

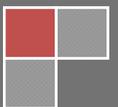
2010

Health Care Reform

The Affordable Care Act

What health care reform means for you, your family and Pennsylvania.

U.S. Senator Robert P. Casey, Jr.
Pennsylvania
9/23/2010



Please use this guide as a resource for learning more about the Affordable Care Act. There are different sections targeting different types of individuals: individual health care consumers, providers and business owners. The Table of Contents can direct you to the appropriate section that will be most helpful to you.

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A Message from Senator Casey

The late Hubert Humphrey said that one of the tests of a government is how it treats those in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and individuals with disabilities.

I am committed to protecting those in the dawn of life – our children – as well as those in the twilight and shadows of life – our more vulnerable citizens and older citizens. All people have a fundamental right to quality health care, particularly children for whom proper health care in the earliest years is so critical. The Affordable Care Act is a landmark piece of legislation that will help thousands of Pennsylvanians and millions of Americans afford health insurance and gain access to quality, affordable health care.

The Affordable Care Act is about providing more choices for individuals, for families and for small businesses. It includes consumer protections, to ensure that you have health insurance when you need it most; tax credits to help small businesses provide health insurance to their employees; free wellness visits to Medicare beneficiaries to ensure that our older citizens can stay healthy in retirement; and investments to train more doctors, nurses and other medical professionals to increase access to health care.

Since the first version of this guide, we have made a lot of progress. Rebate checks to older citizens who have fallen into the Medicare Part D donut hole are being mailed out, the high risk pools are beginning to accept applications and the Department of Health and Human Services has rolled out a new website, www.healthcare.gov, to provide Pennsylvanians, and Americans across the country, more control over their health care by providing the information necessary to make the best choices for themselves and their families.

Most importantly, on September 23, important new protections for you and your family took effect. The next time you renew your health insurance or switch plans, you will be able to keep your adult child on your plan, or add him back to your plan, until he turns 26. You won't have to worry about having a lifetime limit on your benefits if you get sick, and insurers won't be able to discriminate against children with preexisting conditions.

I hope that you will find this guide useful in understanding the Affordable Care Act. I encourage you to check my website frequently, as I will continue to post information about health care reform implementation as it becomes available. If you have further questions, please do not hesitate to contact my office; my staff will be happy to assist you.

Sincerely,



Robert P. Casey, Jr.
United States Senator

Overview of the Affordable Care Act

The final health insurance reform legislation (the Senate bill as modified by the Reconciliation Bill, collectively known as the Affordable Care Act) that became law on March 23, 2010 will ensure that all Americans have access to quality, affordable health care and significantly reduce long-term health care costs. The non-partisan Congressional Budget Office (CBO) has determined that it will provide coverage to 32 million more people, or more than 95 percent of Americans, while lowering health care costs over the long term. This historic legislation will reduce the deficit by \$143 billion over the next ten years, with an estimated \$1.2 trillion in additional deficit reduction in the following 10 years.

Quality, Affordable Health Care for All Americans

- Bars insurance companies from discriminating based on pre-existing conditions, health status, and gender.
- Provides Americans with better coverage and the information they need to make informed decisions about their health insurance.
- Creates health insurance Exchanges – competitive marketplaces where individuals and small business can buy affordable health care coverage in a manner similar to that of big businesses today.
- Offers premium tax credits and cost-sharing assistance to low and middle income Americans, providing families and small businesses with the largest tax cut for health care in history.
- Insures access to immediate relief for uninsured Americans with pre-existing conditions on the brink of medical bankruptcy.
- Creates a reinsurance program in support of employers who offer retirees ages 55-64 health coverage.
- Invests substantially in Community Health Centers to expand access to health care in communities where it is needed most.
- Empowers the Department of Health and Human Services and state insurance commissioners to conduct annual reviews of new plans demanding unjustified, egregious premium increases.

Key Investments in Medicaid and Children's Health

- Expands eligibility for Medicaid to include all non-elderly Americans with income below 133 percent of the Federal Poverty Level (FPL).
- The federal government will pay 100 percent of the cost of covering these newly-eligible individuals for the first three years of the expansion, will decrease its contribution incrementally from 2017 to 2019, and then will pay 90 percent of costs in 2020 and beyond.
- Maintains current funding levels for the Children's Health Insurance Program (CHIP) for an additional two years, through fiscal year 2015.
- Increases payments to primary care doctors in Medicaid.

Improving Medicare

- Adds at least nine years to the solvency of the Medicare Hospital Insurance trust fund.
- Fills the Medicare prescription drug donut hole. In 2010, Medicare beneficiaries who go into the donut hole will receive a \$250 rebate. After that they will receive a pharmaceutical manufacturers' 50 percent discount on brand-name drugs in 2011, and phased-in cost-sharing reductions for all brand-name and generic drugs will completely fill the donut hole by 2020
- Provides new, free annual wellness visits, and eliminates out-of-pocket copayments for preventive benefits under Medicare, such as cancer and diabetes screenings.
- Provides better care of chronic conditions, with doctors collaborating to provide patient-centered care for the 80 percent of older Americans who have at least one chronic medical condition like high blood pressure or diabetes.
- Improves Medicare payments for primary care which will protect access to these vital services.
- Encourages reimbursing health care providers on the basis of value, not volume. The bill includes a number of proposals to move away from the "a la carte" Medicare fee-for-service system toward paying for quality and value while reducing costs for America's seniors.

Preventing Chronic Disease and Improving Public Health

- Promotes preventive health care at all ages and improves public health activities that help Americans live healthy lives and restrain the growth of health care costs over time.
- Eliminates cost-sharing for recommended preventive care, provides individuals with the information they need to make healthy decisions, improves education on disease prevention and public health and invests in a national prevention and public health strategy.

Health Care Workforce

- Makes key investments in training doctors, nurses and other health care providers. Currently, 65 million Americans live in communities where they cannot easily access a primary care provider. An additional 16,500 practitioners are required to meet their needs. The legislation addresses shortages in primary care and other areas of practice by making necessary investments in our Nation's health care workforce.
- Invests in the National Health Service Corps' scholarship and loan repayment programs to expand the health care workforce.
- Includes incentives for primary care practitioners and other providers to practice in underserved areas.

Transparency and Program Integrity

- Provides consumers with information about physician ownership of hospitals and medical equipment companies, as well as nursing home ownership and other characteristics.
- Cracks down on fraud, waste and abuse in Medicare, Medicaid, SCHIP and private insurance.

- Establishes a private, non-profit entity to identify priorities in patient-centered outcomes research that will provide doctors with information on how best to treat patients and end wasteful overspending.

Improving Access to Innovative Medical Therapies

- Establishes a regulatory pathway for FDA approval of biosimilar versions of previously licensed biological products.
- Expands the scope of the existing 340B drug discount program to allow more Americans to have access to medicines at lower costs.

Community Living Assistance Services and Support (CLASS)

- Makes long-term support and services more affordable for millions of Americans by providing a lifetime cash benefit that will help people with severe disabilities remain in their homes and communities.
- CLASS is a voluntary, self-funded insurance program provided through the workplace. For those whose employers participate, affordable premiums will be paid through payroll deductions. Participation by workers is entirely voluntary. The Congressional Budget Office confirms that the program is actuarially sound.

Revenue Provisions

- Reduces the deficit in the next ten years and beyond. The bill is fully paid for with revenue provisions that focus on paying for reform within the health care system.
- Tightens current health tax incentives, collects industry fees, institutes modest excise taxes and slightly increases the Medicare Hospital Insurance (HI) tax for individuals who earn more than \$200,000 and couples who earn more than \$250,000. The taxable base of the HI tax is also broadened by including net investment income. The HI tax increases will not only help fund health care reform, but, when combined with other provisions in the bill, will also extend the solvency of the Medicare Trust Fund by at least twelve years to 2029.
- Includes a fee on insurance companies that sell high cost health insurance plans. The fee is designed to generate smarter, more cost-effective health coverage choices. The reconciliation bill delays this new fee until 2018 so that plans have time to implement reform and begin to save from its efficiencies.
- Changes health care tax incentives by increasing penalties on nonqualified distributions from HSAs, capping FSA contributions and standardizing the definition of qualified medical expenses. The industry fees and excise taxes reflect responsible contributions from health care stakeholders who will benefit from the expanded coverage of millions of additional Americans under health care reform. The bill also assesses a small excise tax on indoor tanning services.
- In total, the revenue provisions in the bill represent a balanced, responsible package of proposals that bend the health care cost curve by putting downward pressure on health spending, closing unintended tax loopholes and promoting tax compliance.

The Affordable Care Act: What this means for Pennsylvania

The Affordable Care Act will ensure that all Pennsylvanians have access to quality, affordable health insurance. The Congressional Budget Office has determined that these two bills are fully paid for, will bend the health care cost curve, and will reduce the deficit by \$143 billion over the next ten years with further deficit reduction in the following decade. The Affordable Care Act will reduce the cost of health care for the middle class, ensure health security to seniors, and provide tax credits to small businesses and individuals to further reduce the cost of health coverage.

Key Benefits for Pennsylvania

1.3 million uninsured Pennsylvanians and **683,000** Pennsylvanians who purchase health insurance through the individual market will be provided with affordable coverage options.ⁱ

As many as **143,451** uninsured Pennsylvanians who have a pre-existing condition will be eligible for new, affordable insurance options.ⁱⁱ

Up to **904,000** Pennsylvanians will receive tax credits to help make health insurance more affordable, bringing **\$14.6 billion** in premium and cost-sharing tax credits into Pennsylvania during the first five years of the health insurance Exchange.ⁱⁱⁱ

Family health insurance premiums will be reduced by **\$1,700 - \$2,430** for the same benefits, as compared to what they would be without health reform by 2016.^{iv}

1.2 million young adults in Pennsylvania will be able to stay on their parents' insurance plans.^v

This bill recognizes the special vulnerability of children and prohibits insurance companies from excluding coverage of pre-existing conditions for the **2.8 million** children in Pennsylvania. This takes effect six months after enactment and applies to all new plans.^{vi}

Health care reform is also good for Pennsylvania jobs and the Pennsylvania economy.

Health care reform will help create **11,400 - 18,300** jobs by reducing health care costs for employers.^{vii}

Small businesses make up **73.6** percent of all Pennsylvania businesses, yet just **48.7** percent of these small businesses are able to offer health insurance to their employees.^{viii} Health care reform changes this.

Starting this year, up to **160,700** Pennsylvania small businesses will be eligible for tax credits for a percentage of their contribution to their employees' health insurance. Small businesses of the size that qualify for these tax credits employ approximately **600,000** Pennsylvanians.

Health care reform will provide more federal funding for **229** Community Health Centers in Pennsylvania.^{ix}

What this Means for Pennsylvania Providers

This section provides information for different types of providers about what health care reform means for them. This includes consumer protections, Community Health Centers and hospitals, and also details about Medicaid and CHIP.

Primary Care Providers

Primary care is the backbone of preventive health care, and a strong primary care workforce is essential to health of our country. The Affordable Care Act creates a new Prevention and Public Health Fund designed to help create the necessary infrastructure to prevent disease, detect it early, and manage conditions before they become severe. This new initiative will increase the national investment in prevention and public health, improve health, and enhance health care quality.

The Administration recently announced the first allocation of \$500 million for the new Prevention and Public Health fund for fiscal year 2010. Half of this fund – \$250 million – will be used to boost the supply of primary care providers in this country by providing new resources for:

- **Creating additional primary care residency slots:** \$168 million for training more than 500 new primary care physicians by 2015;
- **Supporting physician assistant training in primary care:** \$32 million for supporting the development of more than 600 new physician assistants, who practice medicine as members of a team with their supervising physician, and can be trained in a shorter period of time compared to physicians;
- **Increasing the number of nurse practitioners trained:** \$30 million will train an additional 600 nurse practitioners, including providing incentives for part-time students to become full-time and complete their education sooner. Nurse practitioners provide comprehensive primary care;
- **Establishing new nurse practitioner-led clinics:** \$15 million for the operation of 10 nurse-managed health clinics which assist in the training of nurse practitioners. These clinics are staffed by nurse practitioners, which provide comprehensive primary health care services to populations living in medically underserved communities.
- **Encouraging states to plan for and address health professional workforce needs:** \$5 million for States to plan and implement innovative strategies to expand their primary care workforce by 10 to 25 percent over ten years to meet increased demand for primary care services.

The Prevention and Public Health Fund is just one element of a comprehensive, multi-faceted strategy to encourage and educate more physicians, nurse practitioners, and physician assistants to practice in primary care. This strategy includes tax benefits, utilizing Medicare capacity, and making education more affordable.

Expanding tax benefits to health professionals working in underserved areas: In addition to incentives provided by the Departments of Labor and Education to pursue primary care as a profession, the Department of Treasury is responsible for providing tax benefits to students. The Affordable Care Act includes a provision that excludes from taxes the value of student loans that were repaid or forgiven because the individual worked in certain health professions, including

primary care. This provision is retroactive to 2009. Recently, the Internal Revenue Service took steps to ensure health professionals are aware of this benefit. For 2009, approximately \$10 million in tax refunds will be made available to health care professionals who practice medicine in areas that need it most.

Building primary care capacity through Medicare and Medicaid: Currently, there are unused Medicare-funded resident training slots. The Affordable Care Act reallocates Medicare resources to primary care residencies in underserved areas of the country. Teaching hospitals benefiting from the additional slots must ensure that the number of primary care residents is not reduced and at least 75 percent of the slots received must be in primary care or general surgery for at least five years. Medicare will provide a 10 percent bonus payment for primary care provided by qualified physicians from 2011-2015. In addition, Medicaid payment rates to primary care physicians will be increased in 2013 and 2014 to at least 100 percent of associated Medicare rates. Emphasizing the critical importance of primary care by providing financial incentives will build capacity in underserved areas.

Providing financial assistance for students: The Department of Education currently makes more than \$150 billion in aid available to students to help pay for undergraduate and graduate education, through a combination of grants, loans, work study and tax credits. The Affordable Care Act increases the Federal government's investment in Pell Grants by \$40 billion, to ensure that all eligible students receive an award and that these awards are increased in future years to help keep pace with the rising costs of a college education.

Making health care education more accessible: Many individuals in health professions are eligible for generous student loan forgiveness programs under current Department of Education programs. This includes Public Sector Loan Forgiveness, which allows individuals in eligible jobs to have their loans forgiven after 10 years. Qualifying jobs for Public Sector Loan Forgiveness include positions in Federal, State, local, or Tribal governments as well as nearly any non-profit organization, including many hospitals and clinics. In addition, certain nurses and medical technicians are also eligible to have their Perkins loans cancelled. The Affordable Care Act expands the existing income-based student loan repayment programs for new borrowers after July 1, 2014, by capping payments at 10 percent of their discretionary income (down from 15 percent) and forgiving loans after 20 years (down from 25 years). Public sector employees will still have their loans forgiven after 10 years.

Providers as Small Business Owners

Many providers who own their own practices may qualify for a new tax credit for small businesses that provide health insurance for their employees. Please refer to the sections on small businesses for more information and to figure out if your practice may qualify for the tax credit.

Community Health Centers

There are numerous provisions in health reform that impact community health centers both directly and indirectly.

The health reform law contains a total of \$11 billion in *new* funding for Community Health Centers for the next five years. \$9.5 billion of this funding will allow community health centers to expand their operational capacity to serve nearly 20 million new patients and to enhance their medical, oral and behavioral health services. \$1.5 billion of this funding will allow health centers to begin to meet their extraordinary capital needs, by expanding and improving existing facilities and constructing new sites.

Payment Protections and Improvements

The Affordable Care Act requires that health centers receive no less than their Medicaid Prospective Payment System (PPS) rate from private insurers offering plans through the new health insurance Exchanges and requires that these plans contract with health centers. It also ensures that health center patients will not be excluded from new insurance products and that health centers are not underpaid for their services.

The Affordable Care Act adds preventative services to the Federally-Qualified Health Center (FQHC) Medicare payment rate and eliminates the outdated Medicare payment cap on FQHC payments. It begins to modernize health center Medicare payments to ensure health centers are able to provide the highest quality care to Medicare beneficiaries.

Teaching Health Centers

Finally, the Affordable Care Act acknowledges the growing role of health centers in teaching the next generation of primary care providers by authorizing and funding new programs for health center-based residencies. It authorizes a new Title VII grant program for the development of residency programs at health centers and establishes a new Title III program that would provide payments to community-based entities that operate teaching programs; the bill directly appropriates \$230 million over 5 years for the Title III payments.

National Health Service Corps

The Affordable Care Act builds on the important work of the National Health Service Corps (NHSC) to address the nation's workforce demands.

The NHSC repays educational loans and provides scholarships to primary care health care providers who practice in areas of the country that have too few health care professionals to serve people who live there. Eligible providers include primary care physicians, physician assistants and nurse practitioners.

The Affordable Care Act provides \$1.5 billion over five years to expand the National Health Service Corps. This builds on a \$300 million investment in the NHSC in the American Recovery and Reinvestment Act. The combined nearly \$2 billion investment is expected to result in an increase of more than 12,000 additional primary care physicians, nurse practitioners and physician assistants by 2016.

Public Health Service Commissioned Corps

The Public Health Service Commissioned Corps is an elite team of more than 6,000 full-time, well-trained, highly qualified public health professionals dedicated to delivering the Nation's public health promotion and disease prevention programs and advancing public health science

The Affordable Care Act eliminates the artificial cap on the number of Commissioned Corps members, allowing the Corps to expand to meet national public health needs.

The law also establishes a Ready Reserve Corps within the Commissioned Corps for service in times of national emergency. The Ready Reserve Corps replaces the previous Reserve Corps; individuals who were serving in the Reserve Corps will be granted commissions in the Regular Corps.

The new Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere.

To increase the number of individuals serving in the Public Health Service Commissioned Corps, the Affordable Care Act authorizes the Surgeon General to establish a U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavior health specialists and public health professionals emphasizing team-based service, public health, epidemiology and emergency preparedness and response in affiliated institutions. Students who participate in this new program will receive tuition remission and a stipend and will be accepted as Commission Corps officers in the U.S. Public Health Service with a 2-year service commitment for each year of school covered.

Medicaid

Medicaid covers health and long-term care services for over 60 million low-income Americans. States have over forty years of experience operating this program with federal matching funds. The Affordable Care Act, as improved by the reconciliation bill, builds upon this existing state-based administrative structure to extend coverage to all low-income Americans who are not eligible for assistance with their premiums and cost-sharing in the health insurance Exchange.

Expanding affordable coverage options

Health care reform provides access to Medicaid for 637,031 newly eligible Pennsylvanians, by expanding eligibility to non-elderly parents, childless adults, children and pregnant women with income up to 133 percent of the federal poverty level. Please see the chart at the end of this guide for annual federal poverty guidelines for Pennsylvania.

- The federal government will fully fund the cost of covering these newly eligible individuals for three years and will pay 90 percent of these costs after 2020.
 - Prior to health reform, Pennsylvania bore the financial responsibility of its Adult Basic Program. With health reform enacted, Pennsylvania will receive more than half of each dollar it spends on most Adult Basic recipients from the federal government.
- In total, Pennsylvania could receive \$18 billion in federal funding during just the first five years of this coverage expansion.
- No state will receive favorable treatment with respect to federal share of Medicaid costs.

Improving Access to Primary Care Services

To address concerns about access to needed services by Medicaid beneficiaries, the bill will also improve Medicaid payments to primary care physicians for primary care services. These payments will be increased to 100 percent of Medicare rates in 2013, the year before the health insurance Exchange is established and the expansions in Medicaid coverage begin in 2014. The costs of raising these payment rates will be paid entirely by the federal government and will retain and promote access to providers accepting Medicaid coverage.

Improving Access to Home and Community-Based Services

Effective in 2011, states will have the option of covering home and community-based attendant services and supports for individuals who require institutional care but choose to remain in the community and who meet state income levels for nursing home care. The federal share of the cost of these services and supports for these individuals will be over 60 percent.

CHIP

The Children's Health Insurance Program (CHIP) covers over 6 million low-income children who are not eligible for Medicaid. The Affordable Care Act extends full funding for CHIP for two additional years, through 2015.

Section 508

Health care reform included an extension of Section 508 Wage Index Reclassifications through September 30, 2010 that is retroactive to October 1, 2009. The 508 reclassification provides much-needed assistance to twelve Pennsylvania hospitals disadvantaged by the Medicare wage index reimbursement system. While we need a permanent wage index solution, this bill sets the stage for a permanent solution. The extensions included in the Affordable Care Act will help hospitals create jobs and pay competitive wages.

Better Care for Older Americans

Help for Early Retirees: Creates a temporary re-insurance program (until the Exchanges are available) to help offset the costs of expensive health claims for employers that provide health benefits for retirees ages 55-64. *For more information, visit <http://www.errp.gov/>.*

Begins to Close the Medicare Part D Donut Hole: Provides a \$250 rebate to Medicare beneficiaries who hit the donut hole in 2010. This would help about 2.2 million older citizens in Pennsylvania. (Beginning in 2011, institutes a 50 percent discount on brand-name drugs in the donut hole; also completely closes the donut hole by 2020.) *Effective immediately.*

Free Preventive Care under Medicare: Eliminates co-payments for preventive services and exempts preventive services from deductibles under the Medicare program. *Effective January 1, 2011.*

Increasing Access to Care

Community Health Centers: Increases funding for Community Health Centers to allow for nearly a doubling of the number of patients seen by the centers over the next 5 years. *Effective immediately.*

Increasing the Number of Primary Care Doctors: Provides new investment in training programs to increase the number of primary care doctors, nurses and public health professionals. *Effective immediately.*

Creates New, Voluntary, Public Long-Term Care Insurance Program: Creates a long-term care insurance program to be financed by voluntary payroll deductions to provide benefits to adults who become functionally disabled. *Effective January 1, 2011.*

Help for Small Businesses

Small Business Tax Credits: Offers tax credits to approximately 160,700 Pennsylvania small businesses to make employee coverage more affordable.^x Tax credits of up to 35 percent of premiums will be immediately available to firms that choose to offer coverage. (Beginning in 2014, the small business tax credits will cover 50 percent of premiums.) *Effective immediately, for calendar year 2010.*

Consumer Protections

Ends Rescissions: Bans health plans from dropping people from coverage when they get sick. *Effective September 23, 2010.*

No Discrimination Against Children With Pre-Existing Conditions: Prohibits health plans from denying coverage to the approximately 2.8 million Pennsylvania children with pre-existing conditions.^{xi} (Beginning in 2014, this prohibition will apply to all persons.) *Effective September 23, 2010.*

Extends Coverage for Young People Up to Age 26 Through Parents' Insurance: Requires health plans to allow young people up to their 26th birthday to remain on their parents' insurance policy, at the parents' choice.^{xii} *Effective September 23, 2010.*

Bans Lifetime Limits on Coverage: Prohibits health plans from placing lifetime caps on coverage. *Effective September 23, 2010*

Bans Restrictive Annual Limits on Coverage: Tightly restricts new plans' use of annual limits to ensure access to needed care. These tight restrictions will be defined by HHS. (Beginning in 2014, the use of any annual limits would be prohibited for all plans.) *Effective September 23, 2010.*

Prohibits Discrimination Based on Salary: Prohibits new group health plans from establishing any eligibility rules for health care coverage that have the effect of discriminating in favor of higher wage employees. *Effective September 23, 2010.*

Free Preventive Care Under New Plans: Requires new private plans to cover preventive services with no co-payments and with preventive services being exempt from deductibles. (Beginning in 2018, this requirement applies to all plans.) *Effective September 23, 2010.*

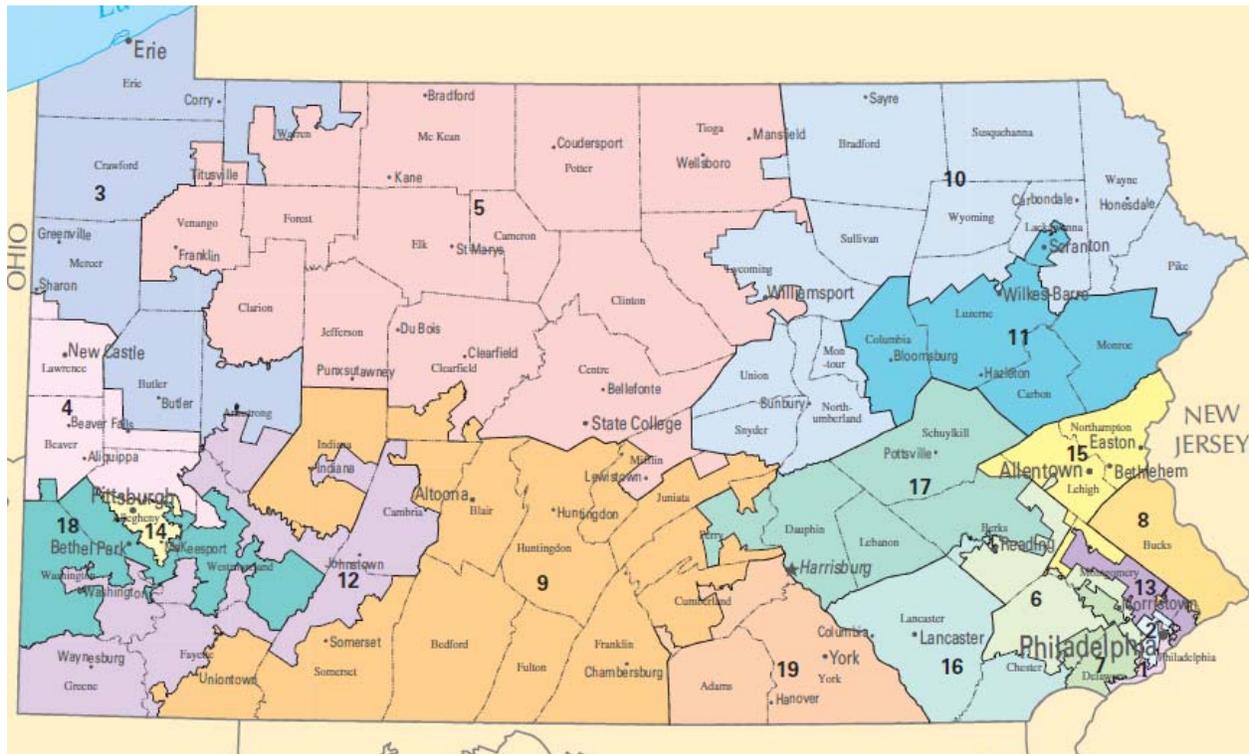
Health Insurance Consumer Information: Provides aid to states in establishing offices of health insurance consumer assistance in order to help individuals with the filing of complaints and appeals. *Effective immediately, for fiscal year 2010.*

New, Independent Appeals Process: Ensures consumers in new plans have access to an effective internal and external appeals process to appeal decisions by their health insurance plan. *Effective September 23, 2010.*

Ensuring Value for Premium Payments: Requires plans in the individual and small group market to spend 80 percent of premium dollars on medical services, and plans in the large group market to spend 85 percent. Insurers that do not meet these thresholds must provide rebates to policyholders. *Effective January 1, 2011.*

Immediate Help for the Uninsured until Exchange is Available (Interim High risk Pool): Provides immediate access to insurance for Americans who are uninsured because of a pre-existing condition - through a temporary high-risk pool. Ensures immediate access to affordable insurance options for as many as **143,451** uninsured Pennsylvanians who have a pre-existing condition.^{xiii} *Effective 90 days after enactment; for more information visit www.pafaircare.com.*

What this Means for Your Congressional District



1st Congressional District (Representative Robert Brady)

- Improve coverage for **289,000** residents with health insurance.
- Give tax credits and other assistance to up to **184,000** families and **10,200** small businesses to help them afford coverage.
- Improve Medicare for **88,000** beneficiaries, including closing the donut hole.
- Extend coverage to **55,000** uninsured residents.
- Guarantee that **12,300** residents with pre-existing conditions can obtain coverage.
- Protect **600** families from bankruptcy due to unaffordable health care costs.
- Allow **51,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **26** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$216** million annually.

2nd Congressional District (Representative Chaka Fattah)

- Improve coverage for **337,000** residents with health insurance.
- Give tax credits and other assistance to up to **180,000** families and **10,300** small businesses to help them afford coverage.
- Improve Medicare for **95,000** beneficiaries, including closing the donut hole.
- Extend coverage to **36,500** uninsured residents.
- Guarantee that **9,200** residents with pre-existing conditions can obtain coverage.
- Protect **600** families from bankruptcy due to unaffordable health care costs.

- Allow **54,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **22** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$120** million annually.

3rd Congressional District (Representative Kathy Dahlkemper)

- Improve coverage for **394,000** residents with health insurance.
- Give tax credits and other assistance to up to **172,000** families and **13,200** small businesses to help them afford coverage.
- Improve Medicare for **118,000** beneficiaries, including closing the donut hole.
- Extend coverage to **17,000** uninsured residents.
- Guarantee that **7,600** residents with pre-existing conditions can obtain coverage.
- Protect **900** families from bankruptcy due to unaffordable health care costs.
- Allow **51,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **22** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$43** million annually.

4th Congressional District (Representative Jason Altmire)

- Improve coverage for **437,000** residents with health insurance.
- Give tax credits and other assistance to up to **146,000** families and **13,400** small businesses to help them afford coverage.
- Improve Medicare for **128,000** beneficiaries, including closing the donut hole.
- Extend coverage to **6,000** uninsured residents.
- Guarantee that **5,800** residents with pre-existing conditions can obtain coverage.
- Protect **1,000** families from bankruptcy due to unaffordable health care costs.
- Allow **37,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **11** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$34** million annually.

5th Congressional District (Representative Glenn Thompson)

- Improve coverage for **394,000** residents with health insurance.
- Give tax credits and other assistance to up to **185,000** families and **13,200** small businesses to help them afford coverage.
- Improve Medicare for **121,000** beneficiaries, including closing the donut hole.
- Extend coverage to **15,000** uninsured residents.
- Guarantee that **7,500** residents with pre-existing conditions can obtain coverage.
- Protect **700** families from bankruptcy due to unaffordable health care costs.
- Allow **58,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **16** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$162** million annually.

6th Congressional District (Representative Tim Gerlach)

- Improve coverage for **523,000** residents with health insurance.
- Give tax credits and other assistance to up to **114,000** families and **16,700** small businesses to help them afford coverage.
- Improve Medicare for **108,000** beneficiaries, including closing the donut hole.
- Guarantee that **6,000** residents with pre-existing conditions can obtain coverage.
- Protect **600** families from bankruptcy due to unaffordable health care costs.
- Allow **52,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **22** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$28** million annually.

7th Congressional District (Representative Joe Sestak)

- Improve coverage for **508,000** residents with health insurance.
- Give tax credits and other assistance to up to **107,000** families and **15,200** small businesses to help them afford coverage.
- Improve Medicare for **111,000** beneficiaries, including closing the donut hole.
- Guarantee that **5,200** residents with pre-existing conditions can obtain coverage.
- Protect **500** families from bankruptcy due to unaffordable health care costs.
- Allow **48,000** young adults to obtain coverage on their parents' insurance plans.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$24** million annually.

8th Congressional District (Representative Patrick Murphy)

- Improve coverage for **502,000** residents with health insurance.
- Give tax credits and other assistance to up to **102,000** families and **18,100** small businesses to help them afford coverage.
- Improve Medicare for **110,000** beneficiaries, including closing the donut hole.
- Guarantee that **4,900** residents with pre-existing conditions can obtain coverage.
- Protect **800** families from bankruptcy due to unaffordable health care costs.
- Allow **43,000** young adults to obtain coverage on their parents' insurance plans.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$25** million annually.

9th Congressional District (Representative Bill Shuster)

- Improve coverage for **397,000** residents with health insurance.
- Give tax credits and other assistance to up to **182,000** families and **13,200** small businesses to help them afford coverage.
- Improve Medicare for **120,000** beneficiaries, including closing the donut hole.
- Extend coverage to **26,000** uninsured residents.
- Guarantee that **9,100** residents with pre-existing conditions can obtain coverage.
- Protect **800** families from bankruptcy due to unaffordable health care costs.
- Allow **48,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **24** community health centers.

- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$45 million** annually.

10th Congressional District (Representative Christopher Carney)

- Improve coverage for **406,000** residents with health insurance.
- Give tax credits and other assistance to up to **179,000** families and **13,300** small businesses to help them afford coverage.
- Improve Medicare for **122,000** beneficiaries, including closing the donut hole.
- Extend coverage to **22,000** uninsured residents.
- Guarantee that **7,900** residents with pre-existing conditions can obtain coverage.
- Protect **800** families from bankruptcy due to unaffordable health care costs.
- Allow **45,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **13** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$46 million** annually.

11th Congressional District (Representative Paul Kanjorski)

- Improve coverage for **420,000** residents with health insurance.
- Give tax credits and other assistance to up to **190,000** families and **14,000** small businesses to help them afford coverage.
- Improve Medicare for **133,000** beneficiaries, including closing the donut hole.
- Extend coverage to **24,000** uninsured residents.
- Guarantee that **8,200** residents with pre-existing conditions can obtain coverage.
- Protect **900** families from bankruptcy due to unaffordable health care costs.
- Allow **52,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **7** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$42 million** annually.

12th Congressional District (Representative Mark Critz)

- Improve coverage for **357,000** residents with health insurance.
- Give tax credits and other assistance to up to **183,000** families and **12,800** small businesses to help them afford coverage.
- Improve Medicare for **137,000** beneficiaries, including closing the donut hole.
- Extend coverage to **20,000** uninsured residents.
- Guarantee that **7,600** residents with pre-existing conditions can obtain coverage.
- Protect **1,000** families from bankruptcy due to unaffordable health care costs.
- Allow **47,000** young adults to obtain coverage on their parents' insurance plans.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$45 million** annually.

13th Congressional District (Representative Allyson Schwartz)

- Improve coverage for **443,000** residents with health insurance.
- Give tax credits and other assistance to up to **135,000** families and **15,000** small businesses to help them afford coverage.
- Improve Medicare for **115,000** beneficiaries, including closing the donut hole.
- Extend coverage to **12,000** uninsured residents.
- Guarantee that **6,800** residents with pre-existing conditions can obtain coverage.
- Protect **500** families from bankruptcy due to unaffordable health care costs.
- Allow **42,000** young adults to obtain coverage on their parents' insurance plans.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$48** million annually.

14th Congressional District (Representative Mike Doyle)

- Improve coverage for **335,000** residents with health insurance.
- Give tax credits and other assistance to up to **181,000** families and **14,700** small businesses to help them afford coverage.
- Improve Medicare for **113,000** beneficiaries, including closing the donut hole.
- Extend coverage to **19,000** uninsured residents.
- Guarantee that **7,000** residents with pre-existing conditions can obtain coverage.
- Protect **1,000** families from bankruptcy due to unaffordable health care costs.
- Allow **54,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **45** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$281** million annually.

15th Congressional District (Representative Charles Dent)

- Improve coverage for **477,000** residents with health insurance.
- Give tax credits and other assistance to up to **151,000** families and **14,800** small businesses to help them afford coverage.
- Improve Medicare for **123,000** beneficiaries, including closing the donut hole.
- Extend coverage to **11,000** uninsured residents.
- Guarantee that **7,800** residents with pre-existing conditions can obtain coverage.
- Protect **800** families from bankruptcy due to unaffordable health care costs.
- Allow **50,000** young adults to obtain coverage on their parents' insurance plans.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$30** million annually.

16th Congressional District (Representative Joseph Pitts)

- Improve coverage for **452,000** residents with health insurance.
- Give tax credits and other assistance to up to **153,000** families and **14,400** small businesses to help them afford coverage.
- Improve Medicare for **114,000** beneficiaries, including closing the donut hole.
- Extend coverage to **43,000** uninsured residents.
- Guarantee that **11,000** residents with pre-existing conditions can obtain coverage.

- Protect **700** families from bankruptcy due to unaffordable health care costs.
- Allow **52,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **8** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$8** million annually.

17th Congressional District (Representative Tim Holden)

- Improve coverage for **444,000** residents with health insurance.
- Give tax credits and other assistance to up to **168,000** families and **13,000** small businesses to help them afford coverage.
- Improve Medicare for **120,000** beneficiaries, including closing the donut hole.
- Extend coverage to **11,000** uninsured residents.
- Guarantee that **7,300** residents with pre-existing conditions can obtain coverage.
- Protect **900** families from bankruptcy due to unaffordable health care costs.
- Allow **47,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **7** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$59** million annually.

18th Congressional District (Representative Tim Murphy)

- Improve coverage for **456,000** residents with health insurance.
- Give tax credits and other assistance to up to **142,000** families and **14,400** small businesses to help them afford coverage.
- Improve Medicare for **130,000** beneficiaries, including closing the donut hole.
- Guarantee that **5,100** residents with pre-existing conditions can obtain coverage.
- Protect **1,000** families from bankruptcy due to unaffordable health care costs.
- Allow **39,000** young adults to obtain coverage on their parents' insurance plans.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$35** million annually.

19th Congressional District (Representative Todd Platts)

- Improve coverage for **502,000** residents with health insurance.
- Give tax credits and other assistance to up to **161,000** families and **12,900** small businesses to help them afford coverage.
- Improve Medicare for **120,000** beneficiaries, including closing the donut hole.
- Extend coverage to **14,000** uninsured residents.
- Guarantee that **7,300** residents with pre-existing conditions can obtain coverage.
- Protect **1,000** families from bankruptcy due to unaffordable health care costs.
- Allow **52,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **6** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **\$19** million annually.

Timeline for Implementation

2010

Immediate Access to Insurance for Uninsured Individuals with a Pre-Existing Condition (the high risk pool): Provides eligible individuals access to coverage that does not impose any coverage exclusions for pre-existing health conditions. This provision ends when Exchanges are operational in 2014. *For more information, visit www.healthcare.gov and www.pafaircare.com.*

Small Business Tax Credit: Initiates the first phase of the small business tax credit for qualified small employers for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There is also up to a 25 percent credit for small nonprofit organizations. *For more information, visit www.healthcare.gov or www.irs.gov.*

Eliminating Pre-Existing Condition Exclusions for Children: Bars health insurance companies from imposing pre-existing condition exclusions on children's coverage.

Prohibiting Rescissions: Prohibits abusive practices whereby health insurance companies rescind existing health insurance policies when a person gets sick as a way of avoiding covering the costs of enrollees' health care needs.

Eliminating Lifetime Limits and Restricting Use of Annual Limits: Prohibits lifetime limits on benefits in all group health plans and in the individual market and prohibits the use of restrictive annual limits.

Covering Preventive Health Services: All new group health plans and plans in the individual market must provide first dollar coverage for preventive services.

Extending Dependent Coverage: Requires any group health plan or plan in the individual market that provides dependent coverage for children to continue to make that coverage available up to age 26.

Bringing Down the Cost of Health Care Coverage: Health plans, including grandfathered plans, must annually report on the share of premium dollars spent on medical care and provide consumer rebates for excessive medical loss ratios.

Reducing the Cost of Covering Early Retirees: Creates a new temporary reinsurance program to help companies that provide early retiree health benefits for those ages 55-64 offset the expensive cost of that coverage. *For more information, please visit <http://www.errp.gov/>.*

Strengthening Community Health Centers and the Primary Care Workforce: Provides funds to build new and expand existing community health centers, and expands funding for scholarships and loan repayments for primary care practitioners working in underserved areas.

Improving Consumer Assistance: Requires that any new group health plan or new plan in the individual market implement an effective appeals process for coverage determinations and claims.

Improving Consumer Information through the Web: Requires the Secretary of HHS to establish an Internet website through which residents of any state may identify affordable health insurance coverage options in that state. The website will also include information for small businesses about available coverage options, reinsurance for early retirees, small business tax credits and other information of interest to small businesses. So-called “mini-med” or limited-benefit plans will be precluded from listing their policies on this website.

Please note: this website has launched at www.healthcare.gov.

Cracking Down on Health Care Fraud: Requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system.

Rebates for the Part D “Donut Hole”: Provides a \$250 rebate for all Part D enrollees who enter the donut hole. Currently, the coverage gap falls between \$2,700 and \$6,154 in total drug costs. *For more information, visit www.healthcare.gov.*

Improving Public Health Prevention Efforts: Creates an interagency council to promote healthy policies at the federal level and establishes a prevention and public health investment fund to provide an expanded and sustained national investment in prevention and public health programs.

Strengthening the Quality Infrastructure: Additional resources provided to HHS to develop a national quality strategy and support quality measure development and endorsement for the Medicare, Medicaid and CHIP quality improvement programs.

Extending Payment Protections for Rural Providers: Extends Medicare payment protections for small rural hospitals, including hospital outpatient services, lab services and facilities that have a low-volume of Medicare patients, but play an important role in their communities.

Establishing a Patient-Centered Outcomes Research Institute: Establish a private, non-profit institute to identify national priorities and provide for research to compare the effectiveness of health treatments and strategies.

Ensuring Medicaid Flexibility for States: A new option allowing states to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL) and receive current law Federal Medical Assistance Percentage (FMAP) will take effect.

Non-Profit Hospitals: Establishes new requirements applicable to non-profit hospitals beginning in 2010, including periodic community needs assessments.

Expanding the Adoption Credit and Adoption Assistance Program: Increases the adoption tax credit and adoption assistance exclusion by \$1,000, makes the credit refundable, and extends the credit through 2011. The enhancements are effective for tax years beginning after December 31, 2009. *The Internal Revenue Service will make additional information available soon.*

Encouraging Investment in New Therapies: A two-year temporary credit subject to an overall cap of \$1 billion to encourage investments in new therapies to prevent, diagnose and treat acute and chronic diseases. The credit would be available for qualifying investments made in 2009 and 2010.

Tax Relief for Health Professionals with State Loan Repayment: Excludes from gross income payments made under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.

Excluding from Income Health Benefits Provided by Indian Tribal Governments: Excludes from gross income the value of specified Indian tribal health benefits. The provision is effective for benefits and coverage provided after the date of enactment.

Establishing a National Health Care Workforce Commission: Establishes an independent National Commission to provide comprehensive, nonbiased information and recommendations to Congress and the Administration for aligning federal health care workforce resources with national needs.

Strengthening the Health Care Workforce: Expands and improves low-interest student loan programs, scholarships, and loan repayments for health students and professionals to increase and enhance the capacity of the workforce to meet patients' health care needs.

Special Deduction for Blue Cross Blue Shield (BCBS): Requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them under Internal Revenue Code (IRC) Section 833, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves.

Indoor Tanning Services Tax: Imposes a ten percent tax on amounts paid for indoor tanning services in lieu of the tax on cosmetic surgery. Indoor tanning services are services that use an electronic product with one or more ultraviolet lamps to induce skin tanning. The tax is effective for services on or after July 1, 2010.

2011

Increasing Reimbursement for Primary Care: Provides a 10 percent Medicare bonus payment for primary care physicians and general surgeons.

Increasing Training Support for Primary Care: Establishes a Graduate Medical Education policy allowing unused training slots to be re-distributed for purposes of increasing primary care training at other sites.

Improving Health Care Quality and Efficiency: Establishes a new Center for Medicare & Medicaid Innovation to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals.

Improving Preventive Health Coverage: Provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and requires new plans to cover preventive services with little to no cost sharing. Creates incentives for state Medicaid programs to cover evidence-based preventive services with no cost-sharing, and requires coverage of tobacco cessation services for pregnant women.

Improving Consumer Assistance: Requires the Secretary of Health and Human Services (HHS) to award grants to states to establish health insurance consumer assistance or ombudsman programs to receive and respond to inquiries and complaints concerning health insurance coverage.

Improving Transitional Care for Medicare Beneficiaries: Establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries.

Expanding Primary Care, Nursing, and Public Health Workforce: Increases access to primary care by adjusting the Medicare Graduate Medical Education program. Primary care and nurse training programs are also expanded to increase the size of the primary care and nursing workforce. Ensures that public health challenges are adequately addressed.

Increasing Access to Home and Community Based Services: The new Community First Choice Option, which allows states to offer home and community based services to disabled individuals through Medicaid rather than institutional care, takes effect on October 1, 2011.

Transitioning to Reformed Payments in Medicare Advantage: Freezes 2011 Medicare Advantage payment benchmarks at 2010 levels to begin transition. Continues to reduce Medicare Advantage benchmarks in subsequent years relative to current levels. Benchmarks will vary from 95 percent of Medicare spending in high-cost areas to 115 percent of Medicare spending in low-cost areas. Changes are phased-in over 3, 5 or 7 years, depending on the level of payment reductions.

Discounts in the Part D “Donut Hole”: Provides a 50 percent discount on all brand-name drugs in the donut hole and begins phasing in additional discounts on brand-name and generic drugs to completely close the donut hole by 2020 for all Part D enrollees.

Reporting Health Coverage Costs on Form W-2: Requires employers to disclose the value of the benefit provided by the employer for each employee’s health insurance coverage on the employee’s annual Form W-2. *Please note that individuals will not pay taxes on this amount.*

Standardizing the Definition of Qualified Medical Expenses: Conforms the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the definition used for the itemized deduction. An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.

Increased Additional Tax for Withdrawals from Health Savings Accounts and Archer Medical Savings Account Funds for Non-Qualified Medical Expenses: Increases the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses would increase from 15 to 20 percent.

Cafeteria Plan Changes: Creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees. This would ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from nondiscrimination requirements applicable to highly compensated and key employees.

Pharmaceutical Manufacturers Fee: Imposes an annual, non-deductible fee on the pharmaceutical manufacturing industry allocated according to market share and not applying to companies with sales of branded pharmaceuticals of \$5 million or less.

2012

Encouraging Integrated Health Systems: Implements physician payment reforms that enhance payment for primary care services and encourage physicians to join together to form "accountable care organizations" to gain efficiencies and improve quality.

Linking Payment to Quality Outcomes: Establishes a hospital value-based purchasing program to incentivize enhanced quality outcomes for acute care hospitals. Also, requires the Secretary to submit a plan to Congress by 2012 on how to move home health and nursing home providers into a value-based purchasing payment system.

Reducing Avoidable Hospital Readmissions: Directs CMS to track hospital readmission rates for certain high-volume or high-cost conditions and uses new financial incentives to encourage hospitals to undertake reforms needed to reduce preventable readmissions, which will improve care for beneficiaries and rein in unnecessary health care spending.

2013

Administrative Simplification: Health plans must adopt and implement uniform standards and business rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.

Encouraging Provider Collaboration: Establishes a national pilot program on payment bundling to encourage hospitals, doctors and post-acute care providers to work together to achieve savings for Medicare through increased collaboration and improved coordination of patient care.

Limiting Health Flexible Savings Account Contributions: Limits the amount of contributions to health FSAs to \$2,500 per year, indexed by CPI for subsequent years.

Eliminating Deduction for Employer Part D Subsidy: Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

Increased Threshold for Claiming Itemized Deduction for Medical Expenses: Increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 to 10 percent. Individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

Additional Hospital Insurance Tax for High Wage Workers: Increases the hospital insurance tax rate by 0.9 percentage points on an individual taxpayer earning over \$200,000 (\$250,000 for married filing jointly). Expands the taxable base to include net investment income in the case of taxpayers earning over \$200,000 (\$250,000 for joint returns).

Medical device excise tax: Establishes a 2.9 percent excise tax on the first sale for use of a medical device. Excepted from the tax are class I devices, eye glasses, contact lenses, hearing aids and any device of a type that is generally purchased by the public at retail for individual use.

Limiting Executive Compensation: Limits the deductibility of executive compensation under Section 162(m) for insurance providers if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements. The deduction is limited to \$500,000 per taxable year and applies to all officers, employees, directors and other workers or service providers performing services, for or on behalf of, a covered health insurance provider. This provision is effective beginning in 2013 with respect to services performed after 2009.

Fee for patient centered outcomes research: Annual fee becomes effective on insured and self-insured plans to fund the patient centered outcomes research trust fund.

2014

Reforming Health Insurance Regulations: Implements strong health insurance reforms that prohibit insurance companies from engaging in discriminatory practices that enable them to refuse to sell or renew policies due to an individual's health status. Health plans can no longer exclude coverage for treatments based on pre-existing health conditions. It also limits the ability of insurance companies to charge higher rates due to health status, gender, or other factors. Premiums can vary only on age (no more than 3:1), geography, family size and tobacco use.

Eliminating Annual Limits: Prohibits health plans from imposing annual limits on the amount of coverage an individual may receive.

Ensuring Coverage for Individuals Participating in Clinical Trials: Prohibits new health plans from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.

Establishing Health Insurance Exchanges: Opens health insurance Exchanges in each state to individuals and small employers. This new venue will enable people to comparison shop for standardized health packages. It facilitates enrollment and administers tax credits so that people of all incomes can obtain affordable coverage.

Ensuring Choice through a Multi-State Option: Provides a choice of coverage through a multi-state plan, available from nationwide health plans under the supervision of the Office of Personnel Management.

Providing Health Care Tax Credits: Makes premium tax credits available through the Exchange to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty who are not eligible for or offered other acceptable coverage. They apply to both premiums and cost-sharing to ensure that no family faces bankruptcy due to medical expenses again.

Ensuring Choice through Free Choice Vouchers: Workers who qualify for an affordability exemption to the individual responsibility policy but do not qualify for tax credits can take their employer contribution and join an Exchange plan.

Promoting Individual Responsibility: Requires most individuals to obtain acceptable health insurance coverage or pay a penalty of \$95 for 2014, \$325 for 2015, \$695 for 2016 (or, up to 2.5 percent of income in 2016), up to a cap of the national average bronze plan premium. Families will pay half the amount for children, up to a cap of \$2,250 per family. After 2016, dollar amounts are indexed. If affordable coverage is not available to an individual, he will not be penalized.

Promoting Employer Responsibility: Requires employers with 50 or more employees who do not offer coverage to their employees to pay \$2,000 annually for each full-time employee over the first 30 employees, as long as one of their employees receives a tax credit. Precludes waiting periods over 90 days. Requires employers who offer coverage but whose employees receive tax credits to pay \$3,000 for each worker receiving a tax credit up to an aggregate cap of \$2000 per full-time employee.

Increasing Access to Medicaid: Medicaid eligibility will increase to 133 percent of poverty for all non-elderly individuals to ensure that people obtain affordable health care in the most efficient and appropriate manner. States will receive increased federal funding to cover these new populations.

Small Business Tax Credit: Continues the second phase of the small business tax credit for qualified small employers.

Quality Reporting for Certain Providers: Places certain providers – including ambulatory surgical centers, long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, PPS-exempt cancer hospitals and hospice providers – on a path toward value-based purchasing by requiring the Secretary to implement quality measure reporting programs in these areas and also pilot test value-based purchasing for each of these providers in subsequent years.

Health Insurance Provider Fee: Imposes an annual, non-deductible fee on the health insurance sector allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are \$25 million or less.

2015

Continuing Innovation and Lower Health Costs: Establishes an Independent Payment Advisory Board to develop and submit proposals to Congress and the private sector aimed at extending the solvency of Medicare, lowering health care costs, improving health outcomes for patients, promoting quality and efficiency and expanding access to evidence-based care.

Paying Physicians Based on Value Not Volume: Creates a physician value-based payment program to promote increased quality of care for Medicare beneficiaries.

2018

Excise Tax on High Cost Employer-Provided Health Plans Becomes Effective: Tax is on the cost of coverage in excess of \$27,500 (family coverage) and \$10,200 (single coverage), increased to \$30,950 (family) and \$11,850 (single) for retirees and employees in high risk professions. The dollar thresholds are indexed with inflation, and employers with higher costs on account of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.

The Affordable Care Act: What does this mean for me?

The Affordable Care Act contains consumer protections to ensure that you have access to the care you need when you get sick and makes comparing insurance plans and purchasing health insurance easier and more transparent.

Consumer Protections

No Discrimination for Pre-Existing Conditions, Gender or Other Characteristics:

- Insurers and health plans will be prohibited from denying individuals health insurance coverage due to a pre-existing condition and from charging individuals with pre-existing conditions higher premiums or excluding coverage for specific conditions.
- Insurers and health plans selling to individuals and small businesses will be prohibited from charging higher premiums due to gender, health status, family history or occupation.
- Limits will be placed on how much premiums may vary based on age (3:1) or tobacco use (1:1.5) on insurers selling to individuals and small businesses.
- Because these changes are dependent upon all Americans having access to quality, affordable health insurance, they take effect when the Exchanges are operational in 2014.

No Pre-Existing Coverage Exclusions for Children:

- Recognizing the special vulnerability of children, all health plans will be prohibited from excluding coverage of pre-existing conditions for children; this provision took effect September 23, 2010 and applies to all plans.

Extension of Dependent Coverage for Young Adults:

- Insurers and health plans will be required to permit adult children to stay on family policies until age 26. This provision took effect September 23, 2010 and applies to all plans in the plan year beginning on or after this date.

Required Coverage for Preventive Care with No Cost-Sharing:

- Insurers and health plans will be required to offer and provide first dollar coverage of preventive health care services. This provision took effect September 23, 2010 and applies to all new plans.

Patient Protections:

- Patients' choice of doctors will be protected by allowing plan members to pick any participating primary care provider, prohibiting insurers and plans from requiring prior authorization before a woman sees an OB-GYN and ensuring access to emergency care. This provision took effect September 23, 2010 and applies to all new plans.

No Coverage Rescissions When Americans Get Sick:

- Insurers and health plans will be prohibited from canceling health coverage when a beneficiary gets sick as way of avoiding paying that person's health care bills. The provision took effect September 23, 2010 and applies to all plans.

No Arbitrary Limits on Coverage:

- All health insurance plans will be prohibited from placing lifetime limits on the dollar amount of the coverage for which they will pay. All new plans, and existing group plans, will be restricted in their use of annual limits until 2014, when the Exchanges are operational and annual limits will be completely prohibited. These provisions took effect September 23, 2010.

Protection from Exorbitant Out-of-Pocket Costs:

- Insurance companies will abide by yearly caps on what they may charge beneficiaries for out-of-pocket expenses in new plans, like co-payments or co-insurance charges.

Notification and Justification of Premium Increases:

- Insurers will be required to publicly disclose the amount of any premium increase prior to the increase taking effect, and to provide a justification for the increase. This will limit the industry's current practice of hiking up insurance rates in order to push less healthy individuals and small businesses off their rolls.
- A health insurer's participation in the Exchanges will depend on its performance. Insurers that jack up their premiums before the Exchanges begin will be excluded – a powerful incentive to keep premiums affordable.

Clear Summaries, Without the Fine Print:

- Insurers will outline coverage options using a simple and standard format that enables consumers to make an apples-to-apples comparison when they are choosing their health insurance plan.

Information About Insurance Plan Expenditures, and a Rebate to Assure Value:

- Each year, insurance companies will report the percentage of Americans' premiums they spend on items other than health care costs, such as bureaucracy, marketing or executive compensation.
- Americans will receive a rebate if their insurance company's non-medical costs exceed 15 percent of premium costs in the group market or 20 percent in the small group and individual market. Using cost data from this year, rebates will begin in 2011 and the policy applies to all insurance companies.

Fair Opportunity to Appeal Coverage and Claims Decisions:

- New health plans will be required to develop an appeals process that, at a minimum, provides beneficiaries with a notice of internal and external appeals processes and allows beneficiaries to review their file and present evidence in their appeal.

Enhanced Transparency:

- New requirements will ensure that insurers and health care providers report on their performance, empowering patients to make the best possible health care decisions.

How will I be affected by health care reform?

This section explains how health care reform will affect you, whether you have employer-based insurance, are self-insured, or are uninsured.

I get health insurance through my employer.

You will be able to keep your coverage, and the consumer protections included in the Affordable Care Act will protect you if you get sick, change or lose your job, or have a child graduate from college without health insurance. If the health insurance you have through your employer costs more than 9.5 percent of your income, in 2014 you will be able to start purchasing health insurance through Pennsylvania's health insurance Exchange. You may be eligible for a tax credit if you purchase your insurance through the Exchange.

I buy my own health insurance policy.

You now have a new tool available to help you compare health insurance policies: www.healthcare.gov. On www.healthcare.gov, you can learn about:

- **Health insurance options available to you and your family in your community.** www.healthcare.gov is the first website to provide consumers across the U.S. with both public and private health coverage options tailored specifically for their needs in a single, easy-to-use tool. By answering just a few simple questions, you can learn what health insurance options are available in your community, and how health plans compare on services, providers and drug benefits. Later this year, information on prices will be added – making this an even more powerful tool.
- **New rights and benefits provided to Americans under the new health care law.** A timeline shows when new programs under the new law will become available between now and 2014, and information is available to help families, older adults, employers, health care providers and others understand how their health care will improve under the new law.
- **Information to help you and your family prevent health problems and lead a healthier, more active life – and to assess the quality of health care provided in your area.**

The website will be updated regularly, as new information about plans, benefits and consumer protections become available.

Starting in 2014, you will be able to purchase health insurance through Pennsylvania's health insurance Exchange. If you earn less than 400 percent of the Federal Poverty Level (about \$88,000 for a family of four), you will be eligible for a tax credit to offset the cost of health insurance. Everyone in the Exchange will be considered part of the same risk pool, which means that the costs will be shared among a larger group of people. Premiums for individuals purchasing health insurance are expected to drop by 14 percent-20 percent; individuals receiving tax credits can expect to see their premiums decrease by an average of 60 percent, and will get better coverage than they have today.

I can't afford to buy health insurance.

If you cannot afford to buy health insurance, depending on your income, you and your family may qualify for Medicaid or for tax credits to help you buy health insurance through the insurance Exchanges that will be established in each state starting in 2014.

If you cannot afford to buy health insurance because you have a pre-existing condition, the insurance available to you is too expensive and you have been uninsured for at least six months, you may qualify for coverage in the new high risk pool. Please refer to the FAQ “What are the high risk pools?” for more information.

To explore what options may be available to you now, visit www.healthcare.gov. By answering just a few simple questions, you can learn what health insurance options are available in your community, and how health plans compare on services, providers and drug benefits. Later this year, information on prices will be added – making this an even more powerful tool. The website will be updated regularly, as new information about plans, benefits and consumer protections become available.

The FAQ has more details about provisions that take effect in 2014, such as how much the tax credits will be and what caps will be placed on your premiums to keep them affordable.

I'm a young adult. Why do I need health insurance?

Young adults are uninsured at very high rates compared to the general population, and while they are often healthy, they may not have access to the preventive care that is recommended. In addition, a serious illness or accident could be financially devastating to a young adult who may not have savings or a spouse's income to help pay medical bills.

There are several provisions in health care reform that will make it easier for you to purchase health insurance. As of September 23, 2010 insurers are required to permit children to stay on family policies until age 26. This applies to all plans in the individual market, new employer plans and existing employer plans, unless you (the adult child) have an offer of coverage through your employer. This requirement kicks in the next time your plan comes up for renewal after the provision goes into effect.

If you were on your parents' plan but lost that coverage when you graduated from college or aged out this year, you will have the option of rejoining your parents' policy the next time it renews. If your parents work at self-insured companies, you are eligible if you do not have an offer of employer-sponsored insurance. Both married and unmarried dependents qualify for this dependent coverage. Beginning in 2014, children up to age 26 can stay on their parents' employer plan even if they have an offer of coverage through their employer. For more information, please see the FAQ at the end of this guide for more details about this provision.

Once you age out of your parents' insurance, if you don't get insurance through your employer you may qualify for tax credits starting in 2014 to help cover the cost; these tax credits are available for people earning up to 400 percent of the federal poverty level, which is about \$43,000 for an individual or \$88,000 for a family of four. There is a table at the end of this guide with more details on federal poverty levels.

To explore what options may be available to you now, visit www.healthcare.gov. By answering just a few simple questions, you can learn what health insurance options are available in your community, and how health plans compare on services, providers and drug benefits. Later this year, information on prices will be added – making this an even more powerful tool. The website will be updated regularly, as new information about plans, benefits and consumer protections become available.

I don't have health insurance. Will I have to buy insurance?

If your employer offers insurance that meets affordability requirements, you will have to purchase it or face a penalty starting in 2014. This is also true for individuals who do not have employer-based insurance or are self-employed. If your employer does not offer health insurance, or that health insurance is unaffordable, you will be able to purchase health insurance through the state health insurance Exchange, and you may be eligible for a tax credit.

The penalty for choosing to remain uninsured will be \$95 for 2014, \$325 for 2015 and \$695 for 2016 (or up to 2.5 percent of income in 2016), up to a cap. Families will pay half the amount for children, up to a cap of \$2,250 per family. After 2016, the amount of the penalty will be indexed. Individuals will be exempt from the requirement if they do not earn enough income to file a tax return, cannot purchase a health insurance plan for less than 9.5 percent of their income or can claim a religious exemption.

I own a small business and I provide health insurance for my employees.

The Affordable Care Act will help insulate small businesses from the dramatic fluctuations of the private market by offering tax credits to offset premium increases. You may qualify for a new tax credit that is effective immediately. To qualify for the tax credit, businesses must have fewer than 25 employees and average annual wages of \$50,000 or less, and the full tax credit is available to businesses with 10 or fewer employees and average annual wages of \$25,000 or less. The sliding-scale tax credit is worth up to 35 percent of a small business's premium costs in 2010. On January 1, 2014, this rate increases to 50 percent. Firms can claim the credit for 2010 through 2013 and for any two years after that.

Small businesses will also be able to purchase affordable, comprehensive health insurance coverage through the Small Business Exchanges that will be established by 2014. Small businesses with up to 100 employees will be eligible to participate in the Exchanges, which will provide clear, consistent explanations and comparisons of the health insurance plans available. You will have the same leverage big businesses enjoy by being pooled together with other small businesses, giving you greater buying power and spreading the cost of coverage across a much larger pool.

Additional information is available in the FAQ section of this guide, and the Internal Revenue Service has made more information available about the tax credit here:

<http://www.irs.gov/newsroom/article/0,,id=220809,00.html>.

I own a small business and I cannot afford to provide health insurance for my employees.

Businesses with 25 or fewer full-time equivalent employees may be eligible for a tax credit to help offset the cost of providing health insurance to their employees. However, you will not be required to do so or penalized for not doing so if you employ less than 50 full-time equivalent employees in 2014 and beyond.

The tax credit is effective immediately. Small businesses that provide coverage for their workers will receive immediate help with their premium costs, and additional firms that initiate coverage this year will get a tax cut as well. The sliding-scale tax credit is worth up to 35 percent of a small business's premium costs in 2010. On January 1, 2014, this rate increases to 50 percent. Firms can claim the credit for 2010 through 2013 and for any two years after that. To qualify for the tax credit, businesses must have fewer than 25 employees and average annual wages of \$50,000 or less, and the full tax credit is available to businesses with 10 or fewer employees and average annual wages of \$25,000 or less.

Additional information is available in the FAQ section of this guide, and the Internal Revenue Service has made more information available about the tax credit here:

<http://www.irs.gov/newsroom/article/0,,id=220809,00.html>.

I own a larger business but do not provide health insurance for my employees.

Health insurance is a shared responsibility. Starting in 2014, you will be required to start providing health insurance for your employees. Employers with more than 200 employees will be required to automatically enroll new full-time employees in coverage.

Any employer with more than 50 full-time employees that does not offer health insurance coverage and has at least one full-time employee receiving the premium assistance tax credit will make a payment of \$2,000 per full-time employee. An employer with more than 50 employees that offers coverage that is deemed unaffordable or does not meet the standard for minimum essential coverage, and has at least one full-time employee receiving the premium assistance tax credit because the coverage is either unaffordable or does not cover 60 percent of total costs, will pay the lesser of \$3,000 for each of those employees receiving a credit or \$750 for each of their full-time employees total.

I am an older citizen on Medicare.

You will get a free annual wellness visit every year and will have no out-of-pocket copayments for preventive benefits, such as cancer and diabetes screenings.

If you have a Medicare Part D prescription drug plan and hit the "donut hole" this year you will be given a \$250 rebate to help purchase drugs. Any senior who falls into the donut hole will automatically qualify for a rebate; Medicare has already started sending out the rebates. The bill gradually closes the donut hole over the next decade, ending it completely in 2020.

More information about the Prescription Drug Coverage Gap is available here:

<http://www.medicare.gov/Publications/Pubs/pdf/11464.pdf>.

I am an older citizen with a Medicare Advantage plan.

You will continue to have access to Medicare Advantage plans. Health care reform does not eliminate the Medicare Advantage program. Almost 850,000 Pennsylvanians currently receive coverage under Medicare Advantage programs. Throughout the process, I have worked to protect current beneficiaries and allow for an adequate transition to the new system.

Medicare Advantage plans will be rewarded for providing high quality and care coordination leading to better care for older citizens and people with disabilities.

Plans will be required to spend 85 percent of revenue on clinical services and activities that improve quality of care.

I am a veteran or military retiree and receive care through the VA or TRICARE.

The Affordable Care Act will not impact VA health care. Veterans eligible for VA health care will remain eligible under health reform; nothing in the Affordable Care Act will affect veterans' access to the care that they currently are receiving. The law makes it clear that the Department of Veterans Affairs will retain full authority over the VA health care system.

The Affordable Care Act will not affect TRICARE or TRICARE for Life. There is no provision in the Affordable Care Act that would lead to increases in co-pays, changes in eligibility requirements, or in any way modify how TRICARE is administered. The Department of Defense will maintain sole authority to operate TRICARE. There is concern that the Affordable Care Act does not specifically state that TRICARE enrollees (active-duty service members) have minimal essential coverage, however the coverage that TRICARE provides meets or exceeds the minimum essential benefits required to avoid the penalty. Congress is expected to clarify the law so that it explicitly states that TRICARE is acceptable coverage. Bills have already been introduced in the House and the Senate to address this issue, and it is expected to be resolved quickly.

I have a child on CHIP (the State Children's Health Insurance Program).

Your child will be able to stay on CHIP, which has been extended and strengthened through health care reform. States will be required to maintain current eligibility levels through 2019.

Federal funding for the Children's Health Insurance Program (CHIP) has been extended for two additional years, to September 30, 2015, and states will receive additional funding to ensure children have access to this proven successful program. There will also be increased outreach and enrollment grants to help reach more eligible children.

To explore what options may be available to your child now, visit www.healthcare.gov. By answering just a few simple questions, you can learn what health insurance options are available in your community, and how health plans compare on services, providers and drug benefits. Later this year, information on prices will be added – making this an even more powerful tool. The website will be updated regularly, as new information about plans, benefits and consumer protections become available.

I have a Health Savings Account.

You will be able to keep your Health Savings Account (HSA) without facing a penalty; most HSA's already meet the definition for minimum essential coverage, and existing plans will be "grandfathered" in.

There are some changes being made to health savings accounts: the definition of "qualified medical expenses" that applies to these accounts is changing slightly to conform to the definition used for the medical expense itemized deduction, which states that medicine and drugs may only be considered qualified medical expenses if the drug is prescribed (regardless of whether it is available over-the-counter or not) or if the drug is insulin. For HSA's, the Affordable Care Act increases the tax on distributions from these accounts before age 65 that are not used for qualified medical expenses, from 10 percent to 20 percent. Finally, contributions to health FSA's under cafeteria plans are limited to \$2,500 per year.

Myths versus Reality on Health Care Reform

MYTH: My tax money will be used to pay for abortion.

REALITY: No taxpayer dollars will be used to pay for abortion. Under the Affordable Care Act, states can decide to prohibit abortion coverage in plans offered through the state Exchanges and individual plans can decide whether or not they want to offer coverage of abortion. Moreover, plans that choose to offer abortion coverage must segregate federal subsidy payments from funds paid by individuals eligible for these subsidies and individuals would then have to pay their premiums with two separate checks, with one going solely to pay for the abortion coverage. By requiring the separation of federal subsidies from premium payments made by individuals, and further requiring that individuals make a separate payment solely for abortion, the bill ensures that no federal funds will be used to pay for abortions.

In addition, all plans will be required to state in their benefit descriptions whether or not a plan includes coverage of abortion, and at least one plan must be available in each Exchange which does not include abortion. Individuals who opt out of abortion coverage by selecting such a plan (regardless of whether or not they are receiving federal subsidies) will not have to pay for abortions with their premiums. State insurance commissioners are charged with the task of ensuring that insurance companies are in compliance with the law; in the Executive Order that President Obama drafted to further ensure that the prohibition on federal funding of abortion is maintained, he directed the Secretary of Health and Human Services and the Director of the Office of Management and Budget to develop a model set of guidelines for state insurance commissioners to use as they oversee the segregation of funds.

MYTH: The Pennsylvania Pre-Existing Condition Plan (PCIP) will cover abortions.

REALITY: According to the terms of the Affordable Care Act and the Executive Order that President Obama issued, no federal funds may be used to fund abortions. This ban applies to every program funded under the Affordable Care Act.

The Affordable Care Act created a temporary program called the Pre-existing Condition Insurance Plan (PCIP). PCIP is also sometimes referred to as the High Risk Pool, and in Pennsylvania it is called PA Fair Care. PCIPs are being created in every state to help uninsured Americans with pre-existing conditions purchase health insurance. Recently, allegations have surfaced that the plan in Pennsylvania covers elective abortions. This is simply not true, and it is not true for several reasons.

As noted earlier, the Affordable Care Act and the President's Executive Order clearly state that no federal funds can be used to fund abortions. This standard is being applied by the United States Department of Health and Human Services

(HHS) as it implements and oversees federally-supported programs under the Affordable Care Act, including the PCIP. Before HHS allows any state to begin operating a PCIP, the state must agree to abide by the regulatory guidance that HHS issued, which further reiterated the Executive Order in stating that federal funds may not be used for abortions. These regulations clearly state that abortion services are not covered by the PCIP.

In addition to the extensive federal protections in place to ensure that federal funds will not be used to pay for abortion, Pennsylvania law prohibits the use of Commonwealth funds and federal funds which are appropriated by the Commonwealth from paying for abortion, except in the case of rape, incest or where the life of the mother is at stake. This provides an additional layer of protection that reinforces the federal laws, regulations and guidance on this subject.

MYTH: This bill is going to increase the federal deficit.

REALITY: The Affordable Care Act will reduce the federal deficit by \$143 billion over the next ten years. In the decade after that, the reforms are expected to reduce the deficit an additional \$1.2 trillion.

The legislation is fully paid for with revenue provisions that focus on paying for reform within the health care system, through tightened health tax incentives, industry fees, modest excise taxes and a slight increase in the Medicare Hospital Insurance (HI) tax for high-income individuals. In total, the revenue provisions in the bill represent a balanced, responsible package of proposals that bend the health care cost curve by putting downward pressure on health spending, close unintended tax loopholes and promote tax compliance.

MYTH: My Medicare benefits are going to be cut.

REALITY: Reform is about strengthening Medicare—a part of our health care system that's working well. For Medicare enrollees, the health reform bill lowers prescription drug costs, makes preventive care free, ensures that you can keep your doctor, improves the quality of your care and extends the program's solvency by nearly a decade.

The Medicare cost savings in health reform affect insurance companies and health care providers, not seniors. Studies show at least 5 percent of Medicare spending currently goes to waste, fraud and abuse. That 5 percent is all this bill would cut. The savings are achieved by reducing excessive profits that private insurance companies are making off Medicare Advantage; requiring hospitals, doctors and other providers to be more efficient; calling for more coordinated care; and cracking down on waste, fraud and abuse. The AARP has concluded that none of these savings will hurt older citizens or cut their benefits.

MYTH: My Medicare Advantage plan is being changed.

REALITY: Many MA plans will continue to offer their services under the new payment system. The plans that are able to operate efficiently and provide extra value to their enrollees through care coordination will continue to flourish. Indeed, under the reform bill, high-quality MA plans will be able to earn bonus payments, which will encourage these plans to move toward higher quality and better care for their enrollees. If an MA plan chooses to leave the market, people will have choices of other MA plans in their community as well as the choice of a stronger traditional fee-for-service Medicare program.

The nonpartisan Congressional Budget Office estimates that, under health reform, there will be about 9 million seniors enrolled in Medicare Advantage plans in 2019—not many fewer than the 10.5 million seniors enrolled today.

MYTH: The bill is a government takeover of our Nation’s health care system.

REALITY: The Affordable Care Act will actually increase competition and offer consumers more choices. If you like the coverage you have, you can keep it; the government will not force you to change it. If you want to change your health insurance, you will have more options than before. By 2019, an estimated 24 million people will be enrolled in private health insurance plans offered through the Exchanges, 19 million of whom will receive tax credits to help keep their health insurance affordable.

MYTH: I will be taxed on the value of my health insurance when it appears on my W-2 form next year.

REALITY: This is completely false. Next year, your W-2 form will only change to show the value of the health care benefits that you have received so you can know more about your benefits and be an empowered consumer. You will not pay any taxes on these benefits.

MYTH: Members of Congress are exempt from the changes to health care.

REALITY: Members of Congress and their staffs will switch from their current insurance (the Federal Employees Health Benefits Program, which insures almost 9 million federal employees, retirees and families) to insurance plans offered through the Exchanges that open in 2014. These are the same insurance plans that will be available to small business owners and their employees, and people purchasing insurance on the individual market.

MYTH: Health care reform will lead to the rationing of health care.

REALITY: The Affordable Care Act will END current forms of rationing, not expand it.

First, there is widespread rationing in today's system. Right now, decisions about what doctor you can see and what treatment you can receive are made by insurance companies, which routinely deny coverage because of cost or the insurance company rules. The Affordable Care Act will do away with many of those rules that result in rationing today.

The Affordable Care Act will prevent insurance companies from denying coverage because you have a pre-existing condition; prevent them from canceling coverage because you get sick; ban annual and lifetime limits on coverage, which often force people to pay huge sums out of pocket if they develop a serious illness; and prevent discrimination based on gender. This bill puts treatment decisions back into the hands of doctors, in consultation with their patients, ensuring that individuals who need care the most will have access to their doctors and medical providers.

Frequently Asked Questions

Where can I go to learn more?

A new website was recently launched to give Pennsylvanians, and Americans across the country, more control over their health care by providing the information necessary to make the best choices for themselves and their families: www.healthcare.gov.

On www.healthcare.gov, you can learn about:

- Health insurance options available to you and your family in your community. www.healthcare.gov is the first website to provide consumers across the U.S. with both public and private health coverage options tailored specifically for their needs in a single, easy-to-use tool. By answering just a few simple questions, you can learn what health insurance options are available in your community, and how health plans compare on services, providers and drug benefits. Later this year, information on prices will be added – making this an even more powerful tool.
- New rights and benefits provided to Americans under the new health care law. A timeline shows when new programs under the new law will become available between now and 2014, and information is available to help families, older adults, employers, health care providers and others understand how their health care will improve under the new law.
- Information to help you and your family prevent health problems and lead a healthier, more active life – and to assess the quality of health care provided in your area.

The website will be updated regularly, as new information about plans, benefits and consumer protections become available.

What is the “federal poverty level”?

The Federal Poverty Guideline is how the federal government determines income levels for individuals to qualify for federal programs, tax credits and other benefits. The table below shows different percents of the federal poverty level; if your family income is on this table, you will qualify for Medicaid or for tax credits to purchase health insurance through the individual market if you do not have affordable insurance from your employer.

2009 Federal Poverty Guideline for Pennsylvania							
Persons in Family	100%	133%	150%	200%	250%	300%	400%
1	\$10,830	\$14,404	\$16,245	\$21,660	\$27,075	\$32,490	\$43,320
2	\$14,570	\$19,378	\$21,855	\$29,140	\$36,425	\$43,710	\$58,280
3	\$18,310	\$24,113	\$27,465	\$36,620	\$45,775	\$54,930	\$73,240
4	\$22,050	\$29,327	\$33,075	\$44,100	\$55,125	\$66,150	\$88,200
5	\$25,790	\$34,301	\$38,685	\$51,580	\$64,475	\$77,370	\$103,160
6	\$29,530	\$39,275	\$44,295	\$59,060	\$73,825	\$88,590	\$118,120
7	\$33,270	\$44,249	\$49,905	\$66,540	\$83,175	\$99,810	\$133,080
8	\$37,010	\$49,223	\$55,515	\$68,020	\$92,525	\$105,030	\$142,040

For families with more than 8 persons, add \$3,740 for each additional person.

****Please note that these numbers will change by 2014 when the tax credits go into effect****

How much will the tax credit be for individuals?

The tax credit available to individuals in 2014 will be based on an individual’s income and the cost of the plan purchased through the Exchange. Citizens and legal immigrants in families with incomes between 133 percent and 400 percent of poverty who purchase coverage through a health insurance Exchange are eligible for a tax credit to reduce the cost of coverage. People eligible for public coverage and people offered coverage through an employer are not eligible for premium tax credits unless the employer plan does not have an actuarial value of at least 60 percent (the plan pays on average 60 percent of the cost of covered benefits) or unless the person’s share of the premium for employer-sponsored insurance exceeds 9.5 percent of income. People who meet these thresholds for unaffordable employer-sponsored insurance are eligible to enroll in a health insurance Exchange and may receive tax credits to reduce the cost of coverage purchased through the Exchange.

The amount of the tax credit that a person can receive is based on the premium for the second lowest cost silver plan in the Exchange and area where the person is eligible to purchase coverage. A silver plan is a plan that provides the essential benefits and has an actuarial value of 70 percent. The amount of the tax credit varies with income such that the premium a person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income (adjusted for family size), as follows:

Income as a percentage of Poverty Level	Maximum Percentage of Income Devoted to Insurance Premiums
Up to 133%	2%
133-150%	3-4%
150-200%	4-6.3%
200-250%	6.3-8.05%
250-300%	8.05-9.5%
300-400%	9.5%

A person who wants to purchase a plan that is more expensive would have to pay the full difference between the cost of the second lowest cost silver plan and the plan that they wish to purchase.

Premium tax credits would be refundable and advanceable. A refundable tax credit is one that is available to a person even if he or she has no tax liability. An advanceable tax credit allows a person to receive assistance at the time that they purchase insurance rather than paying their premium out of pocket and waiting to be reimbursed when filing their annual income tax return.^{xiv}

Is my business eligible for the tax credit?

The small business tax credit targets businesses with 25 or fewer full-time employees. There is a worksheet included at the end of this section to help you determine if your business may be eligible for the tax credit.

Eligibility Rules:

- **Providing health care coverage.** A qualifying employer must cover at least 50 percent of the cost of health care coverage for some of its workers based on the single rate.
- **Firm size.** A qualifying employer must have less than the equivalent of 25 full-time workers (for example, an employer with fewer than 50 half-time workers may be eligible).
- **Average annual wage.** A qualifying employer must pay average annual wages below \$50,000.
- **Both taxable (for profit) and tax-exempt firms qualify.**

Amount of Credit:

- **Maximum Amount.** The credit is worth up to 35 percent of a small business' premium costs in 2010. On Jan. 1, 2014, this rate increases to 50 percent (35 percent for tax-exempt employers).
- **Phase-out.** The credit phases out gradually for firms with average wages between \$25,000 and \$50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

This worksheet can help you determine if your business may be eligible for the tax credits.

Three Simple Steps

If you are a small employer (business or tax-exempt) that provides health insurance coverage to your employees, you can determine if you may qualify for the Small Business Health Care Tax Credit by following these three simple steps.

Determine the total number of your employees (not counting owners or family members):

Full-time employees: _____
(enter the number of employees who work at least 40 hours per week)

1

+

Full-time equivalent of part-time employees: _____
(Calculate the number of full-time equivalents by dividing the total annual hours of part-time employees by 2080.)

= _____ total employees
If the total number of employees is fewer than 25 **GO TO STEP 2**

Calculate the average annual wages of employees (not counting owners or family members):

Take the total annual wages paid to employees: _____

2

÷

Divide it by the number of employees from STEP 1: _____
(total wages ÷ number of employees)

= _____ average wages
If the result is less than \$50,000, **AND**

3

You pay at least half of the insurance premiums for your employees at the single (employee-only) coverage rate, then you may be able to claim the Small Business Health Care Tax Credit.

The tables on the next few pages show different examples of how the tax credit would affect businesses of different types and sizes.

**Small Business Tax Credit as a Percent (Maximum of 35%) of Employer Contribution to Premiums
For-Profit Firms in 2010-2013**

Firm size	Average wage					
	Up to \$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Up to 10	35%	28%	21%	14%	7%	0%
11	33%	26%	19%	12%	5%	0%
12	30%	23%	16%	9%	2%	0%
13	28%	21%	14%	7%	0%	0%
14	26%	19%	12%	5%	0%	0%
15	23%	16%	9%	2%	0%	0%
16	21%	14%	7%	0%	0%	0%
17	19%	12%	5%	0%	0%	0%
18	16%	9%	2%	0%	0%	0%
19	14%	7%	0%	0%	0%	0%
20	12%	5%	0%	0%	0%	0%
21	9%	2%	0%	0%	0%	0%
22	7%	0%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Source: CRS analysis of Affordable Care Act (P.L. 111-148).

A full-time employee is an employee who is employed on average at least 30 hours per week.

EXAMPLE 1: AUTO REPAIR SHOP WITH 10 EMPLOYEES FROM 2010-2013

- **Employees:** 10
- **Wages:** \$250,000 total, or \$25,000 per worker
- **Employee Health Care Costs:** \$70,000
- **Credit Calculation:** The auto repair shop will receive a 35% tax credit of the cost of health insurance (**red** box in the above table)

2010-2013 Tax Credit for Auto Repair Shop: \$24,500 ($\$70,000 * 0.35 = \$24,500$)

EXAMPLE 2: RESTAURANT WITH 40 PART-TIME EMPLOYEES FROM 2010-2013

- **Employees:** 40 half-time employees (the equivalent of 20 full-time workers)
- **Wages:** \$500,000 total, or \$25,000 per full-time equivalent worker
- **Employee Health Care Costs:** \$240,000
- **Credit Calculation:** The restaurant will receive a 12% tax credit of the cost of health insurance (**blue** box in the above table)

2010-2013 Tax Credit for Restaurant: \$28,000 ($\$240,000 * 0.12 = \$28,000$)

Small Business Tax Credit as a Percent (Maximum of 50%) of Employer Contribution to Health Premiums

For-Profit Firms in 2014+

Firm size	Average wage					
	Up to \$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Up to 10	50%	40%	30%	20%	10%	0%
11	47%	37%	27%	17%	7%	0%
12	43%	33%	23%	13%	3%	0%
13	40%	30%	20%	10%	0%	0%
14	37%	27%	17%	7%	0%	0%
15	33%	23%	13%	3%	0%	0%
16	30%	20%	10%	0%	0%	0%
17	27%	17%	7%	0%	0%	0%
18	23%	13%	3%	0%	0%	0%
19	20%	10%	0%	0%	0%	0%
20	17%	7%	0%	0%	0%	0%
21	13%	3%	0%	0%	0%	0%
22	10%	0%	0%	0%	0%	0%
23	7%	0%	0%	0%	0%	0%
24	3%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Source: CRS analysis of Affordable Care Act (P.L. 111-148).

A full-time employee is an employee who is employed on average at least 30 hours per week.

EXAMPLE 1: AUTO REPAIR SHOP WITH 10 EMPLOYEES FOR 2014+

- **Employees:** 10
- **Wages:** \$250,000 total, or \$25,000 per worker
- **Employee Health Care Costs:** \$70,000
- **Credit Calculation:** The auto repair shop will receive a 50% tax credit of the cost of health insurance (red box in the above table)

2014-Beyond Tax Credit for Auto Repair Shop: \$35,000 ($\$70,000 * 0.50 = \$35,000$)

EXAMPLE 2: RESTAURANT WITH 40 PART-TIME EMPLOYEES FOR 2014+

- **Employees:** 40 half-time employees (the equivalent of 20 full-time workers)
- **Wages:** \$500,000 total, or \$25,000 per full-time equivalent worker
- **Employee Health Care Costs:** \$240,000
- **Credit Calculation:** The restaurant will receive a 17% tax credit of the cost of health insurance (blue box in the above table)

2014-Beyond Tax Credit for Restaurant: \$40,800 ($\$240,000 * 0.17 = \$40,800$)

Small Business Tax Credit as a Percent (Maximum of 25%) of Employer Contribution to Premiums

Nonprofit Firms in 2010-2013

Firm size	Average wage					
	Up to \$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Up to 10	25%	20%	15%	10%	5%	0%
11	23%	18%	13%	8%	3%	0%
12	22%	17%	12%	7%	2%	0%
13	20%	15%	10%	5%	0%	0%
14	18%	13%	8%	3%	0%	0%
15	17%	12%	7%	2%	0%	0%
16	15%	10%	5%	0%	0%	0%
17	13%	8%	3%	0%	0%	0%
18	12%	7%	2%	0%	0%	0%
19	10%	5%	0%	0%	0%	0%
20	8%	3%	0%	0%	0%	0%
21	7%	2%	0%	0%	0%	0%
22	5%	0%	0%	0%	0%	0%
23	3%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Source: CRS analysis of Affordable Care Act (P.L. 111-148).

A full-time employee is an employee who is employed on average at least 30 hours per week.

EXAMPLE 3: FOSTER CARE NON-PROFIT WITH 9 EMPLOYEES FOR 2010-2013

- **Employees:** 9
- **Wages:** \$198,000 total, or \$22,000 per worker
- **Employee Health Care Costs:** \$76,000
- **Credit Calculation:** The foster care firm will receive a 25% tax credit of the cost of health insurance (green box in the above table)

2010-2013 Tax Credit for Auto Repair Shop: \$19,000 (\$76,000 * 0.25 = \$19,000)

Small Business Tax Credit as a Percent (Maximum of 35%) of Employer Contribution to Premiums

Nonprofit Firms in 2014+

Firm size	Average wage					
	Up to \$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Up to 10	35%	28%	21%	14%	7%	0%
11	33%	26%	19%	12%	5%	0%
12	30%	23%	16%	9%	2%	0%
13	28%	21%	14%	7%	0%	0%
14	26%	19%	12%	5%	0%	0%
15	23%	16%	9%	2%	0%	0%
16	21%	14%	7%	0%	0%	0%
17	19%	12%	5%	0%	0%	0%
18	16%	9%	2%	0%	0%	0%
19	14%	7%	0%	0%	0%	0%
20	12%	5%	0%	0%	0%	0%
21	9%	2%	0%	0%	0%	0%
22	7%	0%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Source: CRS analysis of Affordable Care Act (P.L. 111-148).

A full-time employee is an employee who is employed on average at least 30 hours per week.

EXAMPLE 3: FOSTER CARE NON-PROFIT WITH 9 EMPLOYEES FOR 2014+

- **Employees:** 9
- **Wages:** \$198,000 total, or \$22,000 per worker
- **Employee Health Care Costs:** \$76,000
- **Credit Calculation:** The foster care firm will receive a 35% tax credit of the cost of health insurance (green box in the above table)

2014-Beyond Tax Credit for Auto Repair Shop: \$26,600 ($\$76,000 * 0.35 = \$26,600$)

A sample of the IRS form you will use to receive this tax credit is available here:

<http://www.irs.gov/pub/irs-dft/f8941--dft.pdf>. **Please note: this is only a sample form; the final form will be available in time for you to file your 2010 tax return.**

What is the definition of a full-time employee? a part-time or seasonal employee?

The definitions of different types of employees are those used by the Internal Revenue Service (IRS).

The IRS has made more information available about the tax credit here:

<http://www.irs.gov/newsroom/article/0,,id=220809,00.html> and their FAQ is located here:

<http://www.irs.gov/newsroom/article/0,,id=220839,00.html>.

There is also information for employers available at www.healthcare.gov.

How does the dependent coverage work? Is my child eligible?

If I have group coverage through my employer, does the insurer have to cover my adult child if she is eligible (under age 26 and not eligible for employer-based insurance)?

Your insurer is required to cover dependents up to age 26 in the plan year that begins on or after September 23, 2010. Your employer will be required to offer this coverage to you the next time you renew your health insurance or switch plans.

My child is about to be dropped from my health insurance. What are my options until my health insurance plan renews?

Many insurers in Pennsylvania offered to extend coverage to dependents in advance of the September deadline, but employers are not required to offer this coverage to their employees until the plan year beginning on or after September 23, 2010. Depending on the type of insurance you have, your child may be able to stay on your plan, or if they are under 26 and don't currently have coverage, they might be able to qualify for coverage. You should check with your employer and your insurer to find out if they are providing coverage to this age group before your plan renews.

Additionally, Pennsylvania state law (Act 4) requires fully-insured group plans to offer employers the option of providing coverage for dependents up to age 30, if the child is not married, has no dependents, is a resident of Pennsylvania or a full-time college student, and is not provided coverage through another policy or a government health care benefits program.

Does my child have to be unemployed or enrolled in college to qualify for the extension of dependent coverage under the Affordable Care Act?

No. The only requirement is that the dependent may not have employer-based insurance available to them. In 2014, this requirement is lifted and all dependents will be able to stay on their parents' plans until age 26.

I am a federal employee. Will my child be able to stay on the Federal Employee Health Benefits Program (FEHBP) with me?

Not quite yet. FEHBP will cover dependents up to age 26 in the 2011 plan year that starts in January 2011. Current law governing FEHBP states that dependent family members are unmarried children under age 22, so FEHBP cannot cover children who age out before January 2011. However, FEHBP currently covers young adults turning 22 for an additional 30 days after their birthdays, and young adults are also eligible for coverage through the Temporary Continuation of Coverage (TCC) program for an additional 36 months. Employees must pay the full cost of TCC insurance. More information on this program is available through the Office of Personnel Management at <http://www.opm.gov/INSURE/health/eligibility/tcc.asp>.

I am insured through TRICARE (the health insurance program for members of the military and their families). Will my child be able to stay on TRICARE with me?

Not yet. TRICARE is governed under separate law from private health insurers. Senator Casey is a cosponsor of legislation in the Senate that would include TRICARE under the requirement to extend coverage to dependents. The TRICARE Dependent Coverage Extension Act would require the Department of Defense to charge an appropriate monthly premium for these young adults. Dependents who age out before this bill passes and is implemented remain eligible for the Continued Health Benefit Program that provides coverage for people who separate from the military and dependents who age out of TRICARE. More information about the Continued Health Benefit Program is available through the TRICARE website at: <http://www.tricare.mil/mybenefit/home/overview/SpecialPrograms/CHCBP>.

What are the high risk pools?

If you are uninsured because of a pre-existing condition, you can apply for coverage through the new Pre-Existing Condition Insurance Plan in Pennsylvania run by the Pennsylvania Insurance Department, known as PA Fair Care. The program began accepting applications earlier this year. Due to the high volume of applicants, there may be a waitlist.

To qualify for coverage

- You must be a citizen or national of the United States or lawfully present in the United States.
- You must have been uninsured for at least the last 6 months before you apply.
- You must have had a problem getting insurance due to a pre-existing condition.

PA Fair Care covers a broad range of health benefits, including primary and specialty care, hospital care and prescription drugs. All covered benefits are available for you, even if it is to treat a pre-existing condition.

Premium	\$283.20 per month
Deductible	\$1,000 in-network \$10,000 out-of-network
Out of Pocket Limit	\$5,000 in-network \$20,000 out-of-network

To learn more about this program, please visit www.pafaircare.com.

Funding

The law appropriates \$5 billion in federal funds to support the new temporary high risk pool program. It was made available beginning on July 1, 2010, the start of many state fiscal years, and remains available until the program ends on January 1, 2014. The program is funded entirely by the federal government.

HHS has proposed allocating funds for the program by using a formula almost identical to what was used for the Children's Health Insurance Program (CHIP). Specifically, funds would be allotted to states using a combination of factors including nonelderly population, nonelderly uninsured and geographic cost as a guide. This combination of factors has been refined over time in the CHIP context, and the CHIP formula has broad Federal and State support. As under CHIP, HHS intends to reallocate allotments after a period of not more than 2 years, based on an assessment of state actual enrollment and expenditure experiences. This proposed reallocation aims to ensure that the capped amount of Federal funding is allocated to states based on both the initial formula and performance. Pennsylvania is expected to receive approximately \$160 million of the funding allocated to the high risk pool.

Is my current insurance plan "grandfathered"?

Certain health insurance plans are "grandfathered," that is, exempt from some of the new regulations. The Department of Health and Human Services recently released a regulation or "rule" that clarifies which plans are grandfathered and what changes would result in a plan losing its grandfathered status.

Grandfathered health plans will be able to make routine changes to their policies and maintain their status. These routine changes include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law or making changes to comply with State or other Federal laws. Premium changes are not taken into account when determining whether or not a plan is grandfathered.

Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers. If a plan loses its grandfathered status, then consumers in these plans will gain additional new benefits including:

- Coverage of recommended prevention services with no cost sharing; and
- Patient protections such as guaranteed access to OB-GYNs and pediatricians.

Under the Affordable Care Act, these requirements are applicable to all new plans, and existing plans that choose to make the following changes that would cause them to lose their grandfathered status.

Compared to their policies in effect on March 23, 2010, grandfathered plans:

- **Cannot Significantly Cut or Reduce Benefits.** For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
- **Cannot Raise Co-Insurance Charges.** Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20 percent of a hospital bill). Grandfathered plans cannot increase this percentage.
- **Cannot Significantly Raise Co-Payment Charges.** Frequently, plans require patients to pay a fixed-dollar amount for doctor's office visits and other services. Compared with the co-payments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next 2 years, it will lose its grandfathered status.
- **Cannot Significantly Raise Deductibles.** Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000, or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of 4-to-5 percent so this formula would allow deductibles to go up, for example, by 19-20 percent between 2010 and 2011, or by 23-25 percent between 2010 and 2012. For a family with a \$1,000 annual deductible, this would mean if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.
- **Cannot Significantly Lower Employer Contributions.** Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15 percent to 25 percent).
- **Cannot Add or Tighten an Annual Limit on What the Insurer Pays.** Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).
- **Cannot Change Insurance Companies.** If an employer decides to buy insurance for its workers from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when employers who provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.

Protecting Against Abuse of Grandfathered Health Plan Status

To prevent health plans from using the grandfather rule to avoid providing important consumer protections, the new regulation provides for:

- Promoting transparency by requiring a plan to disclose to consumers every time it distributes materials whether the plan believes that it is a grandfathered plan and therefore is not subject to some of the additional consumer protections of the Affordable Care Act. This allows consumers to understand the benefits of staying in a grandfathered plan or switching to a new plan. The plan must also provide contact information for enrollees to have their questions and complaints addressed;
- Revoking a plan's grandfathered status if it forces consumers to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing as a means of avoiding new consumer protections; or
- Revoking a plan's grandfathered status if it is bought by or merges with another plan simply to avoid complying with the law.

Projected Impact on Consumers and Plans

Large Employer Plans: The 133 million Americans with employer-sponsored health insurance through large employers (100 or more workers) —who make up the vast majority of those with private health insurance today—will not see major changes to their coverage as a result of this regulation. The regulation affirms that most of these plans will remain grandfathered – more than three-quarters of firms in 2011 – based on the way they changed cost sharing from 2008-2009. Most of these plans already offer the patient protections applied to grandfathered plans such as no pre-existing condition exclusions for children and no rescissions of coverage when a person gets sick. In addition, they are likely to already give their workers and families protections like a choice of OB-GYN and pediatrician and access to emergency rooms in other states without prior authorization. Based on past patterns of behavior, it is expected that large employers will continue to make adjustments to the health plans they offer from year to year so that, by the time the health insurance Exchanges are established in 2014, fewer – but still most – large employer plans will have grandfather status. However, the assumed market changes depend on the choices large employers make in the future.

Small Business Plans: The roughly 43 million people insured through small businesses will likely transition from their current plan to one with the new protections over the next few years. Small plans tend to make substantial changes to cost sharing, employer contributions and health insurance issuers more frequently than large plans. As such, it is estimated that 70 percent of plans will be grandfathered in the first year, but depending on the choices these employers make, this could drop to about one-third over several years. To help sustain small business coverage, the Affordable Care Act also includes a tax credit for up to 35 percent of their premium contributions.

Individual Health Market: The 17 million people who are covered in the individual health insurance market, where switching of plans and substantial changes in coverage are common, will receive the new protections of the Affordable Care Act sooner rather than later. Roughly 40

percent to two-thirds of people in individual market policies change plans within a year. Given this “churn,” the transition for the 17 million people in this market will be swift, irrespective of whatever grandfather plan definition is proposed. In the short run, individuals whose plan changes and is no longer grandfathered will gain access to free preventive services, protections against restricted annual limits and patient protections such as improved access to emergency rooms. These Americans also will benefit from the health insurance Exchanges that will be established in 2014 to offer individuals and workers in small businesses a much greater choice of plans at more affordable rates.

People in Special Types of Health Plans: Fully-insured health plans subject to collective bargaining agreements will be able to maintain their grandfathered status until their agreement terminates. After that point, they are subject to the same rules as other health plans; in other words, they will lose their grandfathered status if they make any of the substantial changes described above. Retiree-only and “excepted health plans” such as dental plans, long-term care insurance or Medigap, are exempt from the Affordable Care Act insurance reforms.

Projections of Employer Plans Remaining Grandfathered, 2011-2013

There is considerable uncertainty about what choices employers will make over the next few years as the market prepares for the establishment of the competitive Exchanges and other market reforms such as new consumer protections, middle-class tax credits and other steps to expand affordability and choice for millions more Americans. This rule estimates the likely decisions of employers based on assumptions and extrapolations of recent market behavior, including the decisions by employers to change their health plans in 2008 and 2009. The table below depicts the results of this analysis:

Type of Plan	Enrollees	Employer Plans Remaining Grandfathered		Explanation
		2011	2013	
Allowable Percent Change in Co-Payments from 2010		Medical inflation* (4%) + 15% = 19%	Medical inflation* (4% = 12%) + 15% = 27%	Deductibles, copayments can increase faster than medical inflation over time
Large Employer	133 million	Low: 87% remain grandfathered Mid-range: 82% remain grandfathered High: 71% remain grandfathered	Low: 66% remain grandfathered Mid-range: 55% remain grandfathered High: 36% remain grandfathered	Large plans are more stable and often self-insured. Regulation permits plans to make routine changes needed to keep premium growth in check.
Small Employer	43 million	Low: 80% remain grandfathered Mid-range: 70% remain grandfathered High: 58% remain grandfathered	Low: 51% remain grandfathered Mid-range: 34% remain grandfathered High: 20% remain grandfathered	Small businesses typically buy commercial insurance and frequently make changes in insurers and coverage. Limited purchasing power and high overhead often force a trade-off between dramatic changes in benefits and cost sharing and affordable premiums.

*Assumes medical inflation at 4%

The “low” percentage is based on the mid-range percentages plus plans that could stay grandfathered with small premium changes.

The “mid-range” percentage is based on assumptions of the number of plans that would lose their grandfathered status if they made changes consistent with the changes that they made in 2008 and 2009 that would not lead to premium increases.

The “high” percentage assumes that some plans would not be able to make the adjustments to employer premium contribution they would need to keep premiums the same while keeping their other cost-sharing parameters within the grandfathering rules. The estimates in this case assume these plans will choose to relinquish their grandfathered status instead.

Choices in 2014 and Subsequent Years

In 2014, small businesses and individuals who purchase insurance on their own will gain access to the competitive market Exchanges. These Exchanges will offer individuals and workers in small businesses with a much greater choice of plans at more affordable rates – the same choice as members of Congress. In fact, the Congressional Budget Office (CBO) has estimated that, on an apples-to-apples basis, premiums will be 14- 20 percent lower than they would be under current law in 2016 due to competition, lower insurance overhead and increased pooling and purchasing power. Small businesses also will have more affordable options. CBO has estimated that a family policy for small businesses would be available in the Exchanges at a premium that is \$4,000 lower than under current law in 2016.

These reduced premiums do not take into account the tax credits available to small businesses and middle-class families to help make insurance affordable. These additional new choices may further lower the likelihood that small businesses workers will remain in grandfathered health plans. Consumers insured through large employers are more likely to remain in grandfathered plans in 2014 and beyond.

How can I appeal a decision made by my insurer?

The Affordable Care Act established new guidelines for internal and external health insurance appeal processes. These guidelines were finalized in rules issued by the Departments of Health and Human Services, Labor, and the Treasury and will standardize both internal processes and external processes that patients use to appeal decisions made by their health plan.

Today, if your health plan tells you it won't cover a treatment your doctor recommends, or it refuses to pay the bill for your child's last trip to the emergency room, you may not know where to turn. Most health plans have a process that lets you appeal the decision within the plan through an “internal appeal” – but depending on your State's laws and your type of coverage, there's no guarantee that the process will be swift and objective. Moreover, if you lose your internal appeal, you may not be able to ask for an “external appeal” to an independent reviewer.

The rules recently issued will end the patchwork of protections that apply to only some plans in some States, and simplify the system for consumers. They will ensure that all consumers in new health plans have access to internal and external appeals processes that are clearly defined, impartial and designed to ensure that, when health care is needed and covered, consumers get it.

Internal Appeals

The internal appeals process will guarantee a venue where consumers may present information their health plan might not have been aware of, giving families a straightforward way to clear up misunderstandings. Under the new rules, new health plans beginning on or after September 23, 2010 must have an internal appeals process that:

- Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage;
- Gives consumers detailed information about the grounds for the denial of claims or coverage;
- Requires plans to notify consumers about their right to appeal and instructs them on how to begin the appeals process;
- Ensures a full and fair review of the denial; and
- Provides consumers with an expedited appeals process in urgent cases.

External Appeals

If a patient's internal appeal is denied, patients in new plans will have the right to appeal to an independent reviewer. External appeals have helped consumers get the care they deserve: one study found that – in States that had external appeals – consumers won their external appeal against the insurance company 45% of the time.

While 44 States provide for some form of external appeal, the laws governing these processes vary greatly and fail to cover millions of Americans. The new rules will ensure that consumers with new health coverage in all States have access to a standard external appeals process that meets high standards for full and fair review.

These standards were established by the National Association of Insurance Commissioners (NAIC). States are encouraged to make changes in their external appeals laws to adopt these standards before July 1, 2011. The NAIC standards call for:

- **External review of plan decisions** to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit.
- **Clear information** for consumers about their right to both internal and external appeals – both in the standard plan materials, and at the time the company denies a claim.
- **Expedited access** to external review in some cases – including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
- **Health plans must pay the cost of the external appeal** under State law, and States may not require consumers to pay more than a nominal fee.
- **Review by an independent body** assigned by the State. The State must also ensure that the reviewers meet certain standards, keep written records and are not affected by conflicts of interest.
- **Emergency processes for urgent claims**, and a process for experimental or investigational treatment.
- **Final decisions must be binding** so, if the consumer wins, the health plan is expected to pay for the benefit that was previously denied.

If State laws don't meet these standards, consumers in those States will be protected by comparable Federal external appeals standards. In addition, people in health plans that are not subject to State law – including new self-insured employer plans – will be protected by the new Federal standards.

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ⁱ HealthReform.gov, accessed 3/20/10

ⁱⁱ [staff estimate using Agency for Healthcare Research and Quality (AHRQ), 4/09 and HealthReform.gov, accessed 3/20/10]

ⁱⁱⁱ HealthReform.gov, accessed 3/20/10; Senate Finance Committee

^{iv} Senate Finance Committee estimate based on CBO, 11/30/09

^v U.S. Census Bureau, 1/7/10

^{vi} [U.S. Census Bureau, 1/7/10]

^{vii} U.S. Public Interest Research Group, 1/20/10

^{viii} AHRQ, accessed 3/20/10; AHRQ, accessed 3/20/10

^{ix} National Association of Community Health Centers, 2009

^x FamiliesUSA, 7/20/10

^{xi} U.S. Census Bureau, 1/7/10

^{xii} U.S. Census Bureau, 1/7/10

^{xiii} Staff estimate using Agency for Healthcare Research and Quality (AHRQ), 4/09 and HealthReform.gov, accessed 3/20/10

^{xiv} Kaiser Family Foundation, <http://kff.org/healthreform/7962.cfm>, accessed 5/5/10