From Families USA

April 2010

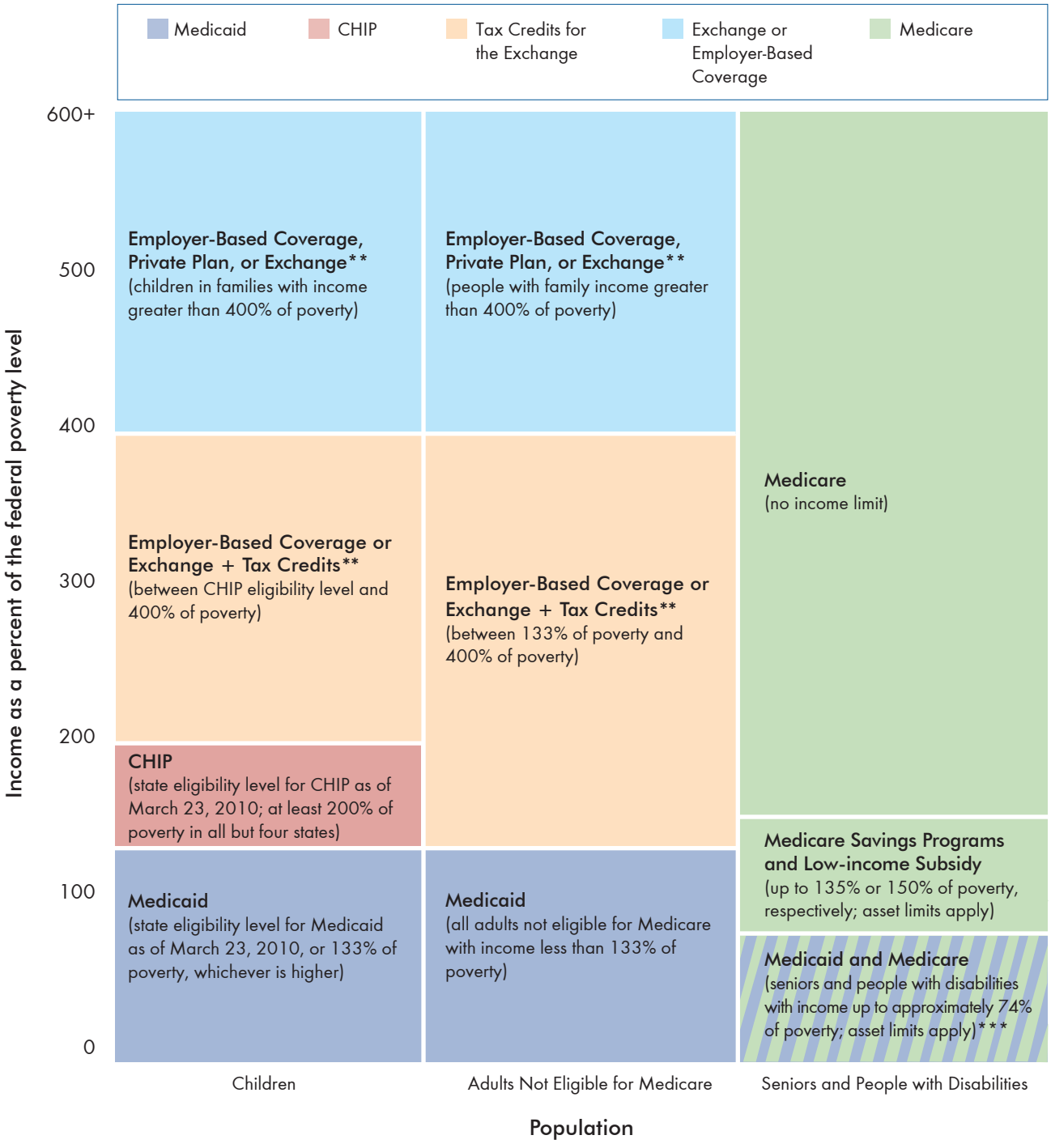
A Summary of the Health Reform Law

President Obama signed historic health reform legislation into law in March 2010. The new law expands health insurance coverage to an estimated 32 million uninsured Americans and strengthens existing coverage. This summary describes major changes in health coverage as a result of health reform, including Medicaid and CHIP coverage, the new affordability provisions, the exchanges, the new individual and employer responsibility requirements, improvements in private market coverage, and changes to Medicare and long-term services and supports. This is not a comprehensive summary of the entire health reform law, however: The law makes changes that affect health care quality, public health, the health care workforce, and many other issues that extend beyond the coverage-related scope of this piece.

Contents

Coverage Under Health Reform, 2014*

(federal minimums; in many cases, states can set more generous eligibility levels than are listed here)



See notes to table on back.

Table Notes

* This table does not reflect Medicaid eligibility for long-term services and supports such as nursing home, other institutional, or home- and community-based care, which will continue to vary by state. Health reform includes several programs that give states incentives to expand Medicaid home- and community-based services. Additionally, it establishes a new, voluntary long-term services insurance program that will be available to everyone.

** Employer-Based Coverage, Private Plan, or Exchange: People with employer-based coverage or individual private coverage can keep that coverage if they want. However, if the costs of participating in the employer's coverage are too high (or if the employer's plan pays less than 60 percent of the cost of covered benefits), people can instead purchase coverage through the exchange. If their incomes are below 400 percent of poverty and they buy coverage through the exchange, they may also be eligible for subsidies in the form of tax credits. (See Families USA, *A Summary of the Health Reform Law*, for details.)

*** During the two-year period when people with disabilities receiving SSDI are ineligible for Medicare coverage, they are eligible for Medicaid if their income is less than 133 percent of poverty.

Medicaid and CHIP

Health reform makes historic changes to Medicaid by ensuring that, beginning in 2014, low-income Americans can enroll in the program regardless of whether or not they have dependent children or a disability. Health reform also protects Medicaid and CHIP from eligibility cuts while other coverage expansions for low-income people are being designed, and it strengthens children's coverage in Medicaid and CHIP.

Medicaid Expansion

- **Eligibility**: Health reform will cover an additional 16 million low-income people by expanding Medicaid to all non-elderly Americans with incomes below 133 percent of poverty (approximately $24,350 for a family of three in 2010). States must implement this expansion beginning in January 2014, but they have the option of beginning implementation before this date.[1] The median Medicaid income eligibility level for parents in 2010 is 64 percent of the federal poverty level ($11,718 for a family of three in 2010), and only 11 states currently provide coverage to adults without dependent children. This expansion will make Medicaid available to those under the age of 65 with income less than 133 percent of poverty, regardless of family composition.[2] Some low-income children who are currently eligible for the state Children's Health Insurance Program (CHIP) will become eligible for Medicaid, which provides a more comprehensive children's benefits package and lower cost-sharing limits (see the CHIP Extension section on page 4 for more details on children's coverage).
- **Financing**: The federal government will pay the full cost of this expansion (for all newly eligible Medicaid enrollees) for the first 3 years, and will then shift 5 percent of this cost to states in 2017. States' share of the cost of the expansion will top out at 10 percent in 2019 and future years. See Table 1 for the matching rates for newly eligible groups. Health reform also rewards states that, at the time health reform was enacted, already provided coverage to both parents and adults without dependent children with incomes up to at least 100 percent of the federal poverty level. These states will receive a higher federal matching rate for the coverage they already provide to adults without dependent children (but not for parents). This enhanced matching rate also begins in January 2014 and varies by state.[3]
- **Income Methodology**: Health reform also changes how income will be calculated

Table 1. Federal Funding for Those Newly Eligible for Medicaid

Year	2014	2015	2016	2017	2018	2019	2020
Federal Funding	100%	100%	100%	95%	94%	93%	90%

for the purposes of determining Medicaid and CHIP eligibility; this change will create consistency between the eligibility processes for these programs and the tax credits available to people with incomes between 133 and 400 percent of the federal poverty level. Beginning in 2014, states must use modified adjusted gross income (MAGI) to determine an individual's or a family's income. There will be a uniform 5 percent income disregard for Medicaid and CHIP eligibility, but states will not be able to use any other disregards in calculating income for most groups of beneficiaries.[4]

■ CHIP Extension

The very popular state Children's Health Insurance Program (CHIP), which today covers just over 7 million low-income children, will continue. Health reform provides the federal funding needed to continue CHIP through the end of federal fiscal year 2015 under the existing financing rules. Beginning in fiscal year 2016, states will receive a 23 percentage point increase in the portion of CHIP coverage that the federal government pays for. However, the program will need to be reauthorized by the end of fiscal year 2015 for this increase to occur. Beginning in 2014, if a state has exhausted its federal CHIP allotment, CHIP-eligible children will be eligible for tax credits to enroll in CHIP-comparable coverage through the new exchanges.

■ Medicaid and CHIP Maintenance of Effort Requirements (MOE)

As a condition of receiving federal funding for Medicaid, states must maintain the Medicaid and CHIP eligibility levels that were in place as of March 23, 2010. This requirement extends until 2019 for children's coverage and until state exchanges are fully operational for adult coverage (January 1, 2014 at the earliest). States cannot implement any policies that make it more difficult to enroll in Medicaid or CHIP than it was March 23, 2010, including premium increases, more frequent recertifications, or additional documentation requirements. During calendar years 2011-2013, there is an exception to the MOE for Medicaid coverage for non-pregnant, non-disabled adults with incomes greater than 133 percent of poverty if the state is facing a budget deficit.

Exchanges

What Is a Health Insurance Exchange?

Health reform requires the establishment of American Health Benefits Exchanges, or simply "exchanges," to provide a regulated marketplace where eligible consumers can buy health insurance. Initially, individuals and small businesses will be eligible to buy health insurance through the exchanges. Depending on their incomes, they may qualify for tax credits to help defray the cost of coverage. Individuals will select coverage through one exchange, and small businesses will select their small business coverage through another, known as the Small Business Health Options Program, or "SHOP exchange." Beginning in 2017, states will have the option of allowing large groups to purchase coverage through the SHOP exchange.

States may elect to operate the exchanges directly or through a contracted entity, enter into agreements with other states to jointly provide an exchange, or leave it to the federal government to run an exchange in their state (See also State Alternatives box on page 6). Some of the duties of an exchange include the following:

- certifying plans as qualified to sell in the exchange;
- maintaining a Web site to help people compare standardized health plans;
- helping individuals determine their eligibility for Medicaid, CHIP, or other state or local public programs;
- helping them calculate available tax credits;
- providing information to the federal government about any people who do not have affordable coverage options, given their incomes, and who are therefore exempt from tax penalties; and
- establishing "Navigator" programs that will make grants to community-based organizations and other entities to provide outreach and help people enroll in coverage.

Qualified Health Plans

Plans that meet certain qualifications can sell to individuals and small businesses in the health insurance exchange. (Those plans can sell policies at the same price outside of the exchange, as well.) To be qualified, these plans must cover the essential package of benefits, offering at least silver and gold level coverage. (This benefit package and the levels of benefits are described on page 13.) They can cover benefits that are outside the essential benefit package, as well, but with two caveats: 1) if they cover abortion services, they must collect separate premium checks for that coverage and cannot use any premium tax credits or other federal funding for those services; and 2) if they are required under state law to cover services beyond the essential benefit package, states will pay any additional costs for those benefits for exchange enrollees.

Two Alternatives for States

Waiver Option

Beginning in 2017, states may request a waiver from the secretary of Health and Human Services (HHS) to provide coverage (and related subsidies for premiums and cost-sharing, and small business tax credits for exchange coverage) in a system other than the exchange. The state would receive the same amount of money that the federal government would have spent on exchange coverage in the state for whatever provisions the state waives; however, the alternative system would have to cover as many people and provide comprehensive benefits and cost-sharing protections at least as strong as those required by the health reform law. The Secretary will issue regulations regarding this process within six months.

State Alternative for Low-Income People

As an alternative to premium subsidies to purchase coverage through the exchange, a state can use a different mechanism to provide coverage for people who do not qualify for Medicaid and who have incomes below 200 percent of the poverty level. To serve this population, states can contract with one or more health plans that provide at least the list of essential benefits described on page 13. States that go this route must limit the population's premiums and cost-sharing to approximately the same levels that would apply if they got credits in the exchange. States that decide to use this alternative will receive federal funding equal to 95 percent of the value of tax credits and cost-sharing reductions that these low-income enrollees would have received in the exchange.

Affordable Coverage

Health reform also makes insurance affordable to middle-income Americans who do not qualify for Medicaid. Generally, individuals and families without health insurance who have incomes between 133 percent and 400 percent of the federal poverty level will receive help with the cost of coverage and care through a system of tax credits.[5] Some people with incomes below 133 percent of poverty who do not qualify for Medicaid (such as people who are legal residents but have not yet been here for 5 years) may get help in this way as well. Sliding-scale assistance with the cost of premiums and cost-sharing will be provided, and reduced limits on out-of-pocket costs will be set. This assistance will be provided for coverage purchased through the American Health Benefits Exchanges created by health reform (for more detail on how exchanges will work, please see the "Exchanges" section on page 5).

In addition, some employees who currently receive health insurance from their employer have the option of instead enrolling in the exchange and receiving assistance with the cost of premiums. Two groups of people might get coverage this way. The first group consists of employees who would have to pay between 8 and 9.8 percent of their household income to participate in their employer's plan and whose household incomes are no greater than 400 percent of poverty. This group can take their employer's contribution with them in the form of a "free choice voucher" that helps them purchase coverage in the exchange. Employers who provide a free choice voucher have fulfilled their responsibility under the health reform law to cover employees and will not have to pay an assessment. The second group consists of employees who would have to pay more than 9.8 percent of their household income to participate in their employer's plan or whose employer's plan pays less than 60 percent of the cost of covered benefits. This group of people can purchase coverage through the exchange and, if their incomes are below 400 percent of poverty, may be eligible for premium subsidies, described below. Employers of people who receive premium subsidies may have to pay an assessment (see page 15).

Premium Subsidies

Individuals and families with incomes between 133 percent and 400 percent of the federal poverty level will receive tax credits toward the cost of premiums for insurance purchased through the exchange. These credits limit the share of income that individuals and families have to spend on their premiums. The credits will apply on a sliding scale, providing the most help to those with the greatest need (see Table 2).

Table 2. Premium Limits by Income as a Percent of the Federal Poverty Level

Income	Premium Spending Limit
Up to 133% of poverty	2% of income
133-150% of poverty	3-4% of income
150-200% of poverty	4-6.3% of income
200-250% of poverty	6.3-8.05% of income
250-300% of poverty	8.05-9.5% of income
300-400% of poverty	9.5% of income

Cost-Sharing and Out-of-Pocket Help

Individuals and families with low and middle incomes who participate in the exchanges are also eligible for extra help with other health care costs. Subsidies will increase the percent of their total health care costs that their health plans pay. A silver plan offered through the exchanges under health reform will pay for 70 percent of covered costs for all of its enrollees. However, lower- and middle-income families who enroll in the silver plan will receive help with a substantially higher percentage of costs, and the federal government will compensate the plan for reducing cost-sharing for these enrollees (see Table 3 on page 8).

People with low and middle incomes will receive the additional help with plan costs in two ways: First, they will have lower out-of-pocket limits than other people. That is, once an enrollee pays a certain amount in deductibles, copayments, and co-insurance, the plan must pay the full cost of any other covered services. (This is described further on page 13.) Second, the health insurers will take other steps to reduce cost-sharing under procedures to be established by the Department of Health and Human Services (HHS). (For instance, HHS could require plans to lower their deductibles for eligible enrollees, or HHS could require plans to reduce their copayments and co-insurance for eligible enrollees. This decision has not yet been made.) Taken together, the reduced out-of-pocket costs and the other cost-sharing assistance will increase the percentage of enrollees' costs that a plan covers. For example, an individual or family earning between 100 and 150 percent of the federal poverty level will receive a plan that covers 94 percent of costs for an average enrollee. This assistance will help lower-income consumers afford health services.

Table 3. Coverage of Out-of-Pocket Costs by Income as a Percent of the Federal Poverty Level

Income Level	Assistance Amount
100-150% of poverty	Plan covers 94% of costs
150-200% of poverty	Plan covers 87% of costs
200-250% of poverty	Plan covers 73% of costs
250-400% of poverty	Plan covers 70% of costs

Out-of-Pocket Limits

As noted above, people with low and middle incomes will have lower out-of-pocket caps on their health care spending than other people. Under health reform, out-of-pocket costs will be capped for all people who purchase coverage through the exchange. This means that no one will have to pay more than a set amount annually in out-of-pocket costs for covered services, such as deductibles, co-insurance, and copayments.

In addition, individuals and families with incomes of up to 400 percent of poverty who participate in the exchange will have reduced out-of-pocket limits, applied on a sliding scale. These limits, or caps, are tied to the out-of-pocket limits that apply to high-deductible plans that are used with Health Savings Accounts (HSAs); the HSA limits are adjusted each year to reflect inflation in premiums, so we do not know the exact amount that will apply in 2014, when the exchanges begin. These limits will protect low- and middle-income families from unaffordable out-of-pocket spending (see Table 4).

Table 4. Out-of-Pocket Spending Limits by Income

Income Level	Out-of-Pocket Spending Limits, or Cap
100-200% of poverty	1/3 HSA limit ($1,983/individual; $3,967/family in 2010)
200-300% of poverty	1/2 HSA limit ($2,975/individual; $5,950/family in 2010)
300-400% of poverty	2/3 HSA limit ($3,967/individual; $7,933/family in 2010)
Above 400% of poverty	100% of HSA limit ($5,950 for an individual; $11,900 for a family in 2010)

Consumer Protections in the Private Market

The new law contains two kinds of reforms for private insurance: 1) reforms to make the market fairer, particularly for people in less than perfect health, and 2) reforms to make insurance more affordable. Reforms phase in gradually: Some provisions of the law go into effect this year to make the market fairer, but more major reforms on both fairness and affordability take place in 2014, when health insurance exchanges are established. An exchange is a marketplace in which people can select among standardized health plans and, depending on their income, receive tax credits towards the cost of coverage (see page 5).

What Happens This Year?

First, federal funding will be available for a variety of initiatives:

- **Temporary High-Risk Pool***:* The secretary of HHS will establish a temporary high-risk pool to serve people who have lacked coverage during the six-month period prior to their application for pool coverage and who have pre-existing conditions. The law appropriates $5 billion over the next 4 years for this pool. With this money, states can either supplement an existing high-risk pool or other mechanism to serve the uninsured, establish a new one, or let HHS operate the pool. Premiums will be set at the standard rates charged to other individuals in the non-group market, and there must be limits placed on enrollees' out-of-pocket costs.
- **Rate Review – Increased Accountability for Premium Value**: States can receive federal grants to strengthen their review of premium increases. If the secretary and states find premium increases to be unreasonable, they can later bar a plan from participating in an exchange. Further, health plans will need to account for their expenses in three categories: 1) medical and clinical costs; 2) expenditures to improve the quality of care; and 3) all other costs. If they have not spent an adequate share of their premium dollars on the first two categories (80 percent for individual plans and small group plans, 85 percent for large group plans), they will pay rebates to enrollees beginning in 2011.

- **Consumer Assistance and Information**: HHS will award grants to states that designate independent offices of consumer assistance or health care ombudsman programs that assist consumers with health insurance complaints, appeals, and inquiries. The law appropriates $30 million for this purpose in 2010.
- **Reinsurance for Early Retirees**: To help employers maintain health plans for early retirees and to keep premiums lower for health plan enrollees, the federal government will pay a share of high-cost claims.
- **Internet Portal to Help People Find Insurance**: HHS will establish a new internet portal through which residents in every state can learn about their options to purchase private insurance; sign up for Medicaid, CHIP, and small business tax credits; or enroll in a high-risk pool.
- **Small Business Tax Credit**: Small businesses with up to 25 full-time equivalent employees can receive tax credits to help them pay premiums for employees' coverage. To be eligible, employers must pay at least half the cost of premiums for employees who elect coverage. The amount of the credit is up to 35 percent of the amount the employer would contribute to the workers' premiums for an average-cost plan in that state's small group market. (The Secretary of HHS will determine average small group premiums for each state.) For small nonprofit tax-exempt employers, the credit is instead up to 25 percent of that amount. The amount of the credit is less for small employers with more than 10 employees, and gradually phases out for employers that pay average wages between $25,000 and $50,000. Effective 2014, tax credits increase to up to 50 percent of employer contributions to coverage purchased through the exchange (or up to 35 percent for nonprofit tax-exempt employers) and are based on average premiums for qualified health plans in the area. Availability of small business tax credits is limited to two consecutive years, beginning in 2014.
- **States Can Receive Money for Exchange Planning**: By early 2011, federal grants will be available to states to plan for the establishment of health benefit exchanges. As explained on page 5, states have a number of choices about whether to establish exchanges themselves or in conjunction with other states or whether to instead use an exchange established by HHS (see also "Waiver Option" in text box on page 6).

Second, new rules that apply to health plans will be phased in, beginning in mid-September 2010. These rules will apply to new policies purchased by individuals or employers after that date. For the most part, these rules will also apply to policies renewed after September, but some exceptions are noted below. Existing collectively bargained plans have a few more years to comply with the new rules:

- **Lifetime and Annual Limits***:* Effective in plan years beginning September 2010 or later, group and individual health plans cannot impose lifetime dollar limits on coverage for a list of essential benefits. Further, plans will be restricted from imposing annual dollar limits on coverage for essential benefits; the secretary of HHS will establish guidelines about such limits now, and plans will not be allowed to impose limits at all after 2014.
- **Preventive Health Services***:* Newly issued group and individual health plans will not require cost-sharing for a list of preventive health services. Included on this list are the following:
  - those which are highly recommended by the U.S. Preventive Services Task Force (Note: in late 2009, a controversial guideline reduced the recommended number of mammograms. The health reform law restores the requirements of the previous guideline for mammograms),
  - immunizations that are recommended by Centers for Disease Control, and
  - those recommended for women and children under guidelines adopted by the Health Research and Services Administration.

  (This provision does not apply to grandfathered health plans—that is, if you or your employer elect to keep and renew a policy issued prior to September that requires cost-sharing for preventive services, that plan may still require cost-sharing.)
- **Young Adults Can Stay on Their Parents' Plans Until the Age of 26***:* Effective in plan years beginning September 2010 or later, young adults can stay on their parents' group or individual health plans until their 26th birthday if those plans offer dependent coverage to children. In order to stay on their parents' employer-based plan, young adults must show that they have had no offer of coverage through their own employer.
- **Coverage of Children's Pre-Existing Conditions***:* Beginning September 2010, plans that include coverage of children cannot deny coverage to a child based on a pre-existing condition, and insurance companies will no longer be able to exclude coverage for a child's pre-existing condition. This provision applies to all group health plans and to newly issued individual plans.
- **No Rescissions (except for fraud or intentional misrepresentation)***:* Group and individual health plans will not be allowed to rescind a covered person's policy unless that person committed fraud or intentionally misrepresented a "material fact" in order to get coverage. Health plans must give advance notice before rescinding the policy.

- **Appeals and Patient Protections:** These new protections apply to all individual and group plans purchased through an insurance carrier and to "self-funded" group health plans ("self-funded" plans are employer-based plans in which the employer pays the cost of claims instead of paying premiums to an insurance company). Enrollees in all health plans will have the right to appeal denials of coverage, both within the plan and to an external reviewer. Health plan enrollees will have a number of new federal protections, such as the right to receive out-of-network emergency services at in-network rates, direct access to women's health providers, and a choice of primary care doctors, including pediatricians.
- **Better Health Plan Information:** Over the course of the next year, HHS will work with insurance commissioners, consumer groups, and others to develop standards regarding health plans' coverage documents and their readability. The goal is to help consumers understand what they are getting when they buy coverage or enroll in a plan. Additionally, plans will have to disclose more information to the public about their rating practices, claims payments, finances, quality of care, and other such data.

What Happens in 2014?

Individuals and employers can keep their current plans if they like them and can add family members and employees to those plans. However, if they buy a new plan, they will have more protections, listed below.

- **Guaranteed Issue and Renewal:** All new health plans will have to sell policies to all new applicants, regardless of their health status. In fact, they cannot establish any eligibility rules that would discriminate against people based on their health status or medical conditions, claims history, disability, or other health-status-related factors. However, health plans will be able to establish premium discounts or rewards for enrollees based on their participation in a wellness program or satisfaction of wellness standards, and consumer advocates will need to watch for federal rules and monitor this closely to make sure wellness rewards are fair and achievable.
- **No Pre-Existing Condition Exclusions:** All (new and existing) group health plans and new individual plans will be barred from excluding coverage of pre-existing health conditions.
- **Rating Reforms:** New health plans will not be allowed to charge higher premiums based on an applicant or enrollee's health status or gender. The most that new health plans can vary premium pricing based on age is 3:1—that is, older adults who buy individual coverage can be charged no more than three times the price charged to young adults, and small businesses that consist mostly of older workers cannot be charged more than three times the price that small businesses with younger workers pay for premiums.

- **Limited Waiting Periods for Employer-Based Coverage:** When a new employee joins an employer's health plan, he or she will not have to wait more than 90 days before coverage begins.
- **Newly Sold Individual and Small Group Plans Will Cover Certain Essential Benefits:** New plans must offer a list of essential benefits, including the following:
  - ambulatory care,
  - emergency care,
  - hospitalization,
  - maternal and newborn care,
  - mental health and substance abuse disorder services,
  - prescription drugs,
  - habilitative and rehabilitative services,
  - preventive and wellness services and chronic disease management, and
  - pediatric services, including oral and vision care for children.

The secretary of HHS will further define what must be covered within these broad categories, and the scope of coverage will be equal to the scope of benefits provided under typical employer plans. Furthermore, all group plans must limit out-of-pocket expenses for covered benefits, using the same out-of-pocket limits that apply to high deductible plans that are used with Health Savings Accounts ($5,950 for an individual; $11,900 for a family in 2010). In the small group market, they must limit deductibles to $2,000 for individuals and $4,000 for families in 2014. After that, these limits will be updated each year as average premiums increase.

Plans that offer essential benefits can offer varying levels of coverage, labeled "bronze," "silver," "gold," and "platinum." These levels refer to the percentage of costs that will be paid for by the plan: A bronze plan will pay for 60 percent of the cost of covered benefits, a silver plan will pay for 70 percent, a gold plan will pay for 80 percent, and a platinum plan will pay for 90 percent. Additionally, plans can offer a lesser level of coverage to individuals under the age of 30 who purchase coverage on the individual market. To these young people, plans can offer "catastrophic plans" that still cover essential benefits but that have very high deductibles ($5,950 for an individual in 2010, to be updated annually by premium inflation). Catastrophic plans are only required to cover three primary care visits before a person satisfies the deductible, whereas other plans must cover all recommended preventive care before a person satisfies the deductible.

Qualified plans must also limit enrollees' cost-sharing: In the small group market, deductibles can generally be no higher than $2,000 for an individual or $4,000 for a family, to be updated after 2014 based on premium inflation; in all markets, qualified plans must limit enrollees' out-of-pocket expenses for covered services (including the

deductible) to $5,950 for an individual or $11,900 for a family (2010 figures, to be updated based on premium inflation). To sell in the exchange, qualified plans must also show that their premium increases over the last several years have been reasonable.

A few new types of plans might sell coverage in the exchange. First, nonprofit, member-owned plans called "co-ops" may form. Second, the federal Office of Personnel Management will contract with plans that may be offered in multiple states; this is similar to the way the federal government now contracts with plans to serve federal employees around the country.

Individual and Employer Responsibility

When major health reforms are in place in 2014, several provisions go into effect to provide incentives for individuals and employers to maintain health insurance coverage.

Individual Responsibility

The "individual responsibility" section of the law requires that individuals who can afford to do so maintain a minimum level of coverage, or else pay a tax penalty. Many types of coverage, including employer-sponsored and individually purchased private plans, Medicare, Medicaid, CHIP, and military and veterans' plans can meet this requirement. The following people are exempt from the individual responsibility requirements: people with low incomes who are not required to file taxes; members of certain religions that are exempted for religious reasons; people who are incarcerated, people who are not legal residents; members of an Indian tribe, people who go without coverage for less than three months; and people who do not have an affordable offer of coverage, either through the exchange or through their employer. In this case, coverage is considered "affordable" if the monthly premium does not consume more than 8 percent of a family's income in 2014 (indexed in later years to account for both premium and wage increases). Individuals who do not fall into any of the categories listed above, but who would face hardship if they purchased coverage, may file for an exemption from the individual responsibility requirements.

The penalties for individuals who do not maintain coverage will phase in over time. In 2014, people who forgo insurance for the year will pay the greater of: a) $95 per adult family member without coverage (and half that amount for each child), up to a maximum of three times that amount for a family ($285); or b) 1 percent of their taxable household income. In 2016, the amounts are $695 per adult family member without coverage, up to a maximum of $2,085 for a family, or 2.5 percent of taxable income. Whether a family pays the flat-dollar penalty or a penalty based on a percentage of taxable income, the penalty they pay will never exceed the national average cost of covering the family through a bronze plan sold in the exchange.

After 2016, penalties will be adjusted by the cost of living. There will be no criminal penalties for failing to meet the individual responsibility requirements.

Employer Responsibility

Starting in 2014, the "employer responsibility" section assesses employers with more than 50 employees if they fall within either of two categories. First, employers of more than 50 employees are assessed if they *do not offer* coverage and have at least one full-time employee who receives a tax credit toward the premium cost to purchase coverage through an exchange. Employers in this group pay $2,000 a year for each full-time-equivalent employee, excluding the first 30 employees. Second, employers with more than 50 employees who *do offer* coverage may also be assessed if one or more employees receive a tax credit for exchange coverage.

Employees can receive a credit and purchase coverage through the exchange if their share of premiums in the employer's plan would consume an unaffordable share of their incomes. In this case, a plan is considered "*un*affordable" if the premiums consume more than 9.8 percent of family income in 2014 (indexed in later years to account for both premium and wage increases). Employers with more than 50 employees who fall into this category will pay the lesser of $3,000 a year for each employee receiving a tax credit or $2,000 a year for each full-time employee, excluding the first 30 employees. The amount of the assessments for employers in both categories will be indexed over time by a factor based on the increase in insurance premiums.

The Need for Individual and Employer Responsibility

The law explains the reasons for these responsibility provisions. Among them are:

- If there were no requirements, some individuals would attempt to self-insure, increasing financial risk both to their households and to medical providers.
- The requirements will help to achieve near-universal coverage and prevent the economy from losing money due to the poorer health and shorter life span of the uninsured.
- The requirements minimize uncompensated care and cost-shifting to insured consumers.
- The requirements bring healthier people into insurance risk pools, which, in turn, brings down the cost of insurance.
- If there were no requirements, people would wait until they needed care to purchase insurance—it would thus be impossible to eliminate pre-existing condition exclusions and implement other insurance reforms in the law without raising premiums.

Medicare

Benefit Improvements

- **Closing the Doughnut Hole:** The coverage gap in the Medicare Part D prescription drug benefit, often referred to as the "doughnut hole," will gradually be closed by 2020. Under existing law, in 2010, the gap begins when beneficiaries' total prescription drug costs reach $2,830. Beneficiaries must pay the next $3,610 in drug costs out of their own pockets, at which point catastrophic coverage begins. Under the new law, beneficiaries who fall into the doughnut hole will receive a $250 rebate in 2010. Starting in 2011, they will receive a 50 percent discount on name-brand drugs while in the doughnut hole and other discounts on generic drugs. These discounts will increase each year until 2020, when beneficiaries will be responsible for only 25 percent of the cost of drugs up to the catastrophic limit (the same percentage they pay for their initial coverage under Part D).
- **Preventive Benefits:** All deductibles and co-insurance for preventive benefits will be eliminated, effective January 1, 2011. Medicare will also now cover a free annual wellness visit. Medicare's coverage for preventive benefits has expanded in recent years, but until now some services and screenings remained subject to deductibles and cost-sharing.
- **Low-Income Subsidy Improvements:** "Dual eligibles" are people who are eligible for both Medicare *and* Medicaid. Dual eligibles in home- and community-based services waiver programs will no longer have to pay cost-sharing for their Part D prescription drugs. Other changes should improve the stability of the Part D low-income subsidy program by reducing the likelihood that beneficiaries will have to change plans each year to avoid paying a premium.

Sustaining Medicare

- **Medicare Advantage:** The privatization of Medicare is rolled back by reducing the overpayments to private Medicare Advantage plans that currently cost, on average, 14 percent more than traditional Medicare. Payments to plans will be frozen in 2011. Thereafter plans will be paid under a new formula that adjusts for geographic variations. Payment reductions will be phased in over 3 to 7 years, depending on the magnitude of the changes. All plans will have to continue to provide all benefits guaranteed by Medicare and high-quality plans will receive bonus payments.
- **Trust Fund:** Under pre-health reform projections, the Medicare Part A Trust Fund will be inadequate to pay full benefits by as early as 2017. The health reform law addresses this problem by extending the life of the trust fund by 9 years. This strengthening of Medicare's financing is accomplished by a combination

in reductions in overpayments to private Medicare Advantage plans (see page 16), increases in Medicare payroll taxes for high-income people, and changes in payments to hospitals and other providers that were agreed to as part of overall health reform.

Long-Term Services and Supports

Health reform includes new programs and makes changes to existing programs designed to help states expand home- and community-based services (HCBS) in Medicaid. These changes will help make home- and community-based services more readily available for the millions who rely on Medicaid to pay for long-term services. Health reform also establishes a new, voluntary long-term care insurance program.

Changes Related to Medicaid and LTSS

- **Community First Choice***:* This is a new option, 1915(k), for states to offer home- and community-based attendant services through a Medicaid state plan amendment starting October 1, 2011. Eligibility is limited to people in Medicaid who meet the state's institutional level of care standard and who have incomes up to 150 percent of poverty (or higher if the state has a higher income level for nursing facility care eligibility). The law specifies program benefits, and gives states the option of adding coverage for some facility-to-community transition costs and additional services identified in an individual's care plan. Services must be provided statewide, with no program caps, and benefits cannot be targeted to specific populations. During the first year a state offers this program, it must maintain the prior fiscal year's Medicaid spending level for seniors and people with disabilities. States that take up the option will receive a 6 percentage point increase in Medicaid matching dollars (FMAP) for program costs. There is no time limit on this added payment. This program gives states a strong incentive to significantly expand Medicaid home- and community-based services.
- **State Balancing Incentives Payment Program:** This new five-year $3 billion program will provide qualifying states with an increased FMAP to build home- and community-based services capacity, starting October 1, 2011. States where non-institutional care accounted for less than 50 percent of total Medicaid long-term care spending in 2009 are eligible for program payments. To qualify, states must submit to HHS, and have approved, an application that includes a detailed a plan and budget for increasing the use of non-institutional care to target levels. The target level is either 25 percent or 50 percent of total Medicaid long-term care spending, depending on the state's spending level in 2009. Participating states cannot apply more restrictive eligibility standards for non-institutional long-term services than were in place at the end of 2010. Within six months of applying, a

state must make Medicaid administrative changes that are designed to increase the use of Medicaid home- and community-based services. The increased FMAP is either 2 or 5 percentage points, depending on a state's 2009 level of Medicaid non-institutional care spending. The FMAP increase applies to specified non-institutional long-term care costs. This program gives states financial incentives to make administrative changes that have been shown in some states to expand the use of home- and community-based services in Medicaid and to curb the growth in long-term services spending over the long term.

- **Improvements to the 1915(i) Option***:* This is an existing option for states to offer Medicaid home- and community-based services through a state plan amendment. This option has not been taken up by many states. Health reform makes changes to the 1915(i) option that would help more people be eligible for services, provide greater protections for those who qualify, and give states more flexibility in the services they can offer. Health reform also removes states' ability to have waiting lists, program caps, and offer services less than statewide—all options under the original program. States can elect to target services to specific populations and to vary the services provided to those populations. Elections to target services are for five-year renewable periods. Program changes are effective April 1, 2010. The changes health reform makes are designed to provide greater individual protections and to make the option more attractive for states that are seeking to expand home- and community-based services in Medicaid.
- **Extending Spousal Financial Protection***:* For a five-year period starting in 2014, states will be required to extend the same spousal impoverishment protections they currently provide to spouses of nursing facility residents to spouses of individuals receiving home- and community-based services. This will make it financially easier for a couple to use Medicaid's home- and community-based services option.
- **Extending and Improving "Money Follows the Person"***:* Health reform extends the Money Follows the Person Medicaid demonstration program through 2016 with an additional $1.7 billion in funding. The program gives states grants to fund systems development and to help qualifying individuals move from long-term care institutions back into the community. The initial 5-year grant program was scheduled to expire in 2011. Health reform not only extends the program, but also makes it easier for individuals to qualify by reducing the pre-eligibility nursing facility residency requirement from six to three months. It also opens the program to individuals who have been in institutions for more than 2 years, a group previously excluded.

- New Voluntary Insurance Program
  - **Community Living Assistance Services and Supports (CLASS)***:* This new government-operated, voluntary insurance program is intended to help people with the cost of long-term services so that they can remain living in the community longer. The program will start in January 2011. Adults who meet a minimal work requirement will be eligible to enroll. To be eligible for benefits, an individual must be enrolled in the program for 5 years and maintain the work requirement for 3 of the first 5 years of his or her enrollment. Overall program premiums and benefits are not yet set. However, the law limits premiums for individuals with incomes below poverty and full-time students under the age of 22 to $5 per month; premiums will vary by age at enrollment. The law also specifies that there will be multiple benefit levels with a minimum level of $50 a day, which is $18,250 a year. The benefit is a lifetime benefit, meaning it lasts for as long as an individual needs it, not just a set number of years. Benefit payments will increase with inflation. Premiums for new enrollees will increase with inflation; however, after enrollment, an individual's premiums are locked-in. They will only increase if an individual drops out and re-enrolls, or if necessary to maintain program solvency. The program will be fully funded by premium payments. CLASS represents a major new program—and a potentially major shift—for long-term care funding. Unlike private long-term care insurance, individuals will be eligible regardless of age or health status, and premium levels will not be tied to health status. It creates a new opportunity for millions to purchase coverage.

Conclusion

Health reform implementation will be a complex, multi-year process. In the coming months, HHS will begin to issue guidance and regulations that will provide clarity on how they interpret the law and the steps states must take to comply with it. Families USA will be following the process each step of the way. Check Health Reform Central at www.familiesusa.org for heath reform related publications and resources.

Endnotes

[1] States already have the option of expanding Medicaid coverage to parents without using a waiver. The new health reform law allows states to expand Medicaid to childless adults without using a waiver, but states will only receive regular FMAP for this coverage until 2014 when the more generous matching formula for expansion populations takes effect.

[2] This expansion does not apply to individuals under the age of 65 who are eligible for Medicare through a disability pathway. These individuals continue to be eligible for Medicare, not Medicaid.

[3] This provision applies to Arizona, Delaware, the District of Columbia, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, Washington, and Wisconsin. Beginning in 2014, the matching rate for adults without dependent children in those states will be greater than the regular FMAP, but not as high as the matching rates for newly eligible groups (shown in Table 1).

[4] This does not apply to Medicare or disability-related determinations, or to those who are eligible through the medically needy "spend-down" category. Existing income methodologies can continue to be used for these eligibility categories.

[5] Individuals and families with incomes up to 133 percent of poverty who do not qualify for public programs, such as immigrants who have not yet been in the country for 5 years, will also be eligible for tax credits and coverage through the exchange.

More Resources on Health Reform from Families USA

Help Is on the Way: 13 Reasons to Embrace Health Reform (March 2010)

First 90 Days: State Advocates' To Do List (April 2010)

What Will the New Health Reform Law Do in the First Year? (April 2010)

Health Coverage in the States: How Will Health Reform Help? (March 2010)

Efforts to Halt Health Reform: Playing Politics with Our Health (April 2010)

Early Medicaid Expansions under Health Reform (May 2010)

Maintenance of Effort Requirements under Health Reform (March 2010)

Helping People with Long-Term Health Care Needs: Improving Access to Home- and Community-Based Services in Medicaid (April 2010)

*Helping People with Long-Term Health Care Needs: An Insurance Program to Help People Afford Long-Term Services and Support*s (April 2010)

Rate Review: Holding Health Plans Accountable for Your Premium Dollars (April 2010)

Medical Loss Ratios: Making Sure Premium Dollars Go to Health Care—Not Profits (February 2010)

These and other resources are available online in the Health Reform Central section of our website, www.familiesusa.org.

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April 2010