AFSCME Facts

Patient Protection and Affordable Care Act of 2010

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) and on March 30 he signed the accompanying Reconciliation Act of 2010 (H.R. 4872). The legislation makes transformative changes to our nation's health care system, protects and improves worker and retiree benefits, offers access to affordable coverage for 32 million Americans, provides over $900 billion in new federal funding for states and reduces the deficit by $143 billion in the first ten years. Below is more information about the new law's impact:

For Those Who Get Their Coverage at Work

Workers will keep their current health plan.

- Workers and their dependents will keep their employer-provided health plan and doctors in accordance with plan rules. AFSCME will continue to negotiate benefits and costs where we have the right to do so.

For plan years beginning after September 23, 2010:

- Health plans can no longer deny children coverage based on a preexisting condition.
- Health plans must allow children to stay on their parent's insurance plans until age 26 provided the child is not eligible for their own employer-sponsored coverage. This coverage is provided free of federal income tax.
- Health plans are prohibited from dropping people from coverage when they get sick.
- Health plans are prohibited from placing lifetime caps on coverage and the use of annual limits are tightly restricted to ensure access to needed care. The allowable annual limits imposed by health plans through the year 2013 will be defined by the Secretary of the Department of Health and Human Services. Beginning in 2014, the use of any annual limits will be prohibited for all plans.
- Health plans must eliminate co-payments and deductibles for preventive services as recommended by the U.S. Preventive Services Task Force and the Center for Disease Control, including certain immunizations, well woman screenings, etc .

2011

- Over-the-counter drugs not prescribed by a physician can no longer be reimbursed through Flexible Spending Accounts (FSAs), health reimbursement accounts (HRAs) or health savings accounts (HSAs).

2013

- Annual contributions to health care FSAs will be limited to $2,500. In subsequent years this limit is indexed to general inflation.

2014

- Insurance companies cannot deny coverage to anyone with preexisting conditions.
- Health plans would be prohibited from having waiting periods over 90 days.
- The cap on wellness program incentives/penalties increases from 20% of premium to 30% of premium with the possibility to be increased to 50% based on HHS and DOL regulation.
- An employer plan is considered unaffordable (allowing the employee to access subsidies in the exchange if they earn less than 400 % of poverty) if an employee would have to pay more than 9.5% of their income for premiums or if their health plan has an actuarial value less than 60%. (Actuarial value is the percentage of medical expenses covered by the plan that are estimated, on an aggregated average basis, to be paid by the plan. The remainder of the medical expenses is expected to be paid by plan participants. A plan with a higher actuarial value has less participant cost sharing.)
- Employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit will be assessed a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage 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.
- Employers with more than 200 employees will be required to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.
- All new group plans, will be required to offer a comprehensive "essential benefits" package (to be defined by the Dept. of Health and Human Services), to limit cost-sharing to no more than federal HSA limits ($5,950/ individual or $11,900/family in 2010), and to provide at least 60% actuarial value of the covered benefits.

2017

- Larger employers, including state and local governments, would be eligible to join the exchanges at each state's option. Where the option is provided, the decision to enter the exchange is subject to applicable collective bargaining obligations.

2018

- High-cost health plans will be subject to an excise tax. For plans costing more than $10,200 for individuals and $27,500 for families, a 40% tax on the amount above these thresholds will be charged to insurance companies. The thresholds for retirees age 55 – 64 and employees in high risk jobs are slightly higher - $11,850/$30,950. Dental and vision benefit costs are excluded from the calculation and caps are increased for plans that have a higher proportion of older and female participants than average to actuarially reflect higher utilization.

Implementation

For collectively bargained health plans, these reforms apply for plan years beginning after the current agreement's expiration date. Amendments could be made earlier to the plans allowing them to conform to the new requirements without causing a termination of the agreement.

Existing private sector self-insured plans are grandfathered from many requirements. They are however affected by these reforms:

For plan years beginning after September 23, 2010:
- Insurance companies can no longer deny children coverage based on a preexisting condition.
- Insurance companies and plan sponsors must allow children to stay on their parent's insurance plans until age 26 provided the child is not eligible for their own employer-sponsored coverage. This coverage is provided on a tax-free basis to the employee and child.
- Health plans are prohibited from dropping people from coverage when they get sick.
- Health plans are prohibited from placing lifetime caps on coverage and the use of annual limits are tightly restricted to ensure access to needed care. The allowable annual limits imposed by health plans through the year 2013 will be defined by the Secretary of the Department of Health and Human Services. Beginning in 2014, the use of any annual limits would be prohibited for all plans.

For Those Without Employer Coverage

2010/2011

- A temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions is established in June, 2010 until January 1, 2014 when exchanges become operational. People under age 65 who have been uninsured for six months are eligible for this subsidized coverage.
- Health plans will be required 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 improvement 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)

2014

- All legal residents will be required to have health insurance. Exemptions will be granted from the requirement (i.e. if you will spend more than 8% of your income on coverage, have financial hardship, or earn too little to file taxes [$9,350 in 2009]).
- Individuals and small employers (up to 100 workers until 2017) will have access to state-run buying pools called "exchanges" beginning January 1, 2014. The exchanges will offer a selection of commercial and nonprofit health insurance plans. Health plans will be required

to cover and renew all applicants (called "guarantee issue" and "guaranteed renewal") and would not be allowed to vary rates according to gender, or more than 3 to 1 for age, or more than 1.5 to 1 for tobacco use. States must offer at least one exchange for individuals and one for small employers.

- Individuals eligible to buy in the exchanges are people who work for small employers, whose employer offer of coverage is deemed "unaffordable" or persons who now must buy health coverage on their own. Many AFSCME home and child care providers, early retirees and part-timers are likely to qualify to initially enter the exchange.

- Workers and their families will be eligible for tax credits to help cover the cost of insurance in the exchanges. These premium credits will be based on a sliding scale and available for individuals earning from 133% of poverty (the point at which eligibility for Medicaid ceases) up to 400% of poverty ($88,200 for a family of four in 2010).

- The out-of-pocket limits for those with incomes up to 400% FPL are limited to the following levels:
  - 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);
  - 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);
  - 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family).

- Deductibles for health plans in the small group market are limited to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.

- Waiting periods for coverage are limited to 90 days.

- Enrollees will be able to choose from a variety of quality, private health insurance plans with 4 levels of available benefits, plus a catastrophic plan for people under age 30 or who are exempt from the mandate to purchase coverage. The basic package level must have specified "essential benefits", will limit cost-sharing to no more than federal HSA limits ($5,950/ individual or $11,900/family in 2010), and provide at least 60% actuarial value.

Medicaid and Other New Health Options for the Uninsured

- Beginning in 2014, Medicaid is expanded to all individuals under age 65 with income of up to 133% of poverty. (States have the option to expand their own coverage and draw down additional federal funds beginning in 2011).

- Access to care is increased by providing $11 billion for community health centers, beginning in 2011. AFSCME members without employer coverage can utilize these services.

- States also have the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% of poverty.

For Retirees

2010

- A $250 rebate is provided to Medicare beneficiaries who reach the Part D coverage gap in 2010. In 2011, all brand-name drugs paid by seniors who reach the gap will be discounted by 50%, and over time, Medicare will pick up more of the costs. By 2020, the donut hole will be fully eliminated.

- Public and private sector employers, including state and local governments and pension systems, will be able to apply to a temporary $5 billion reinsurance fund until 2014 to maintain their health benefits for early, pre-Medicare retirees (begins June, 2010).

2011

- Seniors will receive free preventive care and an annual preventative check-up, beginning in 2011.

- The CLASS Act, a new long-term assistance program for all Americans to purchase home and community based support services if they become disabled, becomes effective. All workers whose employer participates will automatically be enrolled, unless they choose to opt-out.

- Payments to Medicare Advantage (MA) plans are restructured by setting payments to different percentages of Medicare fee-for-service (FFS) rates.

- MA plans are prohibited from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.

Impact on State and Local Budgets and State Operations

As employers, providers and payers of health care, states will save billions of dollars under reform. States and residents will receive $900.8 billion in new federal funding for health coverage over the next decade (includes residents and governments of the 50 states, Puerto Rico and the District of Columbia). Some of these benefits will be offset by new costs.

- States will receive additional federal funds to pay for people newly-eligible for Medicaid. For the first two years of the expansion, states will receive 100% federal funding, phasing down to 90% in 2020. Although this expansion is ultimately expected to increase state Medicaid costs by a national average of four percent (which will vary slightly by state), the increase is projected to be offset by declines in uncompensated care costs and costs to state-based high risk pools as the number of uninsured drops.

- States will have the option to establish the Community First Choice Option and provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care through their regular Medicaid program, rather than through a waiver. (Beginning in 2011 through 2016)

- A State Balancing Incentive Program will be created to increase the proportion of non-institutionally based long term care services. States will also have additional options for offering home and community-based serves through a much easier approval process (a Medicaid state plan rather than a waiver) as of Oct. 1, 2010, and the Medicaid Money Follows the Person Rebalancing Demonstration program is extended through 2016.

- States must maintain their current levels of eligibility for the Children's Health Insurance Program and Medicaid until 2019.

- The exchanges, which will be operational at the state level in 2014, may be administered by state employees or by private contractors.

- Beginning in 2015, states will receive a 23 percentage point increase in the federal matching rate for the Children's Health Insurance Program (CHIP).

- Both Medicaid and Medicare DSH payments to the states will be reduced beginning in 2014, using a formula based on the reduction in numbers of the uninsured for each state.

- Beginning in 2011 through 2016, states will have various options to enhance their Medicaid matching funds while providing home and community-based services. States will have the option to receive an enhanced FMAP of six additional points for providing community-based attendant supports and services to individuals with disabilities who require an institutional level of care through their regular Medicaid program, rather than through a waiver. States will also have the option to participate in the State Balancing Incentive Program and receive enhanced payments.