



Summary of the Affordable Care Act

The *Affordable Care Act (ACA)* expands access to quality, stable, affordable health care; slows the growth of health care costs; and improves the quality of care. The law is available online at <http://www.ncsl.org/documents/health/ppaca-consolidated.pdf>.

Insurance Reform

The law makes significant improvements to the private insurance system, overhauling the individual and small group health insurance markets to expand access to coverage. A number of those improvements go into effect September 23, 2010, including provisions to:

- Ban co-pays and other out-of-pocket expenses for preventive care and immunizations (Section 2713)
- Extend coverage for adult children up to age 26 (Section 2714)
- Prohibit lifetime limits and cap annual limits of coverage (Section 2711)
- Prohibit pre-existing condition exclusions for children (Section 1255)
- Prohibit all rescissions, or retroactively cancelling insurance (Section 2712)

Some provisions are already in affect, including:

- Starting in most states in July or August 2010, creation of a national, high-risk pool plan for people denied coverage because of medical conditions. This pool is temporary until the Exchange is up and running (Section 1101)

Provisions will be enacted over time; with some beginning in 2011, including:

- Require insurers to devote at least 85 percent of premiums (in the large-group market) and 80 percent (in the small group and individual markets) to medical benefits, and provide consumer rebates if medical spending falls below these percentages (Section 2718)

Additional private insurance requirements begin by 2014, including reforms that:

- Require insurers in the small-group and individual markets to offer coverage to everyone and to renew all policies (Sections 2702 and 2703)
- Prohibit exclusions for pre-existing conditions (Section 2704)
- Bar insurers from basing premiums on health status, gender and other factors. Premiums may vary only based on age, with the spread constrained to a 3:1 ratio, and based on tobacco use within a 1.5:1 ratio. Premiums may also vary by geographic area. (Section 2701)

- Require all health plans to cover essential benefits, which include hospital and outpatient services, prescription drugs, mental health services, maternity care, rehabilitation and preventive care, but not abortion services (Section 1302 and 1303)
- Prohibit annual limits for essential benefits (Section 2711)
- Direct plans to limit yearly out-of-pocket expenses of \$5,800 per individual and \$11,600 per family, indexed to inflation (Section 1302)
- Create multi-state plans to promote competition in the insurance market. (See details in the Health Insurance Options and CO-OPs section below.)

Discussion: Overall, the law creates strong protections to move toward equal access to coverage for people in the private insurance market. The reforms that take effect immediately provide some relief for consumers who currently cannot access coverage. Some provisions are not ideal, however, including basing premiums on tobacco use and age, allowing sale of insurance plans across state lines, limiting coverage for abortion services in Exchange plans, and exempting self-insured plans from rules that bar premium rates based on age and other factors.

Ensuring Affordability

To make coverage affordable, the law expands Medicaid, establishes a sliding-scale subsidy program for low- and moderate-income people, and provides assistance for small businesses. It includes provisions to:

- Expand Medicaid to 133 percent of the federal poverty level (FPL) (\$24,360 per year for a family of three) in 2014 to cover children and non-disabled, childless adults under the age of 65. States could expand Medicaid earlier, starting April 1, 2010 (Section 2001(a)).
- Provide “premium tax credits,” which operate as sliding-scale subsidies, in the Exchange for people earning between 100 and 400 percent FPL (\$18,310 to \$73,240 for a family of three) and for those below 100 percent FPL, but only if they are legal U.S. residents who do not qualify for Medicaid. Individuals only qualify for subsidies if they do not have access to employer-sponsored insurance that meets certain minimum standards and costs less than 9.5 percent of their income. Premiums would start at 2 percent of income for those earning less than 133 percent FPL and rise to 9.5 percent for those between 300 and 400 percent FPL (Section 1401(a)).
- Reduce out-of-pocket maximums for people below 400 percent FPL in the Exchange and offer further out-of-pocket subsidies for people below 250 percent FPL in the Exchange (Section 1402(a)-(c)).
- Give tax credits to small businesses and non-profits that have 25 or fewer full-time equivalent employees, have an average wage of no more than \$50,000, and who contribute at least 50 percent of the premium for employee coverage (Section 1421(a)).

Discussion: The expansion of Medicaid will make health insurance affordable to a large number of low-income people. Other strengths of the Medicaid portion of the law include new quality directives for Medicaid (Sections 2701 and 2702), expansion of medical homes to those with chronic illness (Section 2703), and enrollment simplification measures (Sections 2201 and 2202). The law also requires Medicaid to pay primary care providers at least 100 percent of Medicare rates in 2013 and 2014, and provides full federal funding for the incremental costs (Section 1202.).

Premium subsidies make coverage substantially more affordable for millions of low- and middle-income families who do not have access to coverage through their employers, and provide cost-sharing assistance for many families. However, subsidies remain too low, particularly for low-income families earning up to 200 percent FPL. Also, even with the out-of-pocket protections low- and moderate-income families would continue to face barriers to care and remain at risk of underinsurance if they face a catastrophic illness.

Shared Responsibility

For individuals: Starting in 2014, all U.S. citizens and legal residents will be required to obtain coverage for themselves and for their dependents (Section 1501(b)). Exemptions are allowed for religious objections, financial hardship, undocumented immigrants, American Indians, people earning under the tax filing threshold (which was \$9,350 for a single person or \$18,700 for a couple in the 2009 tax year) short gaps in coverage, and those for whom available coverage costs more than eight percent of their income. The maximum penalty for not obtaining coverage for any family is the national average premium for a bronze plan. The penalty is calculated as the greater of:

- \$95 per year in 2014, \$325 per year in 2015, \$695 in 2016 (half that amount for children under age 18), up to a maximum of three times those penalty amounts per family; **or**
- 1 percent of income above the tax filing threshold in 2014, 2 percent of income above the tax filing threshold in 2015, 2.5 percent of income above the tax filing threshold in 2016 and beyond.

Discussion: The individual mandate includes some critical consumer protections, including the affordability and hardship exemptions. However, the progressive fines for families who do not have insurance are still high and may cause financial hardship in some cases.

For employers: Starting in 2014, employers who do not offer coverage that meets minimum requirements to all their full-time employees (and their dependents), and have at least one full-time employee who qualifies for premium tax credits, will be required to pay \$2,000 per year for each of their full-time employees over thirty. (Section 1513)

Also, even employers who offer coverage that meets minimum requirements to all of their full-time employees but still have at least one full-time employee who qualifies for premium tax credits (because the coverage offered by the employer is not affordable to the employee), will be required to pay \$3,000 for each of their employees receiving a tax credit. (Section 1513)

Employers with fewer than 50 full-time or full-time equivalent employees are exempt from these requirements. (Section 1513)

Additionally, any employer who offers minimum essential coverage to its employees and pays a portion of the costs of that plan must offer a “free choice voucher” to any employee who earns less than 400 percent FPL and whose required contribution to the plan would be between 8 percent and 9.5 percent of their income. The free choice voucher would be equal to the costs that the employer would have paid toward that employee’s coverage under the employer-sponsored plan. The

employee can then apply that free choice voucher toward the cost of any plan offered in the Exchange, but will not be eligible for subsidies. Employers do not have to pay the above free-rider surcharge with respect to employees for whom they offer a “free choice voucher.” (Section 10108)

Discussion: The employer requirements help raise money for subsidies and encourage employers to continue offering coverage to their employees.

Health Insurance Options and CO-OPs

The law does not contain a public health insurance option but offers two proposals to promote accountability in the insurance market. First, it authorizes the Office of Personnel Management (OPM) — the agency that runs the Federal Employee Health Benefits Plan — to enter into contracts with insurers to offer coverage to individuals and small groups through multi-state plans. The plans will be offered through each state’s Exchange and must meet its benefit and plan requirements. At least two plans will be offered in each state; one must be through a non-profit entity. Plans must set premiums using HIPAA rating requirements and must be offered in community-rated states. Enrollees are eligible for credits and subsidies.

Second, it authorizes funds for at least one non-profit, member-run health insurance Consumer Operated and Oriented Plan (CO-OP) in each state that would offer coverage to individuals and small businesses. The state would have to implement all insurance reforms in the law before a CO-OP could operate.

Health Insurance Exchanges

The law directs states to create Exchanges to help individuals and employers compare health plans, make informed choices and facilitate enrollment in the individual and small group insurance markets. The Department of Health and Human Services (HHS) will develop a rating system for state Exchanges to use to help consumers choose the best plan for themselves. While participation in the Exchange is voluntary, subsidies and the multi-state plans would only be available through the Exchange. In addition, the Exchange must provide transparent information about claims, cost-sharing and benefits in health plans. Individuals and small employers may enroll in the Exchange starting in 2014. States have the option of allowing large group employers to participate starting in 2017. States may also set up regional Exchanges. If a state does not take action to set up an Exchange by January 2013, the federal government may do so for that state. No undocumented immigrants may enroll through the Exchange. (Sections 1311, 1312)

Children’s Health

The law increases mandatory Medicaid income eligibility levels for children ages six to 19 up to 133% of the FPL, and it preserves the CHIP program past 2013, with full funding until 2015. It includes provisions to:

- Expand children’s access to the Medicaid program by providing coverage with Early Periodic Screening, Diagnosis and Treatment (EPSDT) for every child at or below 133 percent FPL (Section 2001) and every foster child through age 26 (Section 2004)

- Maintain CHIP through at least Sept. 30, 2015, allowing states to provide CHIP coverage to children of state employees eligible for health benefits. If CHIP is reauthorized after 2015, the federal CHIP match rate will be increased by 23 percent from 2015-2019 (Section 2101)
- Simplify and coordinate enrollment processes for coverage in Medicaid, CHIP and the Exchange (Sections 1413, 2201)
- Provide funding for school-based health centers (Section 4101), oral health education campaigns (Section 4102) and pediatric quality improvement programs (Section 3501)
- Immediately ban insurers from denying coverage to children for pre-existing conditions (Section 1255)
- Require that Medicaid payment rates for pediatric primary care services be no less than 100 percent of Medicare payment rates in 2013 and 2014, and provide 100 percent federal funding to states for the incremental costs (Section 1202)
- Require that all health plans cover the preventive care and screenings identified in Bright Futures at no-cost (Section 2713)
- Fund the development and implementation of evidence-based maternal, infant, and early childhood home visitation models (Section 2951)

Discussion: The expansion of Medicaid will provide more children with access to the comprehensive EPSDT benefits package. Regarding CHIP-eligible children, the law will fund the program until at least until 2015 – ensuring that these children will also maintain access to vital health services. Additionally, increasing Medicaid rates for primary care services will help ensure that Medicaid coverage will be accepted by more doctors, enabling children to more easily access care while enrolled in Medicaid.

Racial and Ethnic Health Disparities

The law aims to reduce racial and ethnic health disparities with provisions to:

- Guarantee \$11 billion more in funding for community health centers (Section 10503)
- Reauthorize and expand Indian Health Services, with goals of reducing disparities and increasing the ability to meet Indian health needs (Section 10221)
- Require all federal health programs and surveys to collect data on the race, ethnicity and primary language of participants, if funding is available; and require the federal government to use the data to monitor health disparities (Section 4302)
- Establish a national quality strategy to improve delivery of care, patient outcomes and population health, including reduction of disparities (Section 3011)
- Provide grants for community programs (Sections 2951, 4002, 4101, 4201, 10212, 10501) and community health workers (Section 5313) to promote wellness and reduce disparities, including by addressing social determinants of health
- Authorize expanded funding to recruit, train and provide financial aid for minority students or those from disadvantaged backgrounds seeking health careers, particularly those who will work in medically underserved areas (Sections 5207, 5401-5404, 10503)
- Support programs that develop cultural competency and health disparities curricula for use in health professions schools and continuing education programs (Section 5307)

Discussion: The law promotes community health initiatives, including those that seek to address social determinants of health, and takes steps to diversify the health workforce and make it more culturally sensitive. It boosts funding for community health centers, which serve many people of color and people without health insurance, allowing these centers to double the number of patients served. Unfortunately, the law maintains the current policy of excluding legal immigrants from Medicaid for five years, and it excludes undocumented immigrants both from access to new insurance subsidies and from buying full-price coverage through the Exchanges.

Consumer Assistance

The law makes positive steps toward institutionalizing consumer support services, by:

- Immediately funding (in 2010) state consumer assistance offices or state ombudsman programs to help consumers enroll in plans, file complaints and appeals, solve problems with programs and track any problems with implementation of the new law. (Section 1002)
- Directing state Exchanges (starting in 2014) to provide grants to Navigators to facilitate enrollment and provide information about plans. Navigators may include community-based non-profits, as well as trade groups. (Section 1311(i))

Prescription Drugs

The law advances prescription drug reforms by promoting the use of the safest, most effective drugs. It also takes significant steps toward reducing the cost of drugs for seniors and all Americans. The law includes provisions to:

- Reduce drugs costs for Medicare Part D enrollees by providing a \$250 rebate to all who enter the “doughnut hole” in 2010; reducing the cost of brand-name drugs in the doughnut hole by 50 percent starting in 2011; and gradually reducing the coinsurance for both brand-name and generic drugs each year until 2020. At that point, the doughnut hole will be closed, and the maximum coinsurance will be 25 percent (Section 1101)
- Require pharmaceutical and medical device companies to report all payments over \$10 (once they total \$100 or more) to physicians and teaching hospitals. Importantly, this data will be made public on a searchable website (Section 6002)
- Require pharmacy benefit managers (PBMs) to report information on the rebates, discounts or price concessions negotiated by the PBM with Medicare D or plans in the Exchange, as well as the payment difference between health plans and PBMs, and between the PBMs and pharmacies. These confidential reports will be disclosed to HHS and the PBM’s health plan clients (Section 6005)
- Require manufacturers to provide higher rebates to Medicaid for brand-name and generic drug purchases and to extend these rebates to new drug formulations (with some exceptions) and to Medicaid managed care plans (Section 2501)
- Establish the non-profit Patient Centered Outcomes Research Institute (PCORI) to coordinate federally-supported research and its dissemination on the comparative effectiveness of interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostic tools and pharmaceuticals (Sections 6301, 10602)
- Raise funds to expand coverage through implementing a fee of approximately \$2.8 billion annually on brand-name drugs, and a 2.9% tax on medical devices (Section 9008)

- Expansion of the discount price program (340B) to cover non-orphan drugs paid for by cancer centers and children's hospitals (Section 7101)
- Require HHS and FDA to assess whether public health would be promoted by changing prescription drug labeling to include a drug facts box or other method to quantify the risks and benefits of prescription drugs. If so, implement such changes within three years (Section 3507)

Discussion: The Medicare rebates and discounts to enrollees and the closing of the doughnut hole are significant improvements for seniors, while the Medicaid drug rebates will help keep Medicaid sustainable. Public reporting of drug and device payments to physicians and teaching hospitals, as well as transparency in PBM contracts, will improve quality and reduce unnecessary costs and conflicts of interest. The provisions on research and dissemination are an important step toward generating and aggregating needed evidence on the relative utility of treatment options for patients and using it to improve practices; it will be important to ensure that PCORI operates with strong conflict-of-interest standards.

Improving Quality

The law includes numerous provisions that promote access to primary and preventive care; strengthen infrastructure by rewarding care coordination, innovation and efficiency within the delivery system; and improve the quality of health care in America. It includes provisions to:

- Develop a National Quality Strategy to improve care delivery, health outcomes and population health (Section 3011). A new Center for Innovation within the Centers for Medicare & Medicaid Services (CMS) would test and evaluate innovative models of care (Section 3021).
- Establish numerous national pilot programs and demonstration programs to test and evaluate new strategies for improving the quality of care people receive while reducing costs, such as bundled payments (Sections 2704, 3023), global payments (Section 2705), accountable-care organizations (Sections 2706, 3022) and medical homes (Sections 2703, 3502, 10333) through multiple payers and settings (also see Section 3021, regarding the Center for Medicare and Medicaid Innovation).
- Establish new quality measures for Medicaid-eligible adults (Section 2701), including grants to states to provide incentives for Medicaid beneficiaries to participate in healthy lifestyle programs (Section 4108). A state option would enroll Medicaid beneficiaries with chronic illnesses into health homes that offer comprehensive, team-based care (Section 2703), and a new optional Medicaid benefit would allow people with disabilities to receive community-based services and supports (Section 2401).
- Reward hospitals for providing value-based care (Section 3001), and penalizes hospitals that perform poorly on quality measures such as preventable hospital readmissions (Section 3025)
- Establish a five-year pilot program that would use public health interventions to reduce chronic illnesses and their associated costs for people between age 55 and 64 (Section 4202)
- Provide incentives for states to shift Medicaid beneficiaries away from nursing homes and toward care in the home or community (Sections 2401 – 2404, 10202)

Discussion: The law takes major strides toward improving quality while reducing costs. Notably, a number of provisions reserve roles for the public and for consumer representation in key efforts, such as establishing new quality measures, determining which models of care to pursue, or evaluating new pilot and demonstration programs. Though much of the hard work will be left for implementation, the law hones in on reducing chronic illness, improving patient-centered care and care coordination, integrating medical care with home- and community-based services, and building capacity at the state and local level to meet many of these objectives.

Strengthening Medicare

The law includes many provisions that will strengthen Medicare's stability and improve beneficiary access to care. In addition to the drug provisions mentioned above, the law:

- Extends the Special Needs Plan program for frail, sick and elderly Medicare beneficiaries to 2013 (Section 3205), and creates a new office within CMS to promote policies and assist states in better integrating care for dually eligible Medicare beneficiaries (Section 2602)
- Limits cost-sharing requirements for certain services in Medicare Advantage plans to the amount charged for the same services in traditional Medicare coverage (Section 3202)
- Creates an independent advisory board to make recommendations to Congress on reducing costs and improving the quality of care in Medicare and in the private sector (Section 3403)
- Provides beneficiaries with free, annual wellness visits and personalized prevention plans, including a comprehensive health risk assessment (Section 4103)
- Creates a "Physician Compare" website for Medicare beneficiaries to compare physician quality and patient experience (Section 10331)
- Saves Medicare money by ensuring that private Medicare Advantage plans spend at least 85 percent of revenue on medical costs or activities to improve care, rather than on profit or overhead (Section 1103); by tying additional payment incentives to quality (Section 1102); and by eliminating overpayments for care given to comparable populations (Section 1102).

The law also begins to address a longstanding gap in the program by creating a voluntary insurance program (CLASS) to provide community-based assistance services and support (Section 8002).

Discussion: The law includes some significant wins for seniors. Especially important are the limitations on cost-sharing for seniors enrolled in Medicare Advantage, payment incentives for quality, and the new CMS office dedicated to improving policies for people eligible for both Medicaid and Medicare. The law also adds a new benefit—free annual wellness visits for all Medicare beneficiaries, starting in January 2011—and curtails cost-sharing for preventive services.

Changes to Safety-Net Services

In addition to new funding for Community Health Centers and the National Health Service Corps, the law makes several significant changes to existing safety-net programs, including:

- New requirements for tax-exempt hospitals to disclose their financial assistance policies, be more transparent in their charges, conduct a community-needs assessments, and have more consumer-friendly billing and collection policies (Section 9007).
- Significant reductions to the amount of funding hospitals and states receive through Medicare (Section 3133) and Medicaid (Section 2551 as amended by S. 1203 of the Reconciliation Bill) Disproportionate Share Hospital (DSH) funding. Cuts to Medicaid DSH are set in the statute, but the Secretary will have to develop a methodology for determining how to divide payment reductions among states.

Discussion: The law's new requirements for tax-exempt hospitals promote fairness, transparency and accountability for people who need to access hospital safety-net services, while creating new energy around hospitals' collaboration on health care planning with the communities they serve. The requirement to develop a methodology to improve how Medicaid DSH dollars are distributed could encourage states to target DSH dollars to hospitals with high numbers of Medicaid patients or uncompensated care – an important provision, since the cuts could hurt many safety-net providers who serve populations unlikely to be fully covered by the new law.

Financing

The law contains an excise tax on the most expensive health insurance plans. The threshold of plan values above which the tax applies is \$10,200 for individual plans and \$27,500 for family plans, with higher limits for retirees and employees in high-risk professions. Stand-alone vision and dental plans are excluded. The tax is 40 percent of the value above those thresholds. Implementation of the excise tax is delayed five years, until 2018. The rate at which the thresholds rise is directly indexed to inflation. The law also levies an additional 0.9 percent Medicare tax on high-income individuals (individuals earning over \$200,000 and families earning over \$250,000), and it applies the tax to net investment income as well as earned income. The law also imposes a 10 percent excise tax on indoor tanning services. Additional financing comes from the fees collected from individuals and employers and from slowing the rate of price increases in Medicare.