2013 Health Care Delivery Reforms

• Requires disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

2014 Health Care Delivery Reforms

• Permits employers to offer employees rewards of up to 30% (or higher) of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establishes 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

Appendix 5: Implementation Schedule for Tax Changes

2010 Tax Changes

• Provides tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that provide health insurance for employees. Credit is up to 35 percent of the employer's contribution to health insurance for employees. There also is a credit of up to 25 percent for small nonprofit organizations.

• Excludes from gross income the value of specified Indian tribal health benefits.

• Imposes additional requirements on non-profit hospitals, including a tax of $50,000 per year for failure to meet these requirements.

• Limits to $500,000 per applicable individual the deductibility of health insurance providers' executive and employee compensation.

• Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas.

• Provides for a two-year temporary credit (subject to an overall cap of $1 billion) to encourage investments to prevent, diagnose and treat acute and chronic diseases.

• Imposes a tax of 10% on amounts paid for indoor tanning services that use an electronic product with one or more ultraviolet lamps to induce skin tanning.

• Increases the adoption tax credit and adoption assistance exclusion, makes the credit refundable and extends the credit through 2011.

• Requires that non-profit Blue Cross Blue Shield organizations have a medical loss ratio of 85 percent or higher to receive special tax benefits provided under Internal Revenue Code Section 833 (including a deduction for 25 percent of claims and expenses, and a 100 percent deduction for unearned premium services).

• Excludes unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.

2011 Tax Changes

• Creates a Simple Cafeteria Plan through which small businesses can provide tax-free benefits to employees. Eases administrative burden on small employer-sponsors and exempts employers who make contributions from non-discrimination requirements applicable to highly-compensated and key employees.

2013 Tax Changes

• Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; For tax years 2013 through 2016, the increase will be waived for individuals age 65 and older.

• Limits the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment.

• Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and imposes a 3.8% assessment on unearned income for higher income taxpayers.

• Eliminates the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

• Imposes an excise tax of 2.3% on the sale of any taxable medical device.

• Imposes an annual fee on insured and self-insured plans to fund a patient-centered outcomes research trust fund.

• Limits the deductibility of executive compensation for insurance providers when at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements; The deduction is limited to $500,000 per taxable year and applies to all officers, employees, directors and other workers or service providers performing services (after 2009), for or on behalf of, a covered health insurance provider.

2014 Tax Changes

• Provides a tax penalty ($95 in 2014; $325 in 2015; $695 or up to 2.5 percent of income in 2016) for U.S. citizens and legal residents without qualifying health coverage. No penalty if affordable coverage is not available.

• Makes premium tax credits available through the Exchange for people with incomes above Medicaid eligibility and below 400% of the Federal Poverty Level who are not offered (or eligible for) acceptable coverage.

• Begins second phase of small business tax credit for qualifying small businesses.

• Assesses a fee of $2,000 per full-time employee (excluding the first 30 employees) against employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit. Employers with 50 or more employees that offer coverage but have at least one full-time employee receiving a premium tax credit will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee (excluding the first 30 employees). Employers with more than 200 employees must automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

• Imposes fees on the health insurance sector according to market share. Will not apply to companies with net premiums written of $25 million or less.

• Requires employers to disclose the value of the benefits provided for each employee's health insurance coverage on form W-2's.

• Increases the tax on distributions from a health savings account that are not used for qualified medical expenses from 10% to 20% of the disbursed amount. The additional tax on Archer MSA withdrawals not used for qualified medical expenses will increase from 15% to 20%.

• Excludes the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a health reimbursement account or health flexible spending account and from being reimbursed on a tax-free basis through a health savings account or Archer Medical Savings Account.

• Imposes new annual fees on the pharmaceutical manufacturing sector, allocated according to market share. Does not apply to companies with $5 million or less in sales of branded pharmaceuticals.

Tax Changes (2015 and Beyond)

• Imposes an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. Uses higher thresholds for employees and retirees from high risk professions. (Effective January 1, 2018).