

Affordable Care Act

1. Small business tax credits
 - a. Effective 01/01/2010
 - b. Up to 4 million small businesses are eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35% of the employer's contribution to the employees' health insurance. Small non-profit organizations may receive up to a 25% credit.
 - i. Qualifying
 1. Must cover at least 50% of insurance costs
 2. Credit applies to portion paid by company
 3. Company must have 25 FTE employees or less
 4. Average employee annual wage must be less than \$50,000
2. \$250 Medicare Drug Cost Rebate
 - a. Effective 06/01/10
 - b. One time \$250 tax free payment for qualifying candidates
 - c. Donut Hole-out of pocket costs born by Medicare & personal plans
3. Expanded coverage for young adults
 - a. Cover persons up to age 26 for health plans beginning on or after 09/23/10
 - b. Regardless of persons
 - i. Marriage status
 - ii. Residence (regardless if live with parent)
 - iii. School status
 - iv. Financial dependence on parent
 - v. Enrollment available on own plan-however until 2014 "grandfathered" plans do not have to offer coverage if youth has group coverage outside of parents plan.
4. Pre-existing condition insurance policies-effective 07/01/10-01/01/2014
 - a. Effective 2014 discrimination against pre-existing conditions prohibited.
 - b. Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums.
 - c. Appropriate \$5 billion to finance the program.
5. Covering more Medicaid expenses
 - a. Effective 4/1/2010
 - b. Provide states with matching funds for additional persons to cover on Medicaid.
 - c. Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate \$10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for FY 2010-2014)
 - d. Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for

individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan (Effective 10/01/2010)

- e. Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years (Effective 10/01/2011)
6. New Resources and new screening procedures for health care providers to reduce Medicare, Medicaid and CHIP fraud.
 - a. Many in effect now
 - b. Increased sentencing, easing fraud investigation processes.
 - c. Increased oversight of providers and suppliers
 - d. Increase funding for enforcement of HCFAC-Health Care Fraud and Abuse Control Act \$350M over the period of 2011-2020
 - e. Share Data across federal agencies to fight fraud-allow DOJ access to some records
 - f. New Tools to prevent fraud such as requiring surety bonds
 - g. Expand overpayment recovery efforts
 - h. Higher civil and monetary penalties
 - i. Greater oversight of private insurance abuses
7. Expand Coverage for Early Retirees
 - a. Preserve employer coverage for folks retiring at age 55-65 (and spouses/dependents). Folks not eligible for Medicare but retired
 - b. Temporary 06/1/2010-01/01/2014-bridge until health insurance exchanges are enacted. .
 - c. Only \$5B allowed to reimburse/reinsure for employment-based plans. Employers must apply and comply to join.
 - d. This will save retirees now but when it is converted to insurance exchanges in 2014 may make remaining employers drop early retiree benefits in favor of using the exchanges.
 - e. Reimburse employers or insurers for 80% of retiree claims between \$15,000-\$90,000.
 - f. Payments from the re-insurance program will be used to lower the costs for enrollees in the employer plan.
8. Provide free preventative care.
 - a. Plans or new plan years starting on or after 9/23/10
 - b. No deductible, co-pay or coinsurance.
 - c. This applies to job-related and individual health plans.
 - d. Services will probably have to be provided within networks.
 - e. If combined with other services, other services can have charges.
9. Prohibit insurance companies from rescinding coverage
 - a. Plans or new plan years starting on or after 9/23/10
 - b. Illegal to rescind on basis of error or technical mistake on application.

10. Appeals process for Insurance Company decisions
 - a. Plans or new plan years starting on or after 9/23/10
 - b. Provides consumers with a way to appeal coverage determinations or claims to their insurance company, and establishes an external review process
11. Eliminate lifetime limits on insurance coverage
 - a. Plans or new plan years starting on or after 9/23/10
12. Regulating annual limits on insurance coverage
 - a. Plans or new plan years starting on or after 9/23/10
 - b. Graduated limits allowed up to 2014 when all limits will be banned.
13. Prohibit denying coverage of children based on pre-existing conditions.
 - a. Plans or new plan years starting on or after 9/23/10
 - b. Up to 19 years of age.
14. Holding Insurance Companies accountable for unreasonable rate hikes.
 - a. Grants start to be awarded in 2010
 - b. The law allows states that have, or plan to implement, 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
 - c. Establish a process for reviewing increases in health insurance premiums and require plans to justify increases.
 - d. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases.
 - e. Provide grants to states to support efforts to review and approve premium increases.
15. Rebuilding Primary Care Workforce
 - a. Effective in 2010
 - b. To strengthen the availability of primary care, there are new incentives in the law to expand the number of primary care doctors, nurses and physician assistants, including funding for scholarships and loan repayments for primary care doctors and nurses working in underserved areas
16. Preventing disease and illness
 - a. Effective in 2010
 - b. A new \$15 billion Prevention and Public Health Fund will invest in proven prevention and public health programs that can help keep Americans healthy – from smoking cessation to combating obesity.
 - c. Develop a national strategy to improve the nation’s health. (Strategy due one year following enactment).
 - d. Establish a Prevention and Public Health Fund for prevention, wellness, and public health activities, including prevention research and health screenings, the Education and Outreach Campaign for preventative benefits, and immunization programs. Appropriate 7 billion for funding in FY 2010-2015.
 - e. Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health

disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning FY 2010).

17. Payments for Rural Health Care Providers
 - a. Effective in 2010
 - b. Today, 68% of medically underserved communities across the nation are in rural areas, and these communities often have trouble attracting and retaining medical professionals. The law provides increased payment to rural health care providers to help them continue to serve their communities
 - c. A 10% Medicare bonus to primary care doctors and surgeons practicing in areas such as inner cities and rural communities which are underserved.
18. Strengthening Community Health Centers
 - a. Effective in 2010
 - b. Improve 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 (effective fiscal year 2011).
 - c. Establish new programs to support school-based health centers (effective fiscal year 2010) and nurse-managed clinics (effective FY 2010).
19. Prescription Drug Discounts
 - a. Effective in 1/1/2011
 - b. For brand-name drugs, require RX manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013)
 - c. For generic drugs, provide federal subsidies of 75% of the generic drug cost by 2020 for prescriptions filled in the Medicare Part D coverage gap (phased in beginning 2011).
20. Free preventative care for seniors.
 - a. Effective 1/1/2011
 - b. The law provides certain free preventive services, such as annual wellness visits and personalized prevention plans, for seniors on Medicare
 - c. Eliminate cost-sharing for Medicare covered preventative services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. Authorize the Secretary to modify or eliminate Medicare coverage of preventative services, based on recommendations of the U.S. Preventative Services Task Force (Effective 01/01/2011)
 - d. Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective 01/01/2011 or when program is developed, whichever is first).
21. Bringing down health care premiums
 - a. Reporting begins in 2010. Rebate program begins 01/01/2011
 - b. 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

22. Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage
- a. Effective 01/01/2011
 - b. Today, 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. The new law levels the playing field by gradually eliminating this discrepancy. People enrolled in a Medicare Advantage plan will still receive all guaranteed Medicare benefits, and the law provides bonus payments to Medicare Advantage plans that provide high quality care.
 - c. 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.
 - d. Provide bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for MA plans, beginning in 2012; qualifying plans in qualifying areas receive double bonuses. Modify rebate system with rebates allocated based on a plan's quality rating. Phase-in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5.7% by 2019. Cap total payments, including bonuses, at current payment levels. Require MA plans to remit partial payments to the Secretary if the plan has a medical loss ratio of less than 85%.
 - e. Require the Secretary to suspend plan enrollment for 3 years if the medical loss ratio is less than 85% for 2 consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for 5 consecutive years.
 - f. Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice, and other Medicare providers and adjust for productivity (Effective dates vary).
 - g. 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)
 - h. Establish 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. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U

and CPI-M, based on a five year period ending that year. If so, beginning 01/15/2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by 01/01/2015.

- i. Reduce 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 (Effective fiscal year 2014)
- j. Eliminate the Medicare Improvement Fund (effective upon enactment)
- k. Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established 01/01/2012)
- l. Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid and CHIP programs (Effective 01/01/2011)
- m. Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions (Effective 10/01/2012)
- n. Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1% (Effective FY 2015)
- o. Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than 01/01/2012).
- p. Expand 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 06/17/09 and have developed certain health conditions as a result (Effective on enactment)

- q. Prohibit MA plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under traditional fee-for-service programs (Effective 01/01/2011)
23. Improving health care quality and efficiency.
- a. Effective no later than 01/01/2011
 - b. The law establishes a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients. These new methods are expected to improve the quality of care and reduce the rate of growth in costs for Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). By January 1, 2011, HHS will submit a national strategy for quality improvement in health care, including these programs.
 - c. Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.
24. Improve care for seniors after they leave the hospital.
- a. Effective 01/01/2011
 - b. The Community Care Transitions Program will help high-risk Medicare beneficiaries who are hospitalized avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities
25. New innovations to bring down costs
- a. Administrative funding becomes available 10/01/2011
 - b. The Independent Payment Advisory Board will begin operations to develop and submit proposals to Congress and the President aimed at extending the life of the Medicare Trust Fund. The Board is expected to 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.
26. Increasing access to services at home and in the community.
- a. Effective beginning 10/01/2011-09/30-2015
 - b. The new Community First Choice Option allows States to offer home and community based services to disabled individuals through Medicaid rather than institutional care in nursing homes.
 - c. State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally based long-term services and supports.
27. Encouraging integrated health care systems
- a. Effective 01/01/2012
 - b. The new law provides incentives for physicians to join together to form “Accountable Care Organizations.” In these groups, doctors can better coordinate patient care and improve the quality, help prevent disease and illness, and reduce unnecessary hospital admissions. If Accountable Care Organizations provide high quality care and reduce costs to the health care system, they can keep some of the money that they have helped save.
 - c. Example: Mayo Clinic model.
28. Understanding and fighting health disparities

- a. Effective March 2012
 - b. To help understand and reduce persistent health disparities, the law requires any ongoing or new Federal health program to collect and report racial, ethnic and language data. The Secretary of Health and Human Services will use this data to help identify and reduce disparities.
 - c. Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.
 - d. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities.
29. Provide new, voluntary options for long-term care insurance
- a. Benefit plan no later than 10/01/2012
 - b. The law creates a voluntary long-term care insurance program – called CLASS - to provide cash benefits to adults who become disabled
 - c. Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following the five-year vesting period, the program 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. (Effective 01/01/2011)
30. Reducing paperwork and administrative costs
- a. First regulation effective 10/01/2012
 - b. Health care remains one of the few industries that relies on paper records. The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and, most importantly, improve the quality of care.
 - c. Insurance company paperwork will be standardized.
31. Linking payment to quality outcomes
- a. Effective for payments for discharges on or after 10/01/2012
 - b. The law establishes a hospital Value-Based Purchasing program (VBP) in Original Medicare. This program offers financial incentives to hospitals to improve the quality of care. Hospital performance is required to be publicly reported, beginning with measures relating to heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care. They will fund programs that test ways to pay medical professionals, hospitals, and other care providers who care for Medicare patients for the duration of admission. They will reduce Medicare payments to hospitals with a high rate of preventable re-admissions.
32. Improving preventative health coverage
- a. Effective 01/01/2013

- b. To expand the number of Americans receiving preventive care, the law provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost.
33. Increasing Medicaid payments for primary care doctors
- a. Effective 01/01/2013
 - b. As Medicaid programs and providers prepare to cover more patients in 2014, the Act requires states to pay primary care physicians no less than 100 percent of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government
 - c. Increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014.
 - d. States will receive 100% federal financing for the increased payment rates (Effective 01/01/2013)
 - e. Provide a 10% bonus payment to primary care physicians in Medicare from 2011-2015. (Effective for five years beginning 01/01/2011)
34. Expanded authority to bundle payments
- a. Effective no later than 01/01/2013
 - b. The law establishes a national pilot program to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care. Under payment “bundling,” hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test or bundles of items or services are billed separately to Medicare. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a “bundled” payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program.
 - c. Establish a national Medicare pilot program 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 that begins three days prior to hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program (Establish pilot program by 01/01/2013; expand program, if appropriate, by 01/01/2016).
 - d. Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction (Effective 01/01/2012)
35. Additional funding for the Children’s Health Insurance Program (CHIP)
- a. Effective 10/01/2013

- b. Under the new law, states will receive two more years of funding to continue coverage for children not eligible for Medicaid.
- c. Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue under current law. Provide states with the option to provide CHIP coverage to children of state employees who are eligible for health benefits if certain conditions are met. Beginning in 2015, states will receive a 23 % point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.

36. Establishing Health Insurance Exchanges

- a. Effective 01/01/2014
- b. 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.
- c. Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a government agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017.
- d. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until 01/01/2015).
- e. Restrict access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.
- f. No similar provision to create a public plan option.
- g. Require 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 abortions beyond those permitted by federal law.
- h. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.
- i. Establishing Health Care Co-Ops

- i. 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.
 - ii. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefits plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (Appropriate \$6 billion to finance the program and award loans and grants to establish CO-Ops by 07/01/2013)
- j. 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.
 - i. Bronze plan represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefits costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit (\$5950 individuals/\$11900 families in 2010)
 - ii. Silver plan provides the essential health benefits, covering 70% of the benefit costs of the plan, with the HSA out-of-pocket limits..
 - iii. Gold plan provides the essential health benefits, covering 80% of the benefit costs of the plan, with the HSA out-of-pocket limits.
 - iv. Platinum plan provides the essential health benefits, covering 90% of the benefit costs of the plan, with the HSA out-of-pocket limits.
 - v. Catastrophic plan available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HAS current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market.
- k. Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
 - i. 100-200% FPL-1/3 of the HSA limits (\$1983/individual and \$3967/family)
 - ii. 200-300% FPL-1/2 of the HSA limits (\$2975/individual and \$5950/family)
 - iii. 300-400% FPL-1/2 of the HSA limits (\$3987/individual and \$7973/family)
 - iv. These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.
- l. Require qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on

quality measures, use a uniform enrollment form and standard format to present plan information.

- m. Require qualified health plans to report information on claims payment policies, enrollment, dis-enrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.
- n. Require the Exchanges to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Require states to develop a single form for applying for a state health subsidy program that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges.
- o. Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges.
- p. Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.
- q. Permit states to prohibit plans participating in the Exchange from providing coverage for abortions.
- r. Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no less than \$1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Prohibit plans participating in the Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.
- s. Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer

protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. (Regulations issued by 01/01/2013, compacts may not take effect before 01/01/2016).

37. Promoting individual responsibility

- a. Effective 01/01/2014
- b. 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
- c. One of the major complaints of the bill is this provision as possibly unconstitutional.
- d. Except in case of financial hardship citizens and legal residents must have health insurance or pay a fine to the IRS of \$95 per person in 2014 up to \$695 per person in 2016. The penalty is capped for families at \$2,250 and after 2016 will be adjusted for inflation.
- e. Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount (\$2085) per family or 2.5% of household income. The penalty will be phased in according to the following schedule:
 - 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)

38. Ensuring Free Choice

- d. Effective 01/01/2014
- e. 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. These new competitive marketplaces will allow individuals and small businesses to buy qualified health benefit plans. Starting in 2014, Members of Congress will be getting their health care insurance through Exchanges and all Americans will have the choice of buying insurance through them, too.
- f. Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to

what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange.

39. Increasing access to Medicaid.

- a. Effective 01/01/2014
- b. Americans who earn less than 133 percent of the poverty level (approximately \$14,000 for an individual and \$29,000 for a family of four) will be eligible to enroll in Medicaid. States will receive 100 percent federal funding for the first three years to support this expanded coverage, phasing to 90 percent federal funding in subsequent years.
- c. Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law in the House and Senate passed bills undocumented immigrants are not eligible for Medicaid.)
- d. All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.
- e. Funding of this provision to finance the coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those who were enrolled in state-funded programs), states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states. States have the option to expand Medicaid eligibility to childless adults beginning 04/04/2010, but will receive their regular FMAP until 2014.
- f. In addition, increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates (Effective 01/01/2014)
- g. Increase 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. (Effective 01/01/2010) Extend the drug rebate to Medicaid managed care plans (Effective upon enactment).
- h. Reduce aggregate Medicaid DSH allotments by \$.5 billion in 2014, \$.6 billion in 2015, \$.6 billion in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020. Require the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the

largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers. (Effective 10/01/2011).

- i. Prohibit federal payments to states for Medicaid services related to health care acquired conditions (Effective 07/01/2011).
40. Make care more affordable
- a. Effective 01/01/2014
 - b. Tax credits to make it easier 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. These individuals may also qualify for reduced cost-sharing (e.g. co-payments, coinsurance, and deductibles)
 - c. Limit availability of premium credits and cost sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.5% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.
 - d. Provide refundable and advanceable premium credits to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels:
 - i. Up to 133% FPL: 2% of income
 - ii. 133-150% FPL: 3 – 4% of income
 - iii. 150-200% FPL: 4 – 6.3% of income
 - iv. 200-250% FPL: 6.3 – 8.05% of income
 - v. 250-300% FPL: 8.05 – 9.5% of income
 - vi. 300-400% FPL: 9.5% of income
 - e. Increase the premium contributions for those receiving subsidies annually to reflect the excess of the premium growth over the rate of income growth for 2014-2018. Beginning in 2019, further adjust the premium contributions to reflect the excess of premium growth over CPI if aggregate premiums and cost sharing subsidies exceed .54% of GDP.
 - f. Provisions related to the premium and cost sharing subsidies are effective 01/01/2014.
 - g. Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level:
 - i. 100-150% FPL: 94%
 - ii. 150-200% FPL: 87%

- iii. 200-250% FPL: 73%
 - iv. 250-400% FPL: 70%
 - v. Require verification of both income and citizenship status in determining eligibility for the federal premium credits.
- h. Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion.
- 41. Ensuring coverage for individuals participating in clinical trials
 - a. Effective 01/01/2014
 - b. Insurers will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. This applies to all clinical trials that treat cancer or other life-threatening diseases.
- 42. Eliminating annual limits on insurance coverage
 - a. Effective 01/01/2014
 - b. The law prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive.
- 42. No discrimination due to pre-existing conditions or gender.
 - a. Effective 01/01/2014
 - b. The law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual's pre-existing conditions. Also, in the individual and small group market, it eliminates the ability of insurance companies to charge higher rates due to gender or health status.
 - c. Insurance premiums will vary only by age, place of residence, family size, and tobacco use.
- 43. Increasing small business health insurance tax credit
 - a. Effective 01/01/2014
 - b. See #4
 - c. The law implements 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.
 - d. The credit phases out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.
 - e. For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.
- 44. Paying physicians based on value not volume.

- a. Effective 01/01/2015
 - b. A new provision will tie physician payments to the quality of care they provide. Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care.
45. Wal-Mart Provision
- a. 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
 - b. Assess 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 a fee of \$2000 per full-time employee, excluding the first 30 employees from the assessment.
 - c. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3000 for each employee receiving a premium credit or \$2000 for each full-time employee, excluding the first 30 employees from the assessment (Effective 01/01/2014)
 - d. 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.
46. Tax and Fee Provisions
- a. Impose a tax on individuals without qualifying coverage of the of the greater of \$695 per year up to a maximum of three times that amount or 2.5% of household income to be phased-in beginning in 2014.
 - b. Exclude the costs for over-the counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HAS or Archer Medical Savings Account (Effective 01/01/2011)
 - c. Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% from HSAs and from 15% for Archer MSAs) of the disbursed amount (Effective 01/01/2011).
 - d. Limit the amount of contributions to a flexible spending account for medical expenses to \$2500 per year increased annually by the cost of living adjustment. (Effective 01/01/2013)
 - e. Increase 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; waive the increase for individuals age 65 and older for tax years 2013 through 2016 (Effective 01/01/2013).
 - f. 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. (thresholds are not indexed) (Effective 01/01/2013).

- g. 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 (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) for years beginning in 2020). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by \$1,650 for individual coverage and \$3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers. The tax is equal to 30% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA) and coverage for supplementary health insurance coverage, excluding dental and vision coverage. (Effective 01/01/2018)
- h. Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments (Effective 01/01/2013)
- i. Impose new annual fees on the pharmaceutical manufacturing sector, according to the following schedule:
 - i. \$2.8 billion in 2012-2013;
 - ii. \$3.0 billion in 2014-2016;
 - iii. \$4.0 billion in 2017;
 - iv. \$4.1 billion in 2018; and
 - v. \$2.8 billion in 2019 and later.
- j. Impose an annual fee on the health insurance sector, according to the following schedule:
 - i. \$8 billion in 2014;
 - ii. \$11.3 billion in 2015-2016;
 - iii. \$13.9 billion in 2017;
 - iv. \$14.3 billion in 2018
 - v. For subsequent years, the fee shall be the amount from the previous year increased by the rate of premium growth. For non-profit insurers, only 50% of net premiums are taken into account in calculating the fee. Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations (VEBAs) not established by an employer (Effective 01/01/2014)
 - vi. Impose an excise tax of 2.3% on the sale of any taxable medical device (Effective for sales after 12/31/2012).

- vii. Limit the deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers (Effective 01/01/2009)