

## **Affordable Care Act**

### **Recast care model into a more efficient responsive model**

#### **Payment Processes**

1. New resources and new screening procedures for health care providers to reduce Medicare, Medicaid and CHIP fraud.
2. Payments for Rural Health Care Providers-A 10% Medicare bonus to primary care doctors and surgeons practicing in areas such as inner cities and rural communities which are underserved. Improve access to care by increasing funding for community and school health centers.
3. Linking payment to quality outcomes-financial incentives to hospitals to improve the quality of care.
4. Expanded authority to bundle payments.
5. Paying physicians based on value not volume- tie physician payments to the quality of care they provide.

#### **Treatment Processes**

1. New innovations to bring down costs-focus on ways to target waste in the system, and recommend ways to reduce costs, improve health outcomes for patients, and expand access to high-quality care.
2. Fund proven disease and illness prevention and public health programs. Develop national strategy to improve nation's health.
3. Establish a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients. Have a national strategy for quality improvement in health care.
  - a. Develop, implement, and evaluate alternatives to current tort litigations.
4. Improve care for seniors after they leave the hospital.- avoiding unnecessary readmissions by coordinating care and connecting patients to services in their communities
5. Increasing access to services at home and in the community.-allows states to offer home and community based services to disabled individuals through Medicaid rather than institutional care in nursing homes.
6. Encouraging integrated health care systems-Example: Mayo Clinic Model
7. Understand and fight health disparities- help identify and reduce disparities based on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.
8. Rebuild primary care workforce-add more primary care doctors, nurses and physicians assistants.
9. Reducing paperwork and administrative costs-standardize billing and insurance paperwork. Enact secure, confidential, electronic exchange of health information.

### **Expand coverage of Medicaid and CHIP**

1. Increasing access to Medicaid.
2. Additional funding for the Children's Health Insurance Program (CHIP).
3. Cover more Medicaid expenses –provide states with more matching funds and more flexibility of use.

4. Improving preventative health coverage-new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost.
5. Increase Medicaid payments for primary care doctors-provide a 10% bonus payment to primary care physicians in Medicare.

### **Changes to Medicare**

1. \$250 Medicare Drug Cost Rebate-One time \$250 tax free payment for qualifying candidates (donut hole)
2. Prescription Drug Discounts-Brand-name drug discounts 50% (Medicare Part D) and a discount of 75% on generic drugs (Medicare Part D).
3. Free preventative care for seniors. Certain free preventive services, such as annual wellness visits and personalized prevention plans, for seniors on Medicare
4. Overpayments (Restructure Payments) to Big Insurance Companies and Strengthening Medicare Advantage
  - a. Currently Medicare pays Medicare Advantage insurance companies over \$1,000 more per person on average than is spent per person in Original Medicare. This results in increased premiums for all Medicare beneficiaries, including the 77 percent of beneficiaries who are not currently enrolled in a Medicare Advantage plan.
  - b. Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phase-in revised payments over 3 years beginning in 2011, for plans in most areas, with payments phased-in over longer periods (4 years and 6 years) for plans in other areas.
5. Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple (effective 01/01/2011)
6. Prohibit MA plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under traditional fee-for-service programs
7. Reward providers who provide cost-efficient quality care and rescind certification for those who do not.

### **Long-term care**

1. Provide new, voluntary options for long-term care insurance-a voluntary long-term care insurance program – called CLASS - to provide cash benefits to adults who become disabled. Will provide individuals with functional limitations a cash benefit of not less than an average of \$50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions; all working adults will be automatically enrolled in the program, unless they choose to opt-out.

### **Increase coverage/controls under private insurance policies**

1. Expanded coverage for young adults (under 26) regardless of marriage status, residence, school status, financial dependence on parent.
2. Provide free preventative care-no deductible, co-pay or coinsurance.
3. Eliminate lifetime limits on insurance coverage
4. Regulating annual limits on insurance coverage
5. Prohibit denying coverage of children based on pre-existing conditions.
6. Pre-existing condition insurance policies-07/01/10-01/01/2014-Effective 2014 discrimination against pre-existing conditions prohibited. Establishes a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions
7. Ensure coverage for individuals participating in clinical trials-prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial for life-threatening diseases.
8. No discrimination due to pre-existing conditions or gender-prohibit insurance companies from refusing to sell coverage or renew policies because of an individual's pre-existing conditions. Insurance premiums will vary only by age, place of residence, family size, and tobacco use.

### **Limiting cost increases of insurance companies**

1. To ensure premium dollars are spent primarily on health care, the new law generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. If insurance companies do not meet these goals because their administrative costs or profits are too high, they must provide rebates to consumers.
2. Hold insurance companies accountable for unreasonable rate hikes. Provide measures that require insurance companies to justify their premium increases to be eligible for \$250 million in new grants. Insurance companies with excessive or unjustified premium increases may not be able to participate in the new health insurance Exchanges in 2014.
3. Prohibit insurance companies from rescinding coverage-illegal to rescind on basis of error or technical mistake on application.
4. Appeals process for Insurance Company decisions-provide consumer with a way to appeal coverage determinations or claims to their insurance company and establish an external review process.

### **Establishing Health Insurance Exchanges**

1. Starting in 2014 if your employer doesn't offer insurance, you will be able to buy insurance directly in an Exchange -- a new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges will offer you a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of

Congress will be getting their health care insurance through Exchanges, and you will be able buy your insurance through Exchanges too.

- a. No similar provision to create a public plan option.
- b. Create 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 DC to offer qualified health plans.
- c. Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets.
- d. Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
- e. Require qualified health plans participating in the Exchange to meet marketing, quality of care and customer service requirements

### **Credits to increase coverage**

1. Temporary-Small business tax credits-credits to small business to help cover employee health insurance acquired in current market. For firms with less than 25 employees who make less than \$50K per year. This is a bridge program until the Exchanges are established.
2. Increasing small business health insurance tax credit-the second phase of the small business tax credit for qualified small businesses and small non-profit organizations. In this phase, the credit is up to 50 percent of the employer's contribution to provide health insurance for employees. There is also up to a 35 percent credit for small non-profit organizations.
3. Coverage for Early Retirees-provide reimbursement for private insurance coverage for folks retiring at age 55-65-not eligible for Medicare but retired. Temporary until health insurance exchanges are enacted.
4. Tax credits for the middle class to afford insurance will become available for people with incomes above 100 percent and below 400 percent of poverty (\$43,000 for an individual or \$88,000 for a family of four in 2010) who are not eligible for or offered other affordable coverage Can't be eligible for qualified group co
5. Workers meeting certain requirements who cannot afford the coverage provided by their employer may take whatever funds their employer might have contributed to their insurance and use these resources to help purchase a more affordable plan in the new health insurance Exchanges.

### **Required coverage**

#### **Individual responsibility**

1. Under the new law, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption
  - i. \$95 or flat fee 1% of taxable income in 2014
  - ii. \$325 or flat fee 2% of taxable income in 2015
  - iii. \$695 or flat fee 2.5% of taxable income in 2016

- iv. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than 3 months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9350 for singles and \$18700 for couples)

### **Corporate responsibility**

1. Employers with more than 50 workers will be penalized for \$2000 times their total employees if their workers get coverage through the exchange and receive a tax credit. They may deduct the first 30 workers. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

### **Tax and Fee Provisions**

1. Impose a tax on individuals without qualifying coverage (see above).
2. Exclude the costs for over-the counter drugs not prescribed by a doctor from being reimbursed through an health savings account
3. Increase the tax on distributions from a health savings account that are not used for qualified medical expenses to 20%
4. Limit the amount of contributions to a flexible spending account for medical expenses.
5. Increase the threshold for the itemized deduction for un-reimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes.
6. Increase the Medicare Part A (hospital insurance) rate on wages from 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individuals and \$250,000 for married couples filing jointly and impose a 3.8% tax on unearned income for higher-income taxpayers.
7. Impose 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 (with certain adjustments).
8. Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments
9. Impose new annual fees on the pharmaceutical manufacturing sector-\$2.8 billion to \$4.1 billion through 2012-2018-dropping afterward.
10. Impose an annual fee on the health insurance sector-\$8 billion to \$14.3 billion through 2014-2018 and forward.
11. Impose an excise tax of 2.3% on the sale of any taxable medical device.
12. Limit the deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers.