

September 20, 2010

To: NRLN Grassroots Network Members
From: Bill Kadereit, NRLN President
Subject: Insights Into New Health Care Law

I enjoy reading the various Retiree Association newsletters that I receive. When reading the latest newsletter from the Association of US West Retirees Colorado/Wyoming group, I was impressed by a column written by Barbara Wilcox. The column responded to questions from US West/Qwest retirees about the new national health care law.

I've met Barbara at AUSWR meetings and know she is an experienced researcher. I called Barbara and received her approval to share her column with NRLN Grassroots Network members through an email and by posting it on the NRLN website at www.nrln.org. I think you will see below that the questions from US West/Qwest retirees are similar to questions that many other NRLN Grassroots Network members have about the new health care law. I think many of you will be interested in Barbara's answers.

The references to Qwest were changed to the word "Company" so that you might more readily identify with the questions and answers for your own personal situation regarding the new health care law.

I also asked Barbara if she would consider researching answers to questions from NRLN Grassroots Network members that I could periodically share with NRLN email "subscribers." Although Barbara is very busy with a number of volunteer projects, she said she would search out answers as her time permits. If you have questions about the new health care law, send them to nrlnmessage@msn.com. Don't expect an immediate personal response. The NRLN will gather the questions and group those that are similar before forwarding them to Barbara. Barbara will include these NRLN questions in her future columns, as appropriate.

At the end of Barbara's column, I inserted the health care law implementation timeline from the Kaiser Foundation website. At the very end, Barbara has listed a number of websites that are good resources for information about the health care law. If you don't find the answer to your questions on one of those websites, send your questions to the NRLN.

Bill Kadereit, President
National Retiree Legislative Network

National Retiree Legislative Network (NRLN)

A Review of the Patient Protection and Affordable Health Act of 2010

By Barbara Wilcox, Association of U.S. West Retirees (AUSWR)– NRLN Association

The Q's and A's and other information provided below were developed to provide information on changes that potentially impact us as retirees, as a result of passage of The Patient Protection and Affordable Health Act (PPAHA) of 2010. Comments are made with references to current insurance coverage but company plans are subject to change at annual enrollment time.

This review includes the Q's and A's followed by the detailed PPAHA timeline as published by the Kaiser Family Foundation. Also, several useful sources are recommended at the end of this review.

IMPACT OF HEALTH CARE LAW:

General:

Q-1. What changes might the new law make in the health care benefits Companies provide retirees?

A. The new law makes no changes in what Companies are required to provide to retirees.

Q-2. But, I thought the new law required large employers to either cover the people who work for them or pay a penalty.

A. YES, that's true for **active employees**. But, the new law makes NO requirement that employers cover **retirees**.

You Are Not on Medicare Yet:

Q-3. I'm a retiree, but I'm not yet 65, so I'm not eligible for Medicare. My Company is providing my health care. Is there anything in the new law that benefits me?

A. YES. There is a temporary reinsurance program for retirees age 55-64. The Federal Government will begin subsidizing the costs of the health care claims filed under your Company-provided health insurance by paying 80% of costs between \$15,000 and \$90,000. This subsidy is supposed to reduce your costs and it will also reduce company costs. Because of the cost reduction, this is a significant incentive for Companies to continue to provide your health insurance. Once the new Health Insurance Exchanges are operating, in 2014, this subsidy ends, and retirees in your situation will be able to purchase insurance on the Exchange if they choose to do so.

You Are On Medicare:

Q-4. I'm on Medicare. Will the new law make changes for me?

A. YES. It depends on whether you are on traditional Medicare or a Medicare Advantage plan exactly what changes you may experience.

Q-5. How do I know which kind of Medicare I'm on? I just chose from the options my Company gave me at open enrollment.

A. If you were with a HMO (Health Maintenance Organization), you most likely enrolled in that HMO's Medicare Advantage plan when you became eligible for Medicare. Companies may offer different HMOs in different geographical locations. If you are not in one of these HMOs, you probably have traditional Medicare.

Traditional Medicare Changes:

Q-6. I'm on traditional Medicare. Will I have changes?

A. YES. There are several enhancements being made to traditional Medicare. A number of preventive services, such as annual physicals, mammograms, colonoscopies, will be covered free of charge, beginning 1/1/2011. There will be new programs to provide coordination of care if you are hospitalized or have a chronic condition. Reimbursements to primary care doctors and general surgeons will be increased by 10% for five years, so there should be more of these doctors for you to choose from.

Medicare Advantage Plan Changes:

Q-7. I've heard that Medicare Advantage plans will go away, or will get more expensive. Is this true?

A. NO & MAYBE. The Medicare Advantage program is not going away. Up until now, these plans have enjoyed a larger subsidy from the Federal government than traditional Medicare, and that will be phased-down to equal the subsidy to traditional Medicare. The private companies that offer Medicare Advantage may make changes as a result. For example, they may take away some of the perks they've offered in the past, such as health club memberships. They may also charge higher premiums or co-pays, but that is nothing new. These plans are required to offer benefits at least as good as traditional Medicare.

Tricare for Veterans:

Q-8. I am a veteran and am on Tricare. Will there be any changes for me?

A. NO. Defense Secretary Gates has issued a statement saying that Tricare meets all of the requirements of the new health care law.

FINANCING OF HEALTH CARE LAW:

Q-9. Is it true that money is being taken from Medicare to pay for covering the uninsured?

A. The new law contains a provision requiring that any savings in Medicare go to reduce patient costs, improve Medicare benefits, protect patients' access to providers (doctors) and extend solvency of the Medicare Trust Fund. In 2011-2013, money is being taken from the Medicare Advantage programs until the Federal subsidies of that program are matched to subsidies of traditional Medicare. This money, along with other Medicare savings, will be used to enhance basic Medicare benefits and extend the life of Medicare. Overall, the solvency of the Medicare Trust Fund will be extended by nearly a decade, according to the Congressional Budget Office. But, since some of the money won't be needed until later years, it will be "loaned" via special Treasury bills to pay for Non-Medicare expenses, such as coverage for the uninsured.

Q-10. Large companies, such as AT&T, Deere & Co., and Verizon, announced in March that they may cut prescription drug coverage for Medicare-eligible retirees because their federal subsidy from the Medicare Part D program will no longer be tax-free. Will this tax change affect the prescription drug benefits of my Companies retirees?

A. Since the Medicare D prescription drug program was started in 2006, employers have been given a 28% tax free subsidy to encourage them to provide prescription drug coverage to their Medicare eligible employees and retirees. Some Companies reported the future loss of the tax benefit on the subsidy in first quarter financial results, which indicates that they will continue to provide the Medicare prescription drug coverage. Employers will still get the 28% subsidy, but it will no longer be tax-free. Still the subsidy is a good incentive for Companies to keep the prescription drug coverage. None of us can predict what our Companies will do. But, it seems unlikely that this tax change would cause most Companies to drop prescription drug coverage.

Q-11. I've heard that "Cadillac" health plans are going to be taxed. Will that apply to the health care insurance we retirees get from our Companies?

A. It will not apply to those of us who are on Medicare, because most Companies only supplement our Medicare coverage. For those not yet on Medicare in 2018, when the tax on high value plans begins, it will depend on what your insurance premium level is (retiree plus Company cost, not including dental insurance).

The threshold for persons over 55 will be \$11,850 annually for single coverage and \$30,950 for a family.

Q-12. Are there any other new taxes that are likely to hit retirees?

A. That depends on your individual circumstances and income levels. For individuals with adjusted gross income over \$200,000 or \$250,000 for couples, a 3.8% Medicare tax will be assessed on investment income. For those at this income level who are still working, there also will be an additional 0.9% payroll tax. These taxes begin in 2013.

Q-13. What are the changes in the way deductions can be taken for health care expenses?

A. In 2013, the threshold for itemized deductions of out-of-pocket medical expenses will increase from 7.5% of adjusted gross income to 10%. For those 65 and older, this increase is postponed until 2017.

The Truth About Some Myths:

Q-14. I received an email saying that we would have to pay income tax on the value of my Company-provided health insurance. Is this true?

A. NO. There is confusion, because the Affordable Care Act does require that employers begin reporting the value of the health insurance they provide on employees' W-2 forms. But individuals do not pay income taxes on that value. Health insurance could be taxed in the future if the value exceeds certain limits, but the insurance Company will pay the tax, not the insured person. (See discussion of Cadillac plans in Q-11.)

Q-15. I heard that the health care reform law has a new real estate tax in it. They're saying that, if I sell my home, I'll have to pay a 3.8% sales tax. Is this true?

A. NO. There is no real estate or sales tax in the Affordable Care Act. There is a 3.8% income tax on investment income beginning in 2013, but only for individuals earning more than \$200,000 or couples earning more than \$250,000. So, if you fall in that high income bracket, and you sell your house, you might have to pay the 3.8% tax, on any gain you made over and above the cost of the house, depending on other details in your earnings.

RULEMAKING:

The Federal Department of Health and Human Services (HHS) is conducting rule-making procedures to set the specifics of how each provision of the new law will be implemented.

New Rules for Medicare:

Q-16. What new benefits are added to Medicare in 2011?

A. As of January 1, 2011, Medicare will cover many preventive services at no expense to the patient, including annual wellness visits with your primary care physician.

Q-17. What other changes are happening in Medicare next January?

A. Rules have been issued for providing increased payment to primary care doctors and surgeons.

New Rules for Grandfathered Plans:

Q-18. Is the health insurance we get from our Company considered to be grandfathered, under the new law?

A. YES, right now it is an existing, grandfathered plan.

Q-19. As a grandfathered plan, will our insurance have to make any changes under the new law?

A. YES. The Affordable Care Act does make certain requirements of all health insurance plans, regardless of whether they are existing plans or new plans. These rules are known as the Patients' Bill of Rights, which takes effect for plan years beginning after Sept. 23, 2010. Depending on the exact plan you are on, here are some key provisions that may cause improvements in your insurance:

- No lifetime limits on coverage.
- Phase out of annual dollar-amount limits on coverage.
- Extension of parents' coverage of young adults up to age 26.

Q-20. Will a Company-provided insurance always be grandfathered?

A. The rules list a number of changes to a plan that would cause it to lose grandfathered status. For example, the plan cannot significantly cut or reduce benefits or increase deductibles or co-pays beyond specified amounts. Neither can the employer offering the plan tighten or decrease its cap on the amount of premium the employer pays.

Q-21. If my Company-provided insurance should lose its grandfathered status, what happens?

A. Then the Company would have to meet additional requirements that any new plan has to meet. For example, they would have to provide specified preventive care at no cost to you.

National Healthcare Reform Implementation Timeline

This Kaiser Family Foundation implementation timeline reflects the provisions of the Patient Protection and Affordable Care Act, which President Obama signed on March 23, 2010, as well as provisions in the Health Care & Education Reconciliation Act, which was signed on March 30, 2010. Major provisions of the acts will be implemented during the 2010 – 2014 but a few important provisions are scheduled to take effect in 2015 or later.

2010

Insurance Reforms

- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014)
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by

the Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.

- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014)
- 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)
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases. 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.

Medicare

- Provide a \$250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020.
- 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 June 17, 2009 and have developed certain health conditions as a result.
- Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.
- Reduce annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units.
- Ban new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limit the growth of certain grandfathered physician-owned hospitals.

Medicaid

- Create a state option to cover childless adults through a Medicaid state plan amendment.
- Create a state option to provide Medicaid coverage for family planning services up to the highest level of eligibility for pregnant women to certain low-income individuals through a Medicaid state plan amendment.
- Create a new option for states to provide Children's Health Insurance Program (CHIP) coverage to children of state employees eligible for health benefits if certain conditions are met.
- 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; and extend the drug rebate to Medicaid managed care plans.
- Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).
- Require the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.

Prescription Drugs

- Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

Quality Improvement

- Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute.
- Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.
- Reauthorize and amend the Indian Health Care Improvement Act.

Workforce

- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.

Tax Changes

- Impose additional requirements on non-profit hospitals. Impose a tax of \$50,000 per year for failure to meet these requirements.
- Limit the deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers.
- Impose a tax of 10% on the amount paid for indoor tanning services.
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.

2011

Long-term Care

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice

- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Prevention/Wellness

- Eliminate cost-sharing for Medicare covered preventive 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 preventive services based on recommendations of the U.S. Preventive Services Task Force.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Provide grants for up to five years to small employers that establish wellness programs.
- Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare

- Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
- Provide 10% Medicare bonus pay to primary care physicians, and general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)
- Restructure payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service rates.
- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
- Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.
- Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels, and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple.
- Create an Innovation Center within the Centers for Medicare and Medicaid Services.

Medicaid

- Prohibit federal payments for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid to states enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion.
- Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

Quality Improvement

- Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.
- Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.
- Establish a new trauma center program to strengthen emergency department and trauma center capacity.
- 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; establish new programs to support school-based health centers and nurse-managed health clinics.

Workforce

- Establish Teaching Health Centers to provide payments for primary care residency programs in community-based ambulatory patient care centers.

Tax Changes

- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a health reimbursement account or health flexible spending account and from being reimbursed on a tax-free basis through a health savings account or Archer medical savings account.
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount.
- Impose new annual fees on the pharmaceutical manufacturing sector.

2012

Medicare

- 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.
- Allows providers to organize as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
- Reduce annual market basket updates for home health agencies, skilled nursing facilities, hospices, and other Medicare providers.
- Create the Medicare Independence at Home demonstration program.
- Establish a hospital value-based purchasing program in Medicare and develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Provide bonus payments to high-quality Medicare Advantage plans.
- Reduce rebates for Medicare Advantage plans.

Medicaid

- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capital payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

Quality Improvement

- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

2013

Insurance Reforms

- 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 the District of Columbia to offer qualified health plans. (Appropriate \$6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013.)
- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than \$1 per covered life. (Effective April 1, 2014.)

Prevention/Wellness

- Provide states that offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the federal medical assistance percentage (FMAP) for these services.

Medicare

- Begin phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25% in 2020, in addition to the 50% manufacturer brand-name discount).
- 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.

Medicaid

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.

Quality Improvement

- Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biological, and medical supplies.

Tax Changes

- 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; waives increase for individuals age 65 and older for tax years 2013-2016.
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly and impose a 3.8% assessment on unearned income for higher-income taxpayers.
- Limit the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year increased annually by the cost of living adjustment.
- Impose an excise tax of 2.3% on the sale of any taxable medical device.
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014

Individual and Employer Requirements

- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- 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 \$2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees from the assessment. 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.

Insurance Reforms

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.
- Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
 - 100-200% FPL: one-third of the HSA limits (\$1,983/individual and \$3,967/family in 2010);
 - 200-300% FPL: one-half of the HSA limits (\$2,975/individual and \$5,950/family in 2010);

- 300-400% FPL: two-thirds of the HSA limits (\$3,987/individual and \$7,973/family in 2010).
- Limit deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan.
- 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.
- 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.
- Allow states the option of merging the individual and small group markets.
- Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
- Require qualified health plans to meet new operating standards and reporting requirements.

Premium Subsidies

- Provide refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges.

Medicare

- Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019).
- 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.
- 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. Require Medicare Advantage plans to have medical loss ratios no lower than 85%.

Medicaid

- 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 (MAGI) and provide enhanced federal matching for new eligibles.
- Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments.
- Increase spending caps for the territories.

Prevention/Wellness

- Permit employers to offer employees rewards of up to 30%, increasing to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establish 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

Tax Changes

- Impose fees on the health insurance sector.

2015 and later

Insurance Reforms

- Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (Compacts take effect January 1, 2016.)

Medicare

- Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015.)

Tax Changes

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. (Effective January 1, 2018)

To read the full text of the Patient Protection and Affordable Health Care Act, H.R. 3590: go to <http://thomas.gov> and check Bill Number, then enter H.R. 3590 and click Search.

For more information about the new health reform law, the following sources are recommended:

- Kaiser Family Foundation: <http://healthreform.kff.org/>
- AARP: <http://www.aarp.org/health/health-care-reform/>
- Alliance for Retired Americans: <http://www.retiredamericans.org/issues/healthcare-reform>
- U.S. Department of Health and Human Services: <http://www.healthcare.gov/>
- Speaker of the House: <http://www.speaker.gov/newsroom/legislation?id=0361>
- The White House: <http://www.whitehouse.gov/>