



Summary of the National Health Care Reform Law (Updated May 2010)

This summary includes the *Patient Protection and Affordable Care Act* (signed into law on March 23, 2010) and the reconciliation amendment (signed on March 30, 2010). The combined law expands access to quality, stable, affordable health care; slows the growth of health care costs; and improves the quality of care. The law is available online at <http://www.ncsl.org/documents/health/ppaca-consolidated.pdf>.

Insurance Reform

The law makes significant improvements to the private insurance system, overhauling the individual and small-group health insurance markets to expand access to coverage. A number of those improvements go into effect in September 2010, including provisions to:

- Ban co-pays or other out-of-pocket expenses for preventive care and immunizations
- Prohibit all rescissions when insurance is retroactively canceled, including for grandfathered, or existing, plans
- Extend dependent coverage in all plans up to age 26, including grandfathered plans
- Prohibit lifetime benefit limits in all plans, including grandfathered plans
- Prohibit pre-existing condition exclusions for children
- Require insurers to devote at least 85 percent of premiums in the large-group markets and 80 percent in the small and individual markets to medical benefits, or provide consumer rebates if medical-benefit spending falls below this percentage
- Create a national, high-risk pool plan for people denied coverage because of medical conditions. This pool is temporary until the Exchange is up and running.

Additional private insurance requirements begin by 2014, including reforms that:

- Require insurers in the small-group and individual markets to offer coverage to everyone and to renew all policies
- Prohibit exclusions for pre-existing conditions, including grandfathered plans
- Prohibit annual benefit limits for essential services, including grandfathered plans
- Bar insurers from basing premiums on health status, gender and other factors. Premiums may vary based on age, with the spread constrained to a 3:1 ratio, and based on tobacco use up to a 1.5:1 ratio. Premiums may also vary by geographic area and family size.
- Require all health plans to cover essential benefits, which include hospital and outpatient services, prescription drugs, mental health services, maternity care, rehabilitation and preventive care, but not abortion services
- Direct plans to meet out-of-pocket expense limits of \$5,800 per individual and \$11,600 per family, indexed to inflation
- Create multi-state plans to promote competition in the insurance market. (See details in the Public Health Insurance Option and CO-OPs section below.)

Discussion: Overall, the law creates strong protections that would assure equal access to coverage for people in the private insurance market. The reforms that take effect immediately provide some relief for consumers who currently cannot access coverage. Some provisions are not ideal, however, including basing premiums on tobacco use and age, allowing sale of insurance plans across state lines, limiting coverage for abortion services in Exchange plans, and exempting self-insured plans from rules that bar premium rates based on age and other factors.

Ensuring Affordability

To make coverage affordable, the law expands Medicaid, establishes a sliding-scale subsidy program for low- and moderate-income people, and provides assistance for small businesses. It includes provisions to:

- Expand Medicaid to 133 percent of the federal poverty level (FPL) (\$24,360 per year for a family of three) in 2014 to cover children and non-disabled, childless adults under the age of 65. States could expand Medicaid earlier, starting April 1, 2010
- Provide “premium tax credits,” which operate as sliding-scale subsidies, in the Exchange for people earning between 100 and 400 percent FPL (\$18,310 to \$73,240 for a family of three) and for those below 100 percent FPL, but only if they are legal U.S. residents who do not qualify for Medicaid. Individuals only qualify for subsidies if they do not have access to employer-sponsored insurance that meets certain minimum standards and costs less than 9.5 percent of their income. Premiums would start at 2 percent of income for those earning less than 133 percent FPL and rise to 9.5 percent for those between 300 and 400 percent FPL.
- Reduce out-of-pocket maximums for people below 400 percent FPL in the Exchange and offer further out-of-pocket subsidies for people below 250 percent FPL in the Exchange
- Give tax credits to small businesses and non-profits that have 25 or fewer full-time equivalent employees, have an average wage of no more than \$50,000, and who contribute at least 50 percent of the premium for employee coverage

Discussion: The expansion of Medicaid will make health insurance affordable to a large number of low-income people. Other strengths of the Medicaid portion of the law include new quality directives for Medicaid, expansion of medical homes to those with chronic illness, and enrollment simplification measures. The law also requires Medicaid to pay primary care providers at least 100 percent of Medicare rates in 2013 and 2014, and provides full federal funding for the incremental costs.

Premium subsidies make coverage substantially more affordable for millions of low- and middle-income families who do not have access to coverage through their employers, and provides cost-sharing assistance for many families. However, subsidies remain too low, particularly for low-income families earning up to 200 percent FPL. Also, the out-of-pocket protections continue to pose barriers to care for low-income families, putting low- and moderate-income families at risk of underinsurance if they face a catastrophic illness.

Shared Responsibility

For individuals: Starting in 2014, all U.S. citizens and legal residents will be required to obtain coverage for themselves and for their dependents. This coverage must meet minimum requirements, unless the available coverage costs more than eight percent of their income. Exemptions are allowed for religious objections, financial hardship, undocumented immigrants, American Indians, people earning under the tax filing threshold, and for short gaps in coverage. The maximum penalty for not obtaining coverage for any family is the national average premium for a bronze plan. The penalty is calculated as the greater of:

- \$95 per year in 2014, \$325 per year in 2015, \$695 in 2016 (half that amount for children under age 18), up to a maximum of three times those penalty amounts per family, or
- 1 percent of income above the tax filing threshold in 2014, 2 percent of income above the tax filing threshold in 2015, 2.5 percent of income above the tax filing threshold in 2016 and beyond.

Discussion: The individual mandate includes some critical consumer protections, including the affordability and hardship exemptions. However, the progressive fines for families who do not have insurance are still high and may cause financial hardship.

For employers: Starting in 2014, employers who do not offer coverage that meets minimum requirements to all their full-time employees (and their dependents), and have at least one full-time employee who qualifies for premium tax credits, will be required to pay \$2,000 per year for each of their full-time employees.

Also, even employers who offer coverage that meets minimum requirements to all of their full-time employees but still have at least one full-time employee who qualifies for premium tax credits (because the coverage offered by the employer is not affordable to the employee), will be required to pay \$3,000 for each of their employees receiving a tax credit.

Any employer who offers minimum essential coverage to its employees and pays a portion of the costs of that plan must offer a “free choice voucher” to any employee who earns less than 400 percent FPL and whose required contribution to the plan would be between 8 percent and 9.8 percent of their income. The free choice voucher would be equal to the costs that the employer would have paid toward that employee’s coverage under the employer-sponsored plan. The employee can then apply that free choice voucher toward the cost of any plan offered in the Exchange, but will not be eligible for subsidies. Employers do not have to pay the above free-rider surcharge with respect to employees for whom they offer a “free choice voucher.”

Employers with fewer than 50 full-time or full-time equivalent employees are exempt from these requirements.

Discussion: The employer requirements help raise money for subsidies and encourage employers to continue offering coverage to their employees. Because employers must count part-time employees as full-time equivalents, more will be subject to these requirements.

Health Insurance Options and CO-OPs

The law does not contain a public health insurance option but offers two proposals to promote competition in the insurance market. First, it authorizes the Office of Personnel Management (OPM) to enter into contracts with insurers to offer coverage to individuals and small groups through multi-state plans. The plans will be offered through each state's Exchange and must meet its benefit and plan requirements. At least two plans will be offered in each state; one must be through a non-profit entity. Plans must set premiums using HIPAA rating requirements and must be offered in community-rated states. Enrollees are eligible for credits and subsidies.

Second, it authorizes funds for at least one non-profit, member-run health insurance Consumer Operated and Oriented Plan (CO-OP) in each state that would offer coverage to individuals and small businesses. The state would have to implement all insurance reforms in the law before a CO-OP could operate.

Health Insurance Exchange

The law directs states to create Health Benefit Exchanges to help individuals and employers compare health plans, make informed choices and facilitate enrollment. Exchanges also must develop a rating system to help consumers choose the best plan for them. Subsidies and the multi-state plans would be available through the Exchange, and participation in the Exchange is voluntary. In addition, the Exchange must consult with consumers about its processes, and provide transparent information about claims, cost-sharing and benefits. Eligibility for the Exchange starts in 2014 for individuals and small employers. No undocumented immigrants may enroll through the Exchange.

Discussion: The Exchange has the authority to certify plans and help consumers make comparisons through a rating system. Pooling risk for plans both inside and outside of the Exchange would reduce adverse selection and prevent the Exchange plans from having higher premiums. The actuarial benefit levels for plans, however, could leave consumers vulnerable to higher out-of-pocket costs.

Children's Health

The law increases mandatory Medicaid income eligibility levels for children ages six to 19, and it preserves the CHIP program past 2013, with full funding until 2015. It includes provisions to:

- Expand children's access to the Medicaid program by providing coverage with Early Periodic Screening, Diagnosis and Treatment (EPSDT) for every child at or below 133 percent FPL and every foster child through age 26
- Maintain CHIP through at least Sept. 30, 2015, allowing states to provide CHIP coverage to children of state employees eligible for health benefits. The federal CHIP match rate in will be increased in 2015 by 23 percent.
- Simplify and coordinate enrollment processes for coverage in Medicaid, CHIP and the Exchange
- Provide funding for school-based health centers, oral health education campaigns and pediatric quality improvement programs
- Immediately ban insurers from denying coverage to children for pre-existing conditions

- Require that Medicaid payment rates for pediatric primary care services be no less than 100 percent of Medicare payment rates in 2013 and 2014, and provide 100 percent federal funding to states for the incremental costs

Discussion: The expansion of Medicaid will provide more children with access to the comprehensive EPSDT benefits package. Regarding CHIP-eligible children, the law will fund the program until at least until 2015 – ensuring that these children will also maintain access to vital health services. Additionally, increasing Medicaid rates for primary care services will help ensure that Medicaid coverage will be accepted by more doctors, enabling children to more easily access care while enrolled in Medicaid.

Racial and Ethnic Health Disparities

The law aims to reduce racial and ethnic health disparities with provisions to:

- Guarantee \$11 billion more in funding for community health centers
- Reauthorize and expand Indian Health Services, with goals of reducing disparities and increasing the ability to meet Indian health needs
- Require all federal health programs and surveys to collect data on the race, ethnicity and primary language of participants; and require the federal government to use the data to monitor health disparities
- Establish a national strategy to improve delivery of care, patient outcomes and population health, including reduction of disparities
- Provide grants for community health programs and community health workers to promote wellness and address disparities
- Provide loan repayments and scholarships for students from disadvantaged backgrounds seeking to work in medically underserved areas
- Support programs that develop cultural competency and health disparities curricula for use in health professions schools and continuing education programs

Discussion: The law promotes community health initiatives and takes steps to diversify the health workforce and make it more culturally sensitive. It strengthens the safety net by boosting funding for community health centers. However, it drastically cuts funding that supports care for the uninsured at hospitals. Unfortunately, the law maintains the current policy of excluding legal immigrants from Medicaid for five years, and it excludes undocumented immigrants from access to new insurance subsidies.

Consumer Assistance

The law makes very positive steps toward institutionalizing consumer support services, by:

- Immediately funding (in 2010) state consumer assistance offices or state ombudsman programs to help consumers enroll in plans, file complaints and appeals, solve problems with programs and track any problems with implementation of reform
- Authorizing state Exchanges to provide grants to navigators to facilitate enrollment and provide information about plans. Navigators may include community-based non-profits, as well as trade groups.

Discussion: We are very pleased with provisions in the law to provide consumers with the information, support and troubleshooting they need to enroll in the right coverage and to navigate the health care system. In addition, state Exchanges should be required, rather than just permitted, to work with community-based non-profits to provide targeted assistance to consumers.

Prescription Drugs

The law advances prescription drug reforms by promoting the use of the safest, most effective drugs. It also takes significant steps toward reducing the cost of drugs for seniors and all Americans. The law includes provisions to:

- Reduce drugs costs for Medicare Part D enrollees by providing a \$250 rebate to all who enter the “doughnut hole” in 2010; reducing the cost of brand-name drugs in the doughnut hole by 50 percent starting in 2011; and gradually reducing the coinsurance for both brand-name and generic drugs each year until 2020. At that point, the doughnut hole will be closed, and the maximum coinsurance will be 25 percent.
- Require pharmaceutical and medical device companies to report all payments over \$10 to physicians and teaching hospitals. Importantly, this data will be made public on a searchable website.
- Require pharmacy benefit managers (PBMs) to report information on the rebates, discounts or price concessions negotiated by the PBM, as well as the payment difference between health plans and PBMs, and between the PBMs and pharmacies. These confidential reports will be disclosed to HHS and the PBM’s health plan clients.
- Require manufacturers to provide higher rebates to Medicaid for brand-name and generic drug purchases and to extend these rebates to new drug formulations (with some exceptions) and to Medicaid managed care plans
- Establish a non-profit institute to coordinate federally-supported research on the comparative effectiveness of interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostic tools and pharmaceuticals

Discussion: The Medicare rebates and discounts to enrollees and the closing of the doughnut hole are significant improvements for seniors, while the Medicaid drug rebates will help keep Medicaid sustainable. Public reporting of drug and device payments to physicians and teaching hospitals, as well as transparency in PBM contracts, will reduce unnecessary costs and improve quality. The provisions on research are an important step toward generating and aggregating needed evidence on the relative utility of treatment options for patients, although it will be important to ensure that the research institute operates with strong conflict-of-interest standards.

Improving Quality

The law includes numerous provisions that promote access to primary and preventive care; strengthen infrastructure by rewarding care coordination, innovation and efficiency within the delivery system; and improve the quality of health care in America. It includes provisions to:

- Develop a National Quality Strategy to improve care delivery, health outcomes and population health. A new Center for Innovation within the Centers for Medicare & Medicaid Services (CMS) would test and evaluate innovative models of care.

- Establish numerous national pilot programs and demonstration programs to test and evaluate new strategies for improving the quality of care people receive while reducing costs, such as bundled payments, global payments, accountable-care organizations and medical homes through multiple payers and settings
- Establish new quality measures for Medicaid-eligible adults, including grants to states to provide incentives for Medicaid beneficiaries to participate in healthy lifestyle programs. A state option would enroll Medicaid beneficiaries with chronic illnesses into health homes that offer comprehensive, team-based care, and a new optional Medicaid benefit would allow people with disabilities to receive community-based services and supports.
- Reward hospitals for providing value-based care, and penalizes hospitals that perform poorly on quality measures such as preventable hospital readmissions
- Establish a five-year pilot program that would use public health interventions to reduce chronic illnesses and their associated costs for people between age 55 and 64
- Provide incentives for states to shift Medicaid beneficiaries away from nursing homes and toward care in the home or community

Discussion: The law takes major strides toward improving quality while reducing costs. Notably, a number of provisions reserve roles for the public and for consumer representation in key efforts, such as establishing new quality measures, determining which models of care to pursue, or evaluating new pilot and demonstration programs. Though much of the hard work will be left for implementation, the law hones in on reducing chronic illness, improving patient-centered care and care coordination, integrating medical care with home- and community-based services, and building capacity at the state and local level to meet many of these objectives.

Strengthening Medicare

The law includes many provisions that will strengthen Medicare's stability and improve beneficiary access to care. In addition to the drug provisions mentioned above, the law:

- Extends the Special Needs Plan program for frail, sick and elderly Medicare beneficiaries. A new office within CMS will promote policies and assist states in better integrating care for dually eligible Medicare beneficiaries.
- Limits cost-sharing requirements for certain services in Medicare Advantage plans to the amount charged for the same services in traditional Medicare coverage
- Creates an independent advisory board to make recommendations to Congress on reducing costs and improving the quality of care in Medicare and in the private sector
- Provides beneficiaries with free, annual wellness visits and personalized prevention plans, including a comprehensive health risk assessment
- Creates a "Physician Compare" website for Medicare beneficiaries to compare physician quality and patient experience
- Saves Medicare money by ensuring that private Medicare Advantage plans spend at least 85 percent of revenue on medical costs or activities to improve care, rather than on profit or overhead, and ties payment incentives to quality

The law also begins to address a longstanding gap in the program by creating a voluntary insurance program (CLASS) to provide community-based assistance services and support.

Discussion: The law includes some significant wins for seniors. Especially important are the limitations on cost-sharing for seniors enrolled in Medicare Advantage, payment incentives for quality, and the new CMS office dedicated to improving policies for people eligible for both Medicaid and Medicare.

Changes to Safety-Net Services

The law makes several significant changes to existing safety-net programs, including:

- Significant reductions to the amount of funding hospitals and states receive through Medicare and Medicaid Disproportionate Share Hospital (DSH) funding. Cuts to Medicaid DSH are set in the statute, but the Secretary will have to develop a methodology for determining how to divide payments among states.
- New requirements for private tax-exempt hospitals around financial assistance policies, including transparency in hospital charges, conducting community-needs assessments, billing and collection policies, and reporting

Discussion: The law includes new requirements for private tax-exempt hospitals. These provisions promote fairness, transparency and accountability for people who need to access hospital safety-net services, while creating new energy around hospitals' collaboration on health care planning with the communities they serve. The law requires the secretary of Health and Human Services to develop a methodology to improve how Medicaid DSH dollars are distributed. This could encourage states to target DSH dollars to hospitals with high numbers of Medicaid patients or uncompensated care – an important provision, since the cuts could hurt many safety-net providers who serve populations unlikely to be fully covered by national health care reform.

Financing

The law contains an excise tax on the most expensive health insurance plans. The threshold of plan values above which the tax applies is \$10,200 for individual plans and \$27,500 for family plans, with higher limits for retirees and employees in high-risk professions. Stand-alone vision and dental plans are excluded. The tax is 40 percent of the value above those thresholds. Implementation of the excise tax is delayed five years, until 2018. The rate at which the thresholds rise is directly indexed to inflation. The law also levies an additional 0.9 percent Medicare tax on high-income individuals (individuals earning over \$200,000 and families earning over \$250,000), and it applies the tax to net investment income as well as earned income. The law also imposes a 10 percent excise tax on indoor tanning services.