High Level Overview of the Patient Protection and Affordable Care Act

Staff summary of themes, major changes, with a focus on areas that impact state policy decisions- highlighted in color

I. Summary of Select Insurance Market Changes and Expansion of Coverage

- **Early insurance changes (first 6 months):**
  - Creation of new insurance option for uninsured citizens with pre-existing conditions (a.k.a. the new high risk pool) - temporary program with federal funding to 2014 (starts July 2010).
  - Reinsurance program for employers with retiree (non-Medicare) plans - temporary funding to reimburse 80% of claims costs between $15,000 - $90,000 (starts June 2010).
  - Elimination of lifetime maximums (on all plans* effective September 2010); and elimination of annual limits in 2014 (for new individual plans and all employer plans).
  - Prohibition on rescission of coverage(the dropping of a person when they get sick).*
  - Coverage of preventive health services with no cost-sharing for all new plans and Medicare
  - Extension of dependent coverage up to the age of 26 for all plans that offer dependent coverage.*
  - Prohibition on preexisting condition exclusions for children under 19.*
  - Enhanced consumer information: Uniform information on benefits and coverage, new web portal for information and comparison of benefits and plans (July 1), disclosure of claims payments and rating policies, appeals process.
  - Medical loss ratio reporting/share of premiums spent on medical care: In 2010, health plans are required to report the proportion of premiums spent on items other than medical care. In 2011, health plans in the large group market that spend less than 85 percent of their premiums on medical care and health plans in the small-group and individual market that spend less than 80 percent on medical care will be required to offer rebates to enrollees.
  - Annual Review of Premium Increases: In 2010, the HHS secretary and states will establish a process for annual review of unreasonable premium increases.

    (* = *change required for all plans*)

- **New rating rules (2014):**
  - New federal rules for the individual and group markets, including requiring all insurance carriers to accept every individual who applies for coverage (guaranteed issue and renewability); prohibiting rating on the basis of health status, medical condition, claims experience, etc.; limit waiting period for group coverage to 90 days; requires defined essential benefits for individual and small group.
  - Premiums can reflect age, but cannot vary by more than 3:1, tobacco use (maximum variation of 1.5:1), family composition, participation in a health promotion program, and geography.
  - Rating rules must apply to all health insurers and group health plans.
  - Grandfathers in plans in existence March 23, 2010 (exempt from many new requirements but not all).
  - States will have the option to merge the pooling and rating requirements of the individual and small-group markets.

- **State Insurance Exchanges (2014):**
  - Each state is required to establish an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange for individuals and small employers with up to 100

employees; States can opt to provide a single exchange for individuals and small employers, and explore regional exchanges.
        - Redefines the size of small group up to 100; States may limit small groups to 50 until 2016.
        - After 2017, employers with more than 100 employees may purchase through the Exchange.
    - While the individual and small-group markets will not be replaced by the exchanges (plans are grandfathered in), the same market rules will apply inside and outside the exchanges.
    - Essential health benefits package required, with 4 benefit values (60%,70%,80%,90%) with limited cost-sharing (e.g., deductible of $2,000 for small group). Essential benefits package to be defined by HHS. Allows an individual catastrophic-only plan for those under age 30.
    - State benefit mandates above the essential health benefits will require state financial support/reimbursement.
    - Premium subsidies will be available only for plans purchased through the exchanges (or a Basic Health option if the state chooses to create a Basic Health option. Subsidies will be available for premiums and cost-sharing reductions for people with incomes between 133% and 400% of the federal poverty level on a sliding scale.
    - States allowed the option of offering a Basic Health program for low-income not eligible for Medicaid (133% -200% FPL), as alternative to the Exchange for some. States receive 95% of the tax credits and cost-sharing reductions that would have been for the individuals in the Exchange.
    - Exchange will have requirement for: verification of income and citizenship status; link to Medicaid (BH) for eligibility and premium credits; certification of qualified health plans; and reinsurance and risk adjustment, etc..
    - Exchange(s) may be state administered or administered by a non-profit entity.

- **Subsidies for Individuals (2014):**
    - Individuals **in Exchange** eligible for refundable and advanceable premium credits, tied to the second lowest cost silver plan in the area, on a sliding scale so premiums are a percentage of income (0-133% FPL=2%; 133-150%=3-4%; 150-200%=4-6.3%; 200-250%=6.3-8.05%; 250-300%=8.05-9.5%; 300-400%=9.5%).
    - Cost-sharing subsidies will also available by income to reduce cost-sharing and annual limits which increases the actuarial value of the basic benefit plan.
- **Individual Responsibility (2014):**
    - Citizens and legal residents will be required to obtain health insurance coverage or pay a tax levied through the IRS (2014 -$95 or 1% of taxable income; 2015 - $325 or 2% of taxable income, 2016 - $695 or 2.5% of taxable income).
    - Some exceptions include individuals with incomes below the tax filing threshold, where lowest cost plan exceeds 8% of individual's income, religious objections, American Indians, etc.
- **Employer Responsibility (2014):**
    - There is not a requirement to offer coverage.
    - Employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit must pay a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment.
    - Employers with more than 50 employees that offer coverage and have at least one full-time employee receiving a premium tax credit, must pay the lesser of $3,000 for each employee receiving the premium credit or $2,000 for each full-time employee.
    - Employers with 50 or fewer employees are exempt from fee.
    - A critical factor in determining an employer's potential responsibility to pay a fee is whether

their employees would be eligible to receive a premium credit through the Exchange. Eligibility for premium credits is designed so there is not an incentive for employers to drop coverage and have their low wage workers get coverage through an Exchange. Thus, employees who are offered coverage by an employer generally are not eligible for premium credits through the Exchange unless:
    - The employer pays less than 60% of the total allowed costs of benefits provided under the health plan; or
    - The employee's share of the premium for his/her coverage exceeds 9.5% of his/her household income.
  - There is one other situation in which an employee offered employer sponsored coverage can get coverage through an Exchange. If an employee has incomes below 400% of the poverty level and their share of the premium cost is between 8-9.8% of income, then their employer must give them a voucher equal to the amount that the employer would pay toward their coverage. The employee could then use the voucher to buy coverage through the Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.
  - Employers with more than 200 employees 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.

- **Premium subsidies for employers (2010):**
  - 2010 tax credit for small employers with fewer than 25 employees and avg. annual wages of less than $50,000. 2010 - 2013 example - tax credit of up to 35% of employer contribution if employer contributes at least 50% of premium cost or 50% of benchmark premium.

- **Compacts (2016):**
  - Health care choice compact for selling across state lines allowed to take effect in 2016.

II. Expansion of Medicaid Coverage and Significant Changes

- **Early Medicaid Expansion (April 1, 2010):**
  - Washington has the option to expand Medicaid eligibility to childless adults through 2014.
  - DSHS submitted a federal Waiver to refinance the Basic Health Plan and Security Lifeline (formerly GA-U) with Medicaid funding.
  - Medicaid funding would be available at the existing FMAP match rate.
  - Assumes federal approval will be received by December, 2010.

- **Permanent Medicaid Expansion (January 1, 2014):**
  - All non-Medicare eligible individuals under age 65 with incomes below 133% of FPL eligible for Medicaid.
  - 2014 -2016 -100% federally funded
  - 2017 -95% federally funded
  - 2018 -94% federally funded
  - 2019 -93% federally funded
  - 2020 on -90%federally funded

- **Children's Health Insurance Program (CHIP):**
  - Washington must maintain current eligibility levels for children in Medicaid and CHIP until 2019.

- Children of state employees who are eligible for health benefits may be covered through CHIP as a state option.
- Beginning in 2015 Washington will receive a 23% increase in the CHIP match rate.

III. (Medicaid) Aging Population and Long Term Care

- CLASS Act: Establishes a national, voluntary insurance program for purchasing community living assistance services and supports. (Regulations ready/October 2012)
- Creates a federal office to improve coordination for people dual eligible for Medicaid and Medicare. (2010)
- Establishes the Community First Choice Option in Medicaid expanding community-based attendant supports and services. (October 2011)
- Extends the Medicaid Money Follows the Person Rebalancing Program. (Extends program through 2016)
- Provides enhanced federal matching payments to states who increase the proportion of non-institutional long term care services in Medicaid. (October 2011)
- Expands options for offering home and community-based services through a Medicaid state plan up to 300 percent of max SSI. (October 2010)
- Background checks expanded to include workers in long term care facilities. (new funds for background checks 2010-2012)
- Spousal impoverishment rules changes. (January 2014)
- Added funding to State Aging and Disability Resource Centers.
- Elder Justice Act will increase research, worker training and forensic studies on elder abuse.

IV. Health Workforce and Public Health, Prevention and Chronic Care

Data Collection:

- Establishes a National Health Care Workforce Commission to provide comprehensive, unbiased information to Congress and the administration about how to align workforce resources with national needs. Examination of barriers to entering and remaining in primary care careers is added as a high priority.
- Health care workforce assessment is expanded by adding several regional centers to collect, analyze and report data related to the public health service act.

Loans, Grants and Scholarship Program:

- State health care workforce development grants are created to increase the number of skilled health care workers.
- Loan repayment program for those working in a Health Professional Shortage Area, Medically Underserved Area or with a Medically Underserved Population. Loan repayment provided to public health workers and students for working in a federal, state, local or tribal public health agency.
- Loan repayment to allied health professional working in public health agencies or specific types of health care facilities located in HPSA's, MUA or with MUP.
- Grants for public and allied health professional in public and allied health positions at Federal, State, local or tribal level to receive additional training in public or allied health fields.
- Creates a grant program to support nurse-managed health clinics.

- Creates grants for training programs in primary care (financial assistance to trainees and faculty, faculty development in primary care and PA program with priority given to team based approach to care).
- Reinstates a line of dental funding in the Public Health Service Act to allow dental schools to use grants for pre-doctoral training, faculty development, dental faculty loan repayment, and academic administrative units.
- Provides grants to establish training programs for alternative dental health care providers to increase access to dental services in rural, tribal and underserved communities.
- Extends funds to geriatric education centers for training in geriatric, chronic care and long term care for faculty in health professions schools.
- Provides grants to schools to expand training in social work, graduate psychology, and mental health and training to paraprofessionals in child and adolescent mental health.
- Expands programs developing model curricula for cultural competency for working with individuals with disabilities.
- Provides grants to nursing schools to improve nurse retention, adds nursing school faculty as eligible for loan repayment and scholarship programs, and establishes a student loan repayment program for nurses with outstanding debt who pursue careers in nursing education.
- Provide grants to medical schools for physician recruitment and training to practice in underserved rural communities.
- Establishes competitive grants to provide the opportunity for low income individuals (including TANF recipients) to be trained for high demand health care occupations.
- Increases teaching capacity by expanding primary care residency programs at teaching health centers.
- Creates a grant program to support health care providers who treat a high percentage of medically underserved populations.

Prevention of Chronic Disease and Improving Public Health:

- Creates an interagency Council to promote healthy policies at the Federal level. The Council will report to the Congress annually on activities and progress in meeting goals of the national strategy.
- Expands the efforts of the U.S. Preventive Services Task Force and the Community Preventive Services Task Force which both provide recommendations for preventive interventions (e.g. Cancer screening, tobacco cessation, skin cancer prevention etc.).
- Directs the Secretary to convene a national public/private partnership to conduct a prevention and health promotion outreach and education campaign.
- Authorizes a grant program for School-Based Health Centers.
- Creates demonstration programs on oral health delivery including healthcare prevention.
- Authorizes states to purchase adult vaccines under CDC contracts and provides CDC grants to States to improve immunization coverage of children, adolescents, and adults through the use of evidence based interventions.
- Provides funding for public health research, supports worksite health promotion, awards grants to improve responses to infectious diseases and other conditions of public health.
- Authorizes an Institute of Medicine Conference on Pain Care and establishes a grant program to improve health professionals' ability to treat pain.
- Creates funding for a childhood obesity demonstration project to reduce childhood obesity.
- Authorizes programs to address diabetes, depression, congenital heart disease and breast health.

V. Delivery System Improvements; Payment Reforms; Quality Improvements

National Strategies:

- Establishes the- Patient Centered Outcomes Research Institute to conduct research comparing the clinical effectiveness of medical treatments.
- Establishes the Center for Medicare and Medicaid innovation within the Centers for Medicare and Medicaid Services to test new provider models that improve quality and reduce cost within public programs. (January 2011)
- Sets up processes for developing quality measures to be used for reporting and payment under federal programs. These processes will include public input and provide for grants beginning this year.
- Establishes the Independent Payment Advisory Board to submit recommendations to Congress every other year to slow the growth of national health expenditures while improving quality. (2013)

Medicare:

- Establishes a national pilot program to evaluate paying bundled payments for acute, inpatient hospital services, physician services, outpatient hospital services and post-acute services. (2013)
- Creates the Independence at Home demonstration program for high-need Medicare beneficiaries. (2012)
- Allows for a ten percent payment bonus for primary care services for five years beginning 2011.
- Provides for 10 percent increase in payments to general surgeons providing care in designated shortage areas. (2011-2015)
- Establishes a value-based purchasing program for hospitals. (2012)
- Reduces Medicare hospital payments for potentially preventable readmissions for certain eligible conditions. (2012)
- Directs a pay-for-performance pilot program for certain Medicare providers.
- Establishes several value-based purchasing programs for physicians. (2011-2014)
- Provides for enhanced payments for primary care services organized as accountable care organizations. (2012)
- Establishes a physician-compare website. (2011)
- Establishes the Independent Payment Advisory Board tasked with making recommendations to Congress for reducing the per capita growth rate of Medicare.

Medicaid:

- Establishes demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations. (2012- 2016)
- Demonstration projects providing global capitated payments to safety net hospitals. (2010-2012)
- Increase payments to payments to primary care physicians to 100 percent of Medicare rates for 2013 and 2014.
- Establishes the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate services to low- income populations. (2011)
- Increases funding to community health centers, the National Health Service Corps by $11 billion over five years.
- In 2011 states can amend Medicaid state plan to fund medical home services for individuals with at least two chronic conditions or a serious and persistent mental health condition.
- Creates a grant program to establish community health teams charged with supporting patient-centered medical homes. Interdisciplinary community health teams must contract with primary care

providers to provide care coordination, chronic disease management, care planning etc.
- Establishes a demonstration project to allow pediatric providers to organize as accountable care organizations. (January 2012 - December 2016)

VI. Medicare at a glance

- **Medicare Part D Drug Coverage:**
  - Provides a $250 rebate for beneficiaries who reach the "Doughnut Hole;" (January 1, 2010)
  - Beneficiary coinsurance rate reduced from 100% to 25% by 2020;
  - 50% discount from pharmaceutical manufacturers, plus 25% federal subsidy for brand name drugs;
  - 75% federal subsidy for generic drug costs.
- Preventive benefits covered without cost sharing. (2011)

VII. Taxes/Revenue Changes at a glance

- Individual tax for those without qualifying coverage, phase-in begins 2014.
- Exclude over-the counter drugs not prescribed by a doctor from reimbursement on tax-free basis through an HRA or FSA. (January 2011)
- Increase tax on distributions from health savings account or archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSA and 15% for Archer MSA).
- Limit contributions to flexible spending account for medical expenses to $2,500 year, increasing annually. (2013)
- Itemized deduction for unreimbursed medical expenses increases to 10% from 7.5% of gross income for tax purposes. (2013)
- Increase Medicare part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individuals, $250,000 for married filing jointly and impost 3.8% tax on unearned income for higher income taxpayers. (2013)
- New excise tax on insurers of employer plans with aggregate values above $10,200 for individual coverage and $27,500 for family coverage (indexed to CPI) of 40% of value above threshold (2018)
- Eliminate tax deduction for employers who receive Medicare part D retiree drug subsidy payments. (2013)
- Annual fee on pharmaceutical manufacturing sector. (Phase in 2012)
- Annual fee on health insurance sector. (Phase in 2014)
- Excise tax of 2.3% on sale of taxable medical devices. (December 31, 2012)
- 10% tax on indoor tanning services. (July 1, 2010)
- Limit health insurance deductibility of executive and employee compensation to $500,000 per individual. (January 1, 2009)