

Patient Protection Act (with changes made by Reconciliation)

Individual Mandate

All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of \$695 per person (up to a maximum of \$2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016. Exceptions will be given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; if the lowest cost health plan exceeds 8% of income; and if the individual has income below the poverty level (\$10,830 for an individual and \$22,050 for a family of four in 2009).

Guaranteed Issue

Through private market reforms (detailed below) all carriers will be required to have guaranteed issue and guaranteed renewal in order to accommodate the individual mandate beginning in 2014.

American Health Benefit Exchanges

States will create the American Health Benefits Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

- Access to Exchanges will be limited to U.S. citizens and legal immigrants and subsidies will only be available to those without other coverage or whose share of the premium for coverage offered by an employer exceeds 9.8% of their income. Small businesses with up to 100 employees can purchase coverage through the Exchange.
- Although there will not be a public plan option in the Exchanges, the Office of Personnel Management, which administers the Federal Employees Health Benefit Program, will contract with private insurers to offer at least two multi-state plans in each Exchange, including at least one offered by a non-profit entity. In addition, funds will be made available to establish non-profit, member-run health insurance CO-OPs in each state.
- Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.
- The four levels of coverage will be:
 - Bronze – minimum level of coverage, provides essential health benefits. Cover 60% of benefit costs of plans, with an out of pocket limit equal to the HSA current limit (\$5,950 for individual and \$11,900 for family).
 - Silver plan - provides the essential health benefits, covers 70% of the benefit costs of plan, with the HSA out-of-pocket limits.
 - Gold plan – provides the essential health benefits, covers 80% of the benefit costs of plan, with the HSA out-of-pocket limits.
 - Platinum plan – provides the essential health benefits, covers 90% of the benefit costs of plan, with the HSA out-of-pocket limits.
- Premium subsidies will be provided to families with incomes between 100-400% of the poverty level (or \$22,050 to \$88,200 for a family of four in 2009) to help them purchase insurance through the Exchanges. These subsidies will be offered on a sliding scale basis and will limit the

cost of the premium to between 2% of income for those between 100-133% of the poverty level to 9.8% of income for those between 300- 400% of the poverty level.

- Cost-sharing subsidies will also be available to people with incomes between 100-200% of the poverty level to limit out-of-pocket spending.
- Broker Role – HHS Secretary is required to “establish procedures under which a State may allow agents and brokers to enroll individuals” in Exchanges.
- An Advisory Board must be set up by HHS and must include “individuals with experience in facilitating the enrollment in qualified health plans.”
- A “Navigators” Program must be set up by Exchanges to engage in education, marketing, and enrollment activities. Insurance agents and brokers are expressly included in the list of potential “Navigators” but they may not serve as a “Navigator” if they are paid in any way “directly or indirectly” in connection with enrollment in an Exchange-provided plan. Regulations will be forthcoming from HHS on this issue. Importantly, any Navigator must be “qualified, and licensed if appropriate.”

Employer Requirements

There is no employer mandate but employers with more than 50 employees will be assessed a fee of \$2000 per full-time employee (excluding the first 30 employees from the assessment) (excluding the first 30 employees from the assessment) if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers that do offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of \$3,000 for each employee who receives a premium credit or \$750 for each full-time employee.

- Employers that offer coverage will be required to provide a free choice voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 8-9.8% of income and who choose to enroll in a plan in an Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.
- Large employers (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.
- No employer may impose a waiting period that exceeds 90 days.

Private Insurance Mandates

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. These new rules will also require that all new health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage (existing individual and employer-sponsored plans do not have to meet the new benefit standards).

- Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.
- Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.
- Increases in health plan premiums will be subject to review before they can be implemented.
- Young adults will be allowed to remain on their parent’s health insurance up to age 26.
- States will be allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact under a single set of rules.

Merging of Individual and Small Group Markets

Beginning in 2014, the legislation allows states the option of merging the individual and small group markets within the Exchanges.

Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level (\$14,404 for an individual and \$29,327 for a family of four in 2009). This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a current limitation of the program that prohibits most adults without dependent children from enrolling in the program today. Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level will obtain coverage through the newly created state health insurance Exchanges.

- The federal government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for three years (2014-2016). In 2017 and 2018, states will receive an increase in the federal medical assistance percentage (FMAP) based on current state eligibility levels for adults, and then beginning in 2019, all states will receive the same FMAP increase. Different funding rules apply for Nebraska and certain states that are not eligible for the increased FMAP because they have already expanded Medicaid eligibility.

New Taxes and Fees

- "Cadillac Tax"-- Imposes an 40% 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). This tax would apply to self-insured plans and sold in the group market, but not plans sold in the individual market.
- Non-Wage Medicare Tax- starting in 2013, households with incomes above \$200,000 (\$250,000 for married couples) will have a new, 3.8 percent tax applied to their income from interest, dividends, capital gains, and some profits from investments in partnerships and S corporations.
- 0.9% Medicare Tax Increase- starting in 2013, households with incomes above \$200,000 (\$250,000 for married couples) will have a 0.9% increase to their Medicare taxes on their wages.
- Third party administrators and health insurers must pay a three-year aggregate industry fee to fund a reinsurance program that will total \$12 billion in 2014, \$8 billion in 2015, \$5 billion in 2016.
- There is a fee on health insurers and self-insured plans of \$2 per covered beneficiary to fund comparative research initiatives.
- Health insurers must pay a new annual fee based on their market share. The fee will be assessed based on their net premiums written starting in 2014. The fee will total (across all health insurers) \$8 billion in 2014, \$11.3 billion in 2015, \$11.3 billion in 2016, \$13.9 billion in 2017, and \$14.3 billion in 2018. After 2018 the fee will be indexed to growth based on premium growth for the preceding year.
- The pharmaceutical manufacturing sector must pay a new annual fee (\$2.5 billion in 2011).
- The deduction for the subsidy for employers who maintain prescription drug plans for the Medicare part D eligible retirees is eliminated started in 2013.

HSA and FSA Changes

- Only prescribed drugs would be permitted to be reimbursable through a health savings account.

- The tax on distributions from a health savings account that are not used for qualified medical expenses would be increase to 20% (from the current 10%) of the disbursed amount.
- The amount of contributions to FSA's for medical expenses would be limited to \$2,500 per year, adjusted for inflation.

Medical Loss Ratio (MLR)

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

Small Business Tax Credit

Provides a two year tax credit to small businesses (less than 25 employees) with aver annual wages of less than \$40,000 that purchase health insurance with the tax credit.

- For tax years 2010 to 2013, the tax credit would be up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost.
- For tax years 2014 and later, for eligible businesses that purchase through the Exchanges, the tax credit would be up to 50% of the employer's contribution toward the employee's premium if the employer contributes at least 50% of the employee's total premium cost.
- The full credit will be available to employers with 10 or few employees and average annual wages of \$25,000 and less, the credit phases out as firm size and wages increase.

Prevention/Wellness Programs

- Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment)
- Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010)
- Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment)
- 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.
- Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011)
- Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment)
- Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is

unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate.

CLASS Act

Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a 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 January 1, 2011)