The Affordable Care Act:

Moving Forward in West Virginia

Foreword by

Senator Jay Rockefeller

Your Guide to National Health Reform from

West Virginians for Affordable Health Care

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The Affordable Care Act:
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About WVAHC

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Foreword

By Senator Jay Rockefeller

Senator Jay Rockefeller

Just one year ago, Congress passed the Affordable Care Act—a comprehensive health care reform law that is already making a positive difference in the lives of West Virginians.

It took the better part of a generation to get here. Never before have we had so much opportunity to make life better for West Virginians — or so much responsibility. In the last year, West Virginians from all over the state have been working hard to take advantage of this profound opportunity to build a strong new foundation for West Virginia and create a more secure and reliable health care system that works for all. West Virginia is blessed with committed people who care deeply about affordable health care for all West Virginians. I applaud all of the efforts over the past year to implement the new law to help create a more affordable and accessible health care system for West Virginians.

As with any law this comprehensive, it is going to take a lot of minds thinking together to craft the best possible solutions. The West Virginia Department of Health and Human Resources and the West Virginia Offices of the Insurance Commissioner, among other key state agencies, have primary responsibility for implementing this important new law — and there are many others in state government, non-profits, faith-based organizations, and in every part of our health care system working hard to implement this law for the benefit of West Virginians. Achieving real health reform will require an unprecedented level of teamwork — and I am proud of all the dedicated people in our state who are working together to meet this challenge.

I know there are still, and will continue to be, many questions about this new law, which is why *The Affordable Care Act: Moving Forward in West Virginia* is so important. As we move forward with implementation of the law, I hope this guide will serve as a resource to help explain what health care reform will mean for you, your organization, and your community. As new questions arise, I look forward to working with all of our committed state partners to answer your questions and help solve any problems that may arise.

There are so many benefits for West Virginians in the Affordable Care Act, with many more to come. Here are just a few:

- **Tax Credits for West Virginia's Small Businesses.** Health reform will help more than 22,000 small businesses in West Virginia afford to offer health coverage. Since 2010, small businesses in West Virginia have had access to tax credits for up to 35 percent of the cost of health coverage for their employees. The full credit will be increased to up to 50 percent of employer costs staring in 2014.

- **Eliminating the Medicare Prescription Drug "Doughnut Hole" for Seniors.** In 2010, more than 39,000 West Virginia seniors received a $250 rebate to help with the cost of their prescription drugs. In 2011, seniors who reach the Medicare prescription drug "doughnut hole" are receiving a 50 percent discount on brand-name drugs and a 7 percent discount on generic drugs. And, because of health reform, the doughnut hole will be completely closed by 2020.

- **A Patient's Bill of Rights to make health care more consumer-friendly and hold insurance companies accountable.** Health reform contains a Patient's Bill of Rights — important consumer protections for West Virginians to make sure that health insurance companies treat them fairly. The new law prohibits

insurance companies from denying coverage for individuals with pre-existing conditions — right away for our children and as soon as the state health insurance exchanges are up and running for adults. The new law also makes it illegal for health insurance companies to impose arbitrary annual or lifetime dollar limits on benefits and to kick people off of insurance if they get sick.

- **Premium Subsidies to Help West Virginians Afford the Cost of Coverage.** The rising cost of health care has become increasingly unaffordable for West Virginians. Starting in 2014, health reform will provide federal premium subsidies to help with the cost of health coverage for West Virginians earning between 133 percent and 400 percent of the federal poverty level ($14,404 to $43,320 for an individual, or $22,050 to $88,200 for a family of four). This means hundreds of millions of dollars will be coming straight into West Virginia to help our people afford the health care they and their families need.

- **Affordable Care for More West Virginians.** Health reform means that 33 million uninsured Americans will now have access to affordable health insurance, including as many as 184,000 uninsured West Virginians. By expanding coverage to the majority of uninsured West Virginians, health reform will eliminate the uncompensated care burden on West Virginians who already have insurance.

- **More Coverage Options for Young Adults.** Health reform gives young adults up to age 26 the opportunity to stay on their parents' insurance plans.

- **Protecting the Children's Health Insurance Program (CHIP).** Health reform continues the successful, bipartisan Children's Health Insurance Program for an additional two years — until 2015. For the first time, the children of West Virginia's state employees will also be able to enroll in CHIP.

- **Providing Value for the Health Insurance Premiums that West Virginians Pay.** West Virginians will also know that they are getting value for their premium dollars because health insurance companies will be required to spend more money on medical care, not fancy offices, executive salaries, and Wall Street profits. The new law requires health insurers to spend at least 80 cents of every dollar on actual medical care. If they don't, they must provide a rebate to their customers. Up to 9 million Americans could be eligible for rebates starting in 2012 that are worth up to $1.4 billion.

- **Real help for West Virginia's health professionals.** Health reform is providing real help to strengthen West Virginia's health care workforce, attract more doctors to rural areas, and give our health professionals the tools they need to provide high-quality care and spend more time with their patients. Health reform is providing help with loan repayment for primary care providers, millions in grants to community health centers, and quality of care funding for hospitals. In 2011, primary care providers in the Medicare program are receiving a 10 percent payment increase, with additional help for rural health professionals.

The list goes on and on: The health care reform law is creating real, meaningful, life-changing, and in some cases, life-saving new laws and policies for West Virginians and for all Americans.

Health reform implementation cannot happen without the dedication and commitment of our state officials, nonprofit groups like West Virginians for Affordable Health Care (WVAHC), and hundreds of people and communities across our state. Our work continues, and I know that so many West Virginians will continue to work tirelessly to achieve success. In the end, these efforts will mean that more West Virginians are covered with health insurance and can access care, that health insurance is much more consumer-friendly, and that we began the difficult task of reining in health care costs.

Thankfully, because of the efforts of so many, we now have a roadmap to a better America and a better West Virginia.

Jay Rockefeller
United States Senator

CHAPTER 1

Expansion of Health Insurance Coverage

On March 23, 2010 President Obama signed into law the Patient Protection and Affordable Care Act (Affordable Care Act or ACA).[1] This historic piece of legislation moves our nation toward a health care system that covers all Americans, reforms the insurance industry, improves the quality of care and curbs ever-rising costs. There has not been a more important health care bill enacted since 1965 when President Lyndon Johnson signed into law the Medicare and Medicaid legislation.

While Americans have different views about how to best achieve health care reform, there is broad consensus that reform is needed. Health care costs are rising at unsustainable rates. Businesses and individuals are being priced out of the health insurance market, adding to the ranks of the uninsured. While we have the highest health care costs in the world, our health outcomes lag behind many other countries that spend far less than we do.

The Affordable Care Act aims to correct the deep problems in health care that threaten the security of American families, businesses and the economy. West Virginians for Affordable Health Care views the legislation as a critical investment in America's future and a foundation for further improvements that can and should be improved in the future. Like most sound investments, it will require diligence and patience, with an eye on the well-being of generations to come.

This booklet was designed for health care consumers as a roadmap to the new legislation and includes an overview of some of the important federal regulations that have been issued to date and the action taken by the state legislature during the 2011 regular session. Additional information will be posted on the website of West Virginians for Affordable Health Care (www.wvahc.org) as it becomes available.

The three main goals of health care reform as reflected in the Affordable Care Act are to (1) expand coverage to nearly all Americans, (2) provide strong regulation of the health insurance industry, and (3) curb health care costs, particularly in Medicare, while emphasizing quality.

This chapter focuses on expanding coverage. The Affordable Care Act is expected to increase the number of Americans with health insurance by 32 million. By 2016, nearly all Americans (95 percent), excluding unauthorized immigrants, will be covered by a health plan.

Beginning in 2014, as many as 178,300 West Virginians will be eligible for tax credits to purchase private health insurance policies in the health insurance exchange[2] (see page 6 for details on the insurance exchange), and an additional 122,000 low-income West Virginians will become eligible for Medicaid.3

Expanding health coverage to the uninsured is essential in both human and economic terms. There is solid research that uninsured people

1 The Patient Protection and Affordable Care Act was amended by the Health Care and Education Reconciliation Act of 2010. Throughout *The Affordable Care Act: Moving Forward in West Virginia* these two acts are treated as one, and referred to as the Affordable Care Act or ACA.

2 Jennifer Sullivan and Kathleen Stoll, "Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit in West Virginia", Families USA, September 2010. Accessed on April 2, 2011 at http://www.familiesusa.org/assets/pdfs/health-reform/premium-tax-credits/West-Virginia.pdf .

3 John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," Kaiser Commission on Medicaid and the Uninsured. May 2010, Accessed on April 2, 2011 at http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf .

"live sicker and die earlier" than those with health insurance.[4] The uninsured frequently put off seeking health care until their illnesses are more advanced and difficult to treat. They are likely to seek treatment in the few places where they are guaranteed access: emergency rooms and hospitals, the most expensive settings possible. The cost of treating the uninsured is passed on to those who still have health insurance.[5] West Virginia families pay an additional $1,000 in premiums annually to cover the cost of treating the uninsured.

The Affordable Care Act aims to secure health insurance coverage for nearly all Americans through a combination of public programs and private insurance plans. There are five main strategies for expanding health insurance: expanding Medicaid, establishing health exchanges for individuals and small businesses, providing tax credits to individuals and small businesses, adopting an individual mandate, and encouraging employer sponsored insurance plans.

Expansion of Medicaid

The Affordable Care Act creates the largest expansion of Medicaid in its 45-year history. Sixteen million Americans, including an estimated 122,000 low-income West Virginians, will gain Medicaid coverage beginning in 2014. The nonpartisan Congressional Budget Office (CBO) projects the cost of this expansion at $441 billion between 2014 and 2019.

Medicaid is a joint federal and state program. The amount contributed by the federal government varies according to the economic condition of each state. West Virginia receives one of the most favorable federal medical assistance percentage (FMAP) rates in the country. With a current rate of 73.2 percent, West Virginia receives $2.85 from the federal government for every dollar we invest in Medicaid.

TABLE 1

Federal Medical Assistance Percentages (FMAP) for Medicaid Expansion: 2014 through 2020

Year	Federal Share (FMAP)
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and beyond	90%

The FMAP increases dramatically for all states under the Affordable Care Act. The rate of federal reimbursement for newly eligible people will be 100 percent from 2014 through 2016, 95 percent in 2017, and then gradually decreases to 90 percent in 2020 and beyond. (See Table 1.)

If West Virginia has a standard enrollment process, and enrolls 122,000 low-income West Virginians, the federal government will pay 95.9 percent of the expansion from 2014 through 2019. If there is an enhanced enrollment process, and we enroll 157,000 West Virginians in Medicaid, the federal government's share will decrease slightly to 95.1 percent, according to the Kaiser Commission on Medicaid and the Uninsured. Under this enhanced enrollment, West Virginia will receive $4.4 billion from the federal government between 2014 and 2019 to provide health care to these low-income West Virginians, while the state's share is projected to be $217 million from 2017 through 2019.[6]

Low-wage workers will be the primary beneficiaries of this expansion. Currently, the federal government sets minimum eligibility standards for children covered by Medicaid. For example, state Medicaid programs must cover infants up to 150 percent of the FPL. But for adults (other than those who

4 American College of Physicians, "No Health Insurance? It's Enough to Make You Sick," 2000. See also Institute of Medicine, "Care without Coverage: Too Little, Too Late," May 2002. National Academy Press, Washington D.C.

5 Kathleen Stoll and Kim Bailey, "Hidden Health Tax: Americans Pay a Premium," Families USA, May 2009. Accessed April 2, 2011 at http://www.familiesusa.org/assets/pdfs/hidden-health-tax.pdf .

6 John Holahan and Irene Headen, op. cit.

are disabled or pregnant), the federal government does not establish minimum eligibility levels, and states are free to establish their own rules. In West Virginia, parents qualify for Medicaid if they make less than 35 percent of the FPL (about $6,100 a year); childless adults do not qualify even if they are penniless.

Under health care reform, everyone under age 65 who lives in a family that earns less than 133 percent of the FPL will qualify for Medicaid. This translates into an annual income of $24,352 for a family of three in 2010. (See Table 2.)

TABLE 2
Current Federal Poverty Level at 133 Percent (2010)

Persons in Family	133% of FPL
1	$14,404
2	$19,378
3	$24,352
4	$29,326

Additionally, the federal government will pay 100 percent of the cost for the West Virginia Children's Health Insurance Program (CHIP) from 2016 through 2019. Currently, the federal government pays 81 percent of this program.

The Affordable Care Act requires states to maintain their current eligibility levels for children in Medicaid and CHIP through September 30, 2019. States are required to maintain their current eligibility levels for adults in Medicaid until the health exchange is up and running in 2014.

Health Exchanges

A health insurance exchange is a marketplace where individuals and small businesses can shop for health insurance, compare plans and choose the one best suited to their needs. The exchange will simplify the process of purchasing health insurance while promoting competition and consumer choice.

Each state will operate two exchanges, unless they choose to combine them. The American Health Benefit Exchange will serve individuals, and the Small Business Health Options Program (SHOP) will serve small businesses. States can also form regional health exchanges.

All insurance plans sold through the exchange will be required to cover all essential benefits (described below), sell at least one silver and one gold plan in the exchange, charge the same premium for plans sold outside the exchange as those sold inside the exchange, and use a uniform enrollment form and standard format to present plan information.

Eligibility in the individual exchange is limited to legal residents and American citizens who do not have access to affordable employer-sponsored health insurance. Unauthorized immigrants are ineligible to participate in the exchange even if they are willing to pay the entire premium.

Eligibility in the small business exchange is limited to employers with up to 100 employees, although states have the option to restrict eligibility to employers with 50 or fewer employees until 2016. Beginning in 2017, states can expand eligibility to employers with more than 100 employees.

In addition to private insurance companies that will sell policies in the exchanges, the U.S. Office of Personnel Management, the federal agency that operates the Federal Employees Health Benefits program, will contract with at least two multi-state insurance plans to be offered in each state. At least one of these plans must be a nonprofit, and at least one of the plans must not offer abortion services beyond the Hyde restrictions (abortions that involve rape, incest, or the life of the mother).

All the plans will be required to offer essential benefits.

The details of what constitutes an essential benefit (e.g., coverage of autism-related services) are currently being considered by the Institute of Medicine (IOM). The IOM is expected to make

recommendations on essential benefits by the fall of 2011. Based on these recommendations, the Secretary of the U.S. Department of Health and Human Services (HHS) is expected to issue regulations on essential benefits by the end of 2011.

Essential benefits must be covered in all *new* individual and small group plans, including those sold inside and outside the exchanges. Existing individual and group plans are "grandfathered" and are exempt from the essential benefits requirement.[7]

Four levels of plan benefits will be offered through the exchanges, and each must offer the essential benefits outlined above. Bronze-level plans must have a 60-percent "actuarial value," which means that, on average, the insurance company pays 60 percent of the cost and the consumer pays 40 percent of the cost in deductibles and copayments, *excluding* premium payments.

The other three plans to be offered — silver, gold and platinum — will have higher actuarial values (see Table 3). The premiums for these different benefit levels will vary greatly. There will be "out-of-pocket maximum" protection for all plans. Out-of-pocket maximum refers to the total amount that an individual or family has to pay in deductibles and copayments. Once an individual or family has paid the out-of-pocket maximum amount, the insurance company pays 100 percent of covered claims for the remainder of the year. Details of the out-of-pocket maximum protection can be found in Appendix A.

TABLE 3
Plan Levels Offered by Health Exchanges

Plan Level	Actuarial Value (percentage paid by plan)
Bronze	60%
Siler	70%
Gold	80%
Platinum	90%

Essential Benefits

All new health plans offered through health exchanges must cover, at a minimum, these services:

- physician office visits
- in-patient and out-patient hospital services
- maternity and newborn care
- mental health and substance use disorder services
- prescription drugs
- laboratory services
- preventive and wellness services
- chronic disease management
- pediatric services, including oral and vision care

There also will be a catastrophic plan for young adults under the age of 30. The catastrophic plan will have a high deductible, although preventive services and three primary care visits a year are exempt from the deductible. People who cannot find a bronze plan with premiums that costs less than eight percent of their income are also eligible for the catastrophic plan.

The Affordable Care Act provides start-up monies to create a Consumer Operated and Oriented Plan (CO-OP). These are member-run, nonprofit health insurance companies. Any profits generated by the CO-OPs must be returned to the members in the form of reduced premiums, improved benefits, or quality improvements. There is a $6 billion appropriation to help create the CO-OPs, however, the CBO believes that they will have little, if any, impact in many states.

During its 2011 regular session, the West Virginia Legislature passed Senate Bill 408, establishing the West Virginia Health Benefit Exchange. The state exchange will be housed in the Offices of the Insurance Commissioner and will be governed by a ten-member board. The board members include:

7 Grandfathered plans are group and individual insurance plans that were in effect on March 23, 2010 when President Obama signed the Affordable Care Act. There are limits on how much grandfathered plans can change benefits or increase the cost to employees and still maintain their status as a grandfathered plan, and be exempt from some of the reform measures. These limitations are discussed in Chapter 2.

- Four state agency officials: the Insurance Commissioner, the Chair of the Health Care Authority, Director of the Medicaid program and Director of the Children's Health Insurance Program (CHIP);

- Three consumer representatives: one for individual health care consumers, one for small businesses, and one for organized labor;

- Three industry representatives: one for insurance companies, one for health care providers, and one for insurance agents.

The Governor appoints the chair of the exchange board.

The board will govern the operation of both the individual exchange and the small business exchange. Although SB 408 does not make it clear, presumably the board can combine the two markets. The law does limit the definition of what constitutes a small business to employers who had less than 50 employees in the preceding calendar year.

The exchange board is authorized to fund the exchange through an assessment on insurance companies selling policies both in the exchange and outside the exchange. Any assessment must be based on the volume of insurance policies sold in West Virginia.

SB 408 gives authority to the board to set many of the major policies that will shape the exchange. There are, for example, three basic models for how an exchange will operate:

- Utah has adopted what is called a market organizer approach. Any insurance company that meets the minimum state and federal standards is allowed into their exchange.

- Massachusetts, on the other hand, has added additional criteria, and only those insurance companies that meet these additional standards are able to participate in the exchange. This approach is called an active or prudent purchaser.

- Finally, an exchange could actually bargain with an insurance company and allow only those companies that reach agreement with the exchange to offer policies in the exchange.

What approach West Virginia adopts is likely to be decided by the exchange board with oversight by the Governor and legislature.

The Offices of the Insurance Commissioner has already received $1 million in federal funds to plan the establishment of our state's exchange. With the passage of SB 408, West Virginia is in position to apply for a second round of funding that could result in $40 to $50 million in additional federal monies for operation of the exchange until December 31, 2014.

Of critical importance to the success of the West Virginia Health Benefit Exchange are the individuals the Governor appoints to the board. WVAHC will list those appointments on our website as soon as they are made. You can read the final version of SB 408 on WVAHC's website at www.wvahc.org.

Tax Credits for Families

The tax credits for families purchasing health insurance through the health exchanges are substantial. Over the next ten years we will, according to the CBO, spend $466 billion to provide tax credits for families with incomes between 100 percent and 400 percent of the FPL. These tax credits are refundable and "advanceable," meaning that the tax credits can be applied to lower your premiums in the year that you're paying taxes. You don't have to wait to file a tax return.

Tax credits are available on a sliding scale not only to make premiums more affordable, but also to limit the amount that individuals and families spend on deductibles and copayments (cost sharing), and to reduce out-of-pocket maximums. The tax credits to assist with deductibles and copayments are limited to those

earning less than 250 percent of the FPL. Appendix A shows the amount of tax credits for premiums, cost sharing and out-of-pocket maximums.

The Kaiser Family Foundation has developed a premium calculator on their website (see http://healthreform.kff.org/SubsidyCalculator.aspx). According to the calculator, a family of four with an annual income of $55,000 would pay $345 a month in premiums, while the federal tax credit would be $842 a month, slightly more than 70 percent of the total premium. The out-of-pocket maximum for this family would be reduced from almost $12,000 (the unsubsidized out-of-pocket cost) to $6,250.

If this same family of four earned $35,000 a year, they would pay a premium of $116 per month, and the federal tax credit would be $1,070 per month, about 90 percent of the total premium. Their out-of-pocket maximum would be reduced to about $4,200, with additional assistance to reduce their deductible and copayments.

It is important to note that the exact amount of premium assistance that an individual or family will receive is based on the premium of the second lowest cost silver plan sold in the exchange. Individuals and families can choose a better plan (for example, a gold or platinum plan), but must pay the difference in premiums. If they choose the less expensive plan (bronze, for example), they still receive the full tax credit, and as a result, they will pay less in premiums for the cheaper plan.

In Appendix C there are charts showing the amount of premium that a single individual and a family of four will pay and the amount of the federal tax credit.

Tax Credits for Small Businesses

The Affordable Care Act also provides tax credits to make employer-sponsored health plans more affordable for small businesses. These tax credits will cost the federal government $40 billion over ten years, according to CBO. They will be implemented in two phases:

Phase I (2010 through 2013): Employers with 10 or fewer employees and average wages of $25,000 or less will qualify for tax credits of 35 percent of the employers' contribution to premiums. This tax credit is phased out on a sliding scale to larger employers that pay higher salaries — those with fewer than 25 employees and average wages of less than $50,000. Employers that pay 50 percent or more of the total premium are eligible for the tax credit. Nonprofit organizations qualify under the same criteria except their tax credit is capped at 25 percent of the employers' premium payment. Since nonprofit organizations do not pay income tax, their payroll taxes are reduced in order to receive the tax credit.

Phase II (2014 and beyond): Small businesses that purchase health insurance through an insurance exchange will be eligible for tax credits. Most of the same criteria for the tax credits in Phase I apply to the tax credits in Phase II, although the maximum percentage of tax credits increases from 35 percent to 50 percent of the employers' premium contribution. Again, employers that pay 50 percent or more of the total premium qualify for the tax credit. Note: Tax credits in Phase II can only be taken for two years. The maximum tax credit that nonprofit organizations can receive under Phase II is 35 percent.

According to a Families USA report, 90 percent of West Virginia's small businesses (those employing 25 or fewer employees) will qualify for the Phase I tax credits. This includes 6,100 very small employers (ten or fewer employees) that will qualify for the maximum tax credit of 35 percent of the employers' contribution.[8]

Individual Mandate

Beginning in 2014, individuals are required to have qualified health insurance or pay a penalty. There are exemptions from the individual mandate, including:

- those with incomes below the IRS threshold for filing income taxes (currently $9,350 for an individual and $18,700 for a couple under age 65);
- those for whom the lowest cost plan would consume more than eight percent of their income;
- those with religious objections; and
- those who are uninsured for less than three months.

The penalty for non-compliance with the individual mandate is phased in over time. Beginning in 2014, the annual penalty is $95 or one percent of the person's taxable income, whichever is higher. In 2015, the penalty increases to $325 or two percent of taxable income. In 2016, the penalty is $695 or 2.5 percent of taxable income, whichever is higher. After 2016, the penalty is indexed to the consumer price index.

Employer Responsibility

Large employers (more than 50 full-time equivalent employees) are subject to a "free rider" provision. Beginning in 2014, large employers can face penalties if they do not provide health insurance to their employees and one or more of their employees receives a tax credit for a health insurance plan in the exchange. The penalty is $2,000 per full-time employee, although the first 30 employees are exempt from this calculation. For example, an employer with 70 employees would be charged $2,000 times 40.[9] Small businesses (50 or fewer employees) are exempt and will not be affected. It should be noted that 95 percent of employers with more than 50 employees are currently providing insurance to their employees.[10]

Employers with more than 200 employees are required to automatically enroll new employees in the company's health insurance plan after an allowable waiting period. Employees can opt out of the employer's coverage.

Waiting periods: Employers may not impose waiting periods of more than 90 days before a new employee qualifies for health insurance benefits. This requirement applies to group plans, including grandfathered plans.

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8 Claire McAndrew and Kathleen Stoll, *A Helping Hand for Small Businesses: Health Insurance Tax Credits*, Families USA and Small Business Majority (July 2010). Accessed on April 2, 2011 at: http://www.familiesusa.org/assets/pdfs/health-reform/Helping-Small-Businesses.pdf

9 There are two additional provisions that affect employers with more than 50 employees, but it is uncertain how much impact these provisions will have. The two provisions are: Free choice voucher: Qualified employees, those who earns less than 400 percent of the FPL and whose cost for insurance coverage are between 8 percent and 9.5 percent of their income, can receive a voucher from an employer who offers and contributes to the cost of health insurance. The employee can use the voucher to purchase health insurance through a health exchange instead. The voucher, which equals the employer's contribution to their own plan, can be used in the exchange, where the employee may get an equal or better plan for lower cost.

Unaffordable coverage: If an employer offers health insurance, but the premiums cost an employee more than 9.5 percent of his or her income, and the employee qualifies for tax credits in the exchange, then the employer is charged $3,000 for each employee who receives a tax credit.

10 Kaiser Family Foundation and the Health Research & Educational Trust, *Employer Health Benefits 2010 Annual Survey* (September 2010). Accessed April 2, 2011 at http://ehbs.kff.org/?CFID=14391004&CFTOKEN=99750927&jsessionid=60309fb678ff047fdb12336112194f2e7571 .

CHAPTER 2

Strong Regulation of the Health Insurance Industry

The Affordable Care Act includes fundamental changes in the rules that govern the health insurance industry. These important reforms will provide Americans greater health care security and ensure that they won't go bankrupt due to medical expenses or lose coverage when they switch jobs or start a new business.

The first round of reforms are effective when a new plan year begins on or after September 23, 2010. A second major round of reforms will take effect on January 1, 2014.

Insurance Reforms Effective After September 23, 2010

There are a number of insurance reforms that will go into effect *when a new plan year begins on or after September 23, 2010.*[11] They include the following changes:

Pre-existing conditions in children: Insurance companies may not deny coverage to children under the age of 19 due to pre-existing conditions, or issue policies that exclude coverage for pre-existing conditions. This reform applies to nearly all health insurance policies (including grandfathered group plans, but not grandfathered individual policies). The ACA does not immediately prohibit insurance companies from charging a higher premium for children with pre-existing conditions, a practice called medical underwriting. Medical underwriting is not prohibited, even for children, until 2014.

Young adults: Young adults who do not have access to employer-sponsored health insurance will be able to stay on their parents' health insurance policies until their 26th birthday.

The final bill removed a requirement that the young adult had to be unmarried, so married young adults qualify for their parents' coverage. Three federal agencies (Treasury, Labor, and Health and Human Services) issued interim final regulations on this reform.[12] According to these regulations, young adults can stay on their parents' policy even if the parent does not claim the young adult as a dependent on their federal income taxes; nor does the child have

11 Some people have assumed that these reforms began on September 23, 2010. That is not correct. These reforms begin when a new plan year occurs after September 23, 2010. Many insurance plans are on a calendar basis, and the new plan year began January 1, 2011. For PEIA these reforms will not be effective until July 1, 2011.

12 Interim Final Regulations are regulations that go into effect immediately, while a 60-day comment period is conducted, prior to the agency finalizing its regulations.

to live with the parent in order to qualify to stay on their parent's policy. Although married young adults can remain on their parents' policies, their spouses and dependents cannot.

Lifetime limits: Insurance companies will be prohibited from placing lifetime limits on the dollar value of essential benefits. This will ensure that cancer survivors and others with high needs will not lose their insurance.

Annual limits: There are new requirements regarding annual limits on benefits that can be imposed by insurance companies. The same three agencies (Treasury, Labor, and Health and Human Services) also issued interim final regulations on this reform. With new plan years beginning after September 23, 2010 insurance companies cannot have an annual cap on benefits that is less than $750,000. The following year the cap is raised to $1.25 million. And the next year the annual cap is raised to $2 million.

Rescissions: Insurance companies will be prohibited from retroactively cancelling health insurance policies other than in cases of fraud or intentional misrepresentation of a material fact. People who become seriously ill and use their health insurance will no longer have to worry about having their policies cancelled.

Preventive measures: All new insurance plans sold after September 23, 2010 (this reform does not apply to grandfathered plans) must cover preventive measures that have been clinically proven to be effective by the US Preventive Services Task Force. Insurance companies may not charge consumers a deductible, a copayment, or co-insurance for these services. These preventive measures include: well child visits, pap smears, mammograms, colorectal exams, immunizations for both children and adults, and many other screens. The entire list of preventive measures that must be covered without cost sharing by consumers is found in Appendix D.

Patient protection: There are three components to the patient protection provisions. First, patients and parents can choose any primary care physician or pediatrician who is in their insurance company's network and is accepting new patients. This provision primarily affects HMOs that automatically enroll patients with a particular physician or pediatrician. Secondly, women can go to their OB/GYN physician without obtaining prior authorization from their primary care providers. Third, patients can seek emergency care without prior authorization even if the hospital or medical provider is not in the insurance company's network. There are limits placed on what insurance companies can charge patients if they receive emergency services in out-of-network hospitals. These limits attempt to ensure that the consumer is not charged a higher deductible, copayments or co-insurance than the patient's in-network deductible, copayment or co-insurance.

Grandfathered Plans

Individual and group plans that were in effect on March 23, 2010, when President Obama signed the Affordable Care Act are "grandfathered" and not subject to some reforms. Table 4 lists which reforms are applicable to grandfathered plans and which reforms do not apply.

Generally, if an employer or an employee likes what they have now, they can maintain that coverage within certain limits. In order for an employer to maintain its grandfathered status, it cannot:

- Significantly cut benefits, for example eliminating coverage for HIV/AIDS.
- Increase co-insurances, which is a percentage that consumers pay for medical services.
- Increase copayments (a fixed dollar amount that consumers pay for medical services) by more than $5 (adjusted annually for medical inflation), or the medical rate of inflation plus 15 percent, whichever is greater.
- Increase deductibles by more than the medical rate of inflation plus 15 percent.

- Reduce by more than 5 percentage points the employers' contribution to the total premium. For example, if on March 23, 2010, an employer's share of the total premium was 70 percent, the employer cannot reduce its share below 65 percent and maintain its grandfathered status.

Employers must inform their employees if they plan to maintain their grandfathered status. Employees should keep documents outlining the percentage of the employer's premium contribution, and the amount of deductibles, copayments and co-insurance that were in effect on March 23, 2010. These are the baseline data against which future changes in their health insurance policy will be compared in order to determine whether the employer's plan is grandfathered or not.

Insurance Reforms Effective January 1, 2014

Effective January 1, 2014, there will be significant new insurance reforms. These reforms include:

An End to pre-existing conditions: Insurance companies may not deny coverage due to pre-existing conditions, issue policies that exclude pre-existing conditions, or charge higher premiums because of them. This reform applies to nearly all health insurance policies (including grandfathered group plans, but not grandfathered individual policies) and covers all ages.

Guarantee issuance: Insurance companies will be required to sell insurance policies to anyone who applies.

Guarantee renewal: Insurance companies will be required to renew an insurance policy upon request.

TABLE 4

Which Reforms Apply to Grandfathered Plans

2010 Insurance Reforms	New Plans	Grandfathered Plans: Group Plans	Grandfathered Plans: Individual Plans
Young adults to can stay on their parent's policy until age 26	Yes	Yes	Yes
Prohibition on lifetime caps on benefits	Yes	Yes	Yes
Reporting medical loss ratios	Yes	Yes[13]	Yes
End of rescissions	Yes	Yes	Yes
End to pre-existing conditions for kids	Yes	Yes	No
Limits on annual caps on benefits	Yes	Yes	No
Must cover effective preventive measures with no cost sharing	Yes	No	No
Patient Protections	Yes	No	No

13 Does not apply to grandfathered group plans that are self-insured (ERISA plans).

Medical underwriting: Medical underwriting is the practice of charging higher premiums to people with health problems or with perceived health problems. Higher premiums based on a person's health status will be prohibited. Insurance companies will be allowed to charge higher premiums based only on:

1. **Age:** Older people may be charged up to three times the amount young adults pay.

2. **Tobacco use:** Tobacco users may be charged 50 percent more than non-tobacco users.

3. **Geographic area:** Higher premiums can be charged based on local health demographics. For example, those in southern West Virginia may pay higher premiums than those in the eastern panhandle.

4. **Family size:** Premiums may vary based on family size and composition.

5. **Wellness programs:** For employer-sponsored insurance, there can be as much as a 30-percent premium difference between employees who achieve wellness goals and those who don't.

Annual limits: Insurance companies may not impose annual limits on the dollar value of essential benefits. This reform applies to nearly all health insurance policies (including grandfathered group plans, but not grandfathered individual policies).

Equal premiums for women: The ACA ends the practice of charging women higher premiums than men for the exact same policies.

Risk Adjustments

Three risk adjustment mechanisms are required of either the state or the Secretary of HHS in an attempt to equalize risk among insurance companies. Between 2014 and 2016, states are required to contract with a nonprofit reinsurance company that will collect payments from insurance companies in the individual and small group markets and make payment to insurance companies in the individual market that cover high-risk individuals. Also between 2014 and 2016, the Secretary of HHS is required to establish a risk corridor that will compensate insurance companies that have high claims costs by assessing those companies that have low claims costs. Finally, states will be required to adopt a permanent risk adjustment program that assesses insurance plans with lower-than-average risk, and pays insurance plans with higher-than-average risk. This risk adjustment program applies to plans sold in the individual and small group market, but not to grandfathered plans.

There is considerable controversy about whether or not insurance companies will be able to game the system by over-reporting their claims experience. But if the risk adjustments do work, they will eliminate the benefit of enrolling healthy people and avoiding sick people.

CHAPTER 3

Curbing Health Care Costs

Skyrocketing health care costs threaten the economic survival of many American businesses and families. The Affordable Care Act takes important steps toward "bending the curve" and reducing the rate of growth in health care spending. If we are unable to curb these increases, health care costs will continue to harm our families, businesses and the economy.

The Affordable Care Act promotes cost containment by strengthening primary care; establishing a nonprofit office to conduct comparative effectiveness research (studies on which procedures or drugs produce the best patient outcomes); establishing an Independent Payment Advisory Board to streamline changes in Medicare; and establishing an innovation center in Medicare and Medicaid to test different payment reforms. Payment reform moves our system away from paying doctors on a fee-for-service basis, where physicians are reimbursed for every procedure they perform, to a system where quality is also considered. Below is a partial list of the cost containment measures in the Affordable Care Act.

> *"The current (payment) system, based on volume and intensity, does not disincentivize, but rather pays more for overuse and fragmentation."*
>
> — Mark McClellan,
> former Director of the Center for Medicare and Medicaid Services under President W. Bush, and other authors[14]

Strengthening Primary Care

Primary care is one of the lynchpins in controlling health care costs. Studies have shown that having a greater ratio of primary care providers to specialists not only lowers costs,[15] but also helps prevent illnesses and deaths.[16]

The Affordable Care Act includes a number of measures to strengthen primary care. Perhaps the most important is doubling the funding for community health centers. Community health centers provide quality primary care to anyone who comes through their doors — the uninsured, the insured, rich, or poor. Patients are charged on a sliding scale.

Additionally, community health centers participate in a prescription drug program (called 340b) that allows their patients to receive significant savings on their pharmaceuticals. Many drugs are priced 10 percent below Canadian drug prices.

Congress appropriated an additional $11 billion over five years beginning in 2011 for community health centers. Most ($9.5 billion) will be used to expand primary care services, while the remainder ($1.5 billion) will be used for capital improvements, including building new centers.

14 Mark McClellan, Aaron N. McKethan, Julie L. Lewis, Joachim Roski, and Elliott S. Fisher, *A National Strategy To Put Accountable Care Into Practice*, Health Affairs. (May 2010): 982–990.

15 Karen Davis, Cathy Schoen, Stuart Guterman, Tony Shih, Stephen C. Schoenbaum, and Ilana Weinbaum, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?*, The Commonwealth Fund, (January 2007). Accessed on April 2, 2011 at: http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jan/Slowing-the-Growth-of-U-S—Health-Care-Expenditures—What-Are-the-Options.aspx .

16 Barbara Starfield, Leiyu Shi and James Macinko, *Contribution of Primary Care to Health Systems and Health*, The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502).

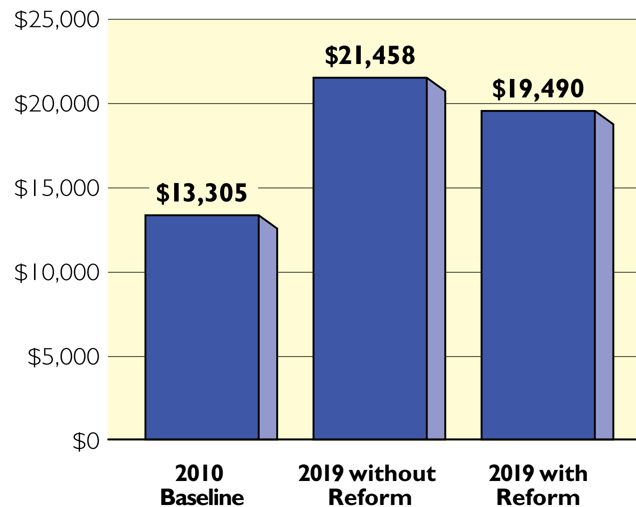
One report found that patients who use community health centers have lower health care costs by $1,093 a year. This report projects that an estimated 17.5 million Americans will receive care at these centers due to the increased funding, and that total health care spending will be reduced by $181 billion between 2010 and 2019.[17]

This is particularly important for West Virginia. The *New England Journal of Medicine* recently reported that a higher percentage of West Virginians receive their health care at community health centers than do the citizens of any other state in the country.[18]

Other efforts to strengthen primary care include:

- Redirecting unused slots for medical student residency programs to train more primary care doctors.
- Increasing payments to primary care providers that treat Medicaid patients in 2013 and 2014. These payment increases will bring Medicaid rates up to Medicare rates and improve access to care for low-income people. The federal government will pay 100 percent of this increased payment.
- Providing a ten-percent bonus payment to primary care providers, including doctors, general surgeons and nurse practitioners, who practice in health professional shortage areas (almost all of West Virginia) from 2011 to 2015.
- Increasing funding for the National Health Services Corps by $1.5 billion over five years. The Corps provides scholarships to medical students enrolled in primary care training in exchange for two years of service in communities with provider shortages.

$2,000 Savings in Total Family Premiums with Reform



Source: Commonwealth Fund, The Impact of Health Reform on Health System Spending, May 2010

Patient-Centered Outcome Research Institute

Comparative effectiveness research compares the clinical effectiveness of the various medical treatments, procedures, and pharmaceuticals. We currently know very little about which treatments or drugs have the best outcomes for patients.

A new Patient-Centered Outcome Research Institute will set research priorities and conduct research projects. All participants in the Institute would be required to disclose conflicts of interest, although participants with conflicts of interest would not be excluded from participating in or governing the Institute.

The Institute is required to widely disseminate the findings of the research, but is prohibited from recommending practice guidelines. The Secretary of HHS can change copayments to discourage use of ineffective procedures and to promote the use of effective treatment options.

17 Leighton Ku, et. al., *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform*, George Washington University (June 2010). Accessed on April 2, 2011 at: http://www.rchnfoundation.org/images/FE/chain207siteType8/site176/client/bending%20the%20curve%20final%20no%20embargo-2.pdf .

18 Eli Y. Adashi, et. al., *Health Care Reform and Primary Care — The Growing Importance of the Community Health Center,* New England Journal of Medicine (April 28, 2010).

Independent Payment Advisory Board

Currently, the Medicare Payment Advisory Commission makes recommendations to Congress on ways to control Medicare costs. Most of their recommendations are ignored by Congress because private insurance companies and other powerful special interests oppose them. The Affordable Care Act would change this by establishing the Independent Payment Advisory Board. The Board is required to make recommendations to change Medicare when the cost of Medicare exceeds established benchmarks. Congress can reject the recommendations of the Board, but Congress would have to develop alternatives that achieve the same cost savings. If they don't, then the recommendations of the Board go into effect.

The Board is prohibited from making recommendations that ration care, raise taxes, or change Medicare benefits, eligibility, or cost to beneficiaries.

Between 2014 and 2019, the Board's authority is expanded to make non-binding recommendations on system-wide health care costs containment measures and quality improvements involving both Medicare and private insurance companies. Beginning in 2020 and each ten years thereafter, the Board is required to make recommendations on means to control national health care spending, including private insurance companies.

Center for Medicare and Medicaid Innovation

The Center for Medicare and Medicaid Services (CMS) is the federal agency that oversees Medicare and Medicaid. A Center for Medicare and Medicaid Innovation will be established within CMS to research and evaluate payment and delivery system reforms that increase quality and reduce costs. There are a number of payment reforms and delivery system reforms that are mandated by the Affordable Care Act that would be evaluated by the new center. A partial list of these measures includes:

- Allowing Medicaid patients with chronic illnesses, including mental illnesses, to designate a provider as a medical home. These providers would be required to report quality data.

- Establishing accountable care organizations (ACOs). ACOs are voluntary associations of doctors and hospitals that agree to be jointly responsible for their patients' quality of care. The ACOs will be compensated with shared savings by Medicare if they meet quality standards and reduce overall cost.

- Using bundled payments by Medicare to pay for an episode of care — a knee replacement, for example. Medicare would make one payment for three days before the patient is admitted to the hospital, his or her entire stay in the hospital and thirty days after the patient is discharged from the hospital. The purpose of basing payment on an episode of care is to get all the health providers to collaborate and work for better outcomes for the patient, rather than being paid for each individual treatment.

- Reducing payment for hospital-acquired conditions. Medicare will begin to reduce payment to hospitals that have high rates of hospital-acquired conditions, such as infections. An estimated 48,000 Americans die in hospitals each year from two preventable infections: pneumonia and sepsis.

- Reducing Medicare payments to hospitals that have a high readmission rate. All too often, Medicare patients are discharged only to be readmitted within 30 days for the same illness. This is both expensive and a disservice to the patient.
- Establishing physician and hospital value-based purchasing programs that pay doctors and hospitals on quality and not just on quantity of services.

Fraud and Abuse

There are a series of steps taken to reduce fraud and abuse in Medicare, Medicaid and the Children's Health Insurance Program. These steps include greater screening of providers (criminal background checks, unscheduled and unannounced site visits, etc.); greater penalties for fraud and abuse; and greater resources ($250 million over five years) to prosecute fraud and abuse cases.

CHAPTER 4

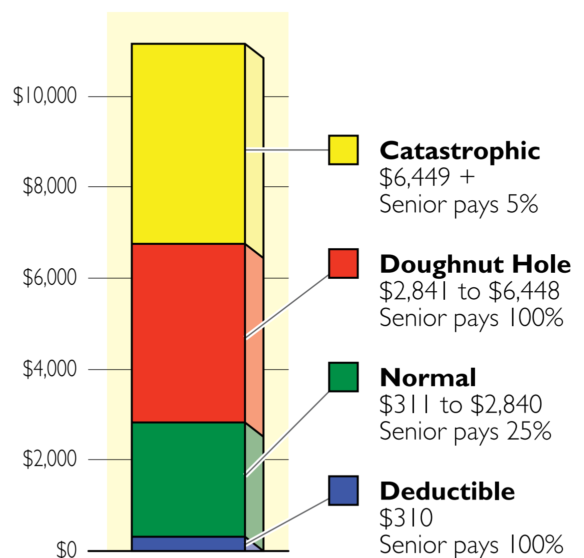
Other Provisions of the Affordable Care Act

The Affordable Care Act includes other significant provisions to improve health and health care in the United States. These include provisions to eliminate the doughnut hole in Medicare's prescription drug program; boost prevention and wellness efforts; establish a voluntary, long-term care insurance program; address racial disparities in health; establish a pre-existing condition insurance plan; increase transparency in prescription drug marketing to doctors; publicize the financial assistance policies of nonprofit hospitals; assist early retirees; and medical malpractice reform.

Medicare Benefit Enhancements

The Affordable Care Act does not change eligibility for Medicare, but it does include significant enhancements in Medicare benefits. The most notable is the elimination of the "doughnut hole" in prescription drug benefits. Currently, there is a $310 deductible for prescription drugs. The government then pays 75 percent while the beneficiary pays 25 percent until the total cost reaches $2,840. At that point, the beneficiary reaches the "doughnut hole," where he or she is responsible for 100 percent of an additional $3,608 in prescription drug costs. Once that amount has been reached, the government and the insurance company then pay 95 percent of all additional prescription drug costs for the remainder of the year.

Doughnut Hole 2011



Source: AARP Public Policy Institute, Health Care Reform Legislation Closes the Medicare Part D Coverage Gap (April 2010)

Here's how the doughnut hole is closed (also see Appendix E):

- Beginning in 2011, pharmaceutical companies will pay 50 percent of the cost of purchasing brand-name drugs in the doughnut hole. This payment by drug manufacturers continues until at least 2019. Beginning in 2013, the government will begin paying a portion of the cost for brand name drugs purchased in the doughnut hole. The government starts by paying 2.5 percent of these costs in 2013, but it grows to 25 percent by 2020, when the drug manufacturers and the government will combine to pay 75 percent of costs of brand name drugs and beneficiaries pay 25 percent.

- The federal government will pay seven percent of the cost of generic drugs purchased in the doughnut hole beginning in 2011. The government's share of the generic drug costs increases by seven percent points a year until 2020, when beneficiaries will pay 25 percent and the federal government pays 75 percent.

Since January 1, 2011, Medicare recipients have been eligible for an annual wellness visit, including a health risk assessment and the development of a personalized prevention plan that may include a cancer screening schedule for the next five years or even ten years. Medicare cannot charge a deductible or coinsurance for this wellness visit.

Additionally, preventive services that have been found to be effective will be provided by Medicare with no deductibles or coinsurances.[19] The Secretary of HHS also may prohibit Medicare from paying for preventive services that have been found to be ineffective.

Prevention and Wellness

A central feature of the Affordable Care Act is its focus on using our health care resources judiciously. To further this aim, the Act includes several provisions to promote good health and reduce the demand for care due to preventable conditions. These include:

Information on calories: The Act requires chain restaurants to post the number of calories in the food they sell on their menus and menu boards, including drive through menu boards, so consumers can instantly see the number of calories before placing their orders.

Prevention and public health: The Prevention and Public Health Investment Fund is established to provide for investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. Seven ($7) billion is appropriated to the Fund between 2010 and 2019.

Pregnant and parenting women: $250 million over ten years is appropriated to assist pregnant and parenting women. States can apply for these grants to improve services to these women in high schools, community health centers, colleges and universities. Funds also can be used to increase awareness of the services available to pregnant and parenting women. Funds are available from 2010 through 2019.

Breastfeeding: Employers with more than 50 employees will be required to provide a reasonable break time and place for women to express breast milk for one year after her child's birth. Breastfeeding has been shown to reduce the incident of asthma, diabetes and obesity.

Long-term care

The ACA establishes a national Community Living Assistance Services and Support (CLASS) program. The CLASS program is a voluntary, self-funded, public, long-term care insurance program to fund community living assistance services and support. After a five-year vesting period, participants will be provided at least $50 a day to purchase services and support in order to stay in their home or community setting. Participation by employers is voluntary. If an employer participates, the employees are automatically enrolled through payroll deduction, but can opt out of the CLASS program.

19 Preventive services that will be exempt from deductibles and copayments must be rated A or B (recommended) by the US Preventive Services Task Force.

Racial Disparities in Health

Despite notable progress in the health of Americans overall, serious and persistent disparities remain in the health status of African Americans and other racial minorities compared to the U.S. population as a whole. To address this issue, the Office of Minority Health at the National Institute of Health is elevated to an Institute instead of a Center. In addition, Offices of Minority Health will be created at the Center for Medicare and Medicaid Services (CMS), the Food and Drug Administration (FDA), Center for Disease Control and Prevention (CDC), and several other federal agencies. Additionally, there will be greater data collection on race and ethnicity in order to reduce racial and ethnic disparities.

Pre-existing Condition Insurance Plan

The Pre-Existing Condition Insurance Plan (PCIP) is established for Americans who have been uninsured for at least six months and have a pre-existing condition. In order to prove that you have a pre-existing condition, you must have evidence that an insurance company denied you coverage or would only insure you by establishing a separate rider for your pre-existing condition. Premiums in this high-risk pool are subsidized to make them more affordable. There is a $5 billion appropriation for this high-risk plan, and the high risk pool will end once the health exchanges are up and running in 2014.

The benefits in PCIP parallel the benefits found in the Federal Employees Health Benefits program, the insurance plan that Congress has. Three different plans are offered, and each plan provides preventive care paid at 100 percent with no deductible or copayment. Benefits include doctor office visits, in-patient and out-patient services, prescription drugs, preventive services, etc. Under the standard plan, West Virginia consumers will pay a monthly premium, ranging from $141 per month for someone under age 18 to $468 a month for someone over the age of 55, plus a $2,000 deductible for covered benefits (except for preventive services) before the plan starts to pay. After consumers pay the deductible, they will pay a $25 copayment for doctor visits, $4 to $30 for most prescription drugs, and 20 percent of the costs of any other covered benefits they receive. The out-of-pocket maximum is $5,950 per year. These costs will be higher if participants use medical providers outside the plan's network.

Pharmaceutical Marketing

The Affordable Care Act boosts transparency in pharmaceutical marketing with a requirement that drug manufacturers report the amount of payment to a physician or teaching hospital. This information is reported to the Secretary of HHS and will be posted on the Internet. If your physician is being paid as a consultant to a drug company, or if his or her office gets free lunches so that the drug rep can encourage your doctor to prescribe brand name drugs, then the of amount of payment and the lunch expenses will be publicly available. The first reports will be made on March 31, 2013, and will cover calendar year 2012.

West Virginia collects this data, but only on an aggregated basis. We know that drug companies are providing millions of dollars to thousands of physicians, but we do not know how much individual physicians are receiving. The national law will be a significant improvement over West Virginia's law.

Nonprofit Hospitals

Nonprofit hospitals will be required to adopt and widely publicize a financial assistance policy that explains who is eligible and how patients can apply when they cannot afford to pay for needed medical treatment. Charges to patients who qualify are limited to the amount charged to insured patients. In addition, nonprofit hospitals will be required to conduct a community needs assessment and develop an implementation strategy to meet the community's needs every three years beginning in 2012.

Early Retirees

Employers that provide health insurance benefits to early retirees (ages 55 to 64) will qualify for a reinsurance program that will pay 80 percent of the retiree's claims between $15,000 and $90,000. Payments from the reinsurance are used to reduce the costs for enrollees in the employer's plan. The reinsurance program began on September 23, 2010, and ends on January 1, 2014, when the exchanges are up and running.

Medical Malpractice

Fifty ($50) million is appropriated for states to experiment with alternatives to resolving medical malpractice disputes. The alternative method of resolving disputes should focus on reducing medical errors and improving patient safety and the quality of health care.

Some people believe that medical malpractice reform will result in significant cost savings because doctors will stop ordering unnecessary tests they currently order to protect themselves from lawsuits. The Congressional Budget Office, however, has estimated that adopting traditional medical practice reforms (placing limits on the awards for pain and suffering and other non-economic damages) will result in a national reduction of health care expenditures of one-half of one percent. Forty percent of these savings are projected to be reduced premium payments made by doctors for their malpractice insurance, and sixty percent (of this one-half of one percent) would be attributable to decreases in defensive medicine.

Finally, under the Affordable Care Act, free clinics are given the same protection from medical malpractice claims that community health centers currently have.

CHAPTER 5

Paying for Health Care Reform

The projected cost of implementing the Affordable Care Act is about $940 billion over the next ten years, according to the CBO. These costs will be paid by a combination of savings in current health care spending (about $500 billion) and new revenues (about $438 billion).

In addition to ensuring health care for nearly all Americans, the CBO predicts that this public investment will reduce the federal deficit by $143 billion by 2019. During the following decade (2019-2029), the CBO projects that health reform will reduce the federal deficit by $1.2 trillion, although the second decade projection is far from certain.

Slowing the rate of growth in Medicare: The most significant savings in current health care spending comes from slowing the rate of inflation in Medicare by:

- Limiting increases in payments to hospitals, skilled nursing homes, home health agencies and other providers, resulting in projected savings of $196 billion over ten years, and;
- Phasing out the overpayment to Medicare Advantage companies, resulting in savings of $136 billion over ten years. Medicare Advantage companies are private insurance companies that provide Medicare benefits. Currently, they are paid 14 percent more than it costs to provide traditional Medicare. Some Medicare Advantage plans provide benefits above traditional Medicare benefits. For example, they may pay for gym membership or prescription glasses that traditional Medicare does not cover. It is reasonable to assume that Medicare Advantage plans will drop these additional benefits as their reimbursement is brought into line with traditional Medicare. They must, however, cover all traditional Medicare benefits (doctor office visits, in-patient and out-patient services, prescription drug benefits, etc.)

The reduction in Medicare spending is projected to slow the growth in Medicare from 6.6 percent to 5.4 percent.[20]

Taxes and Fees: The primary sources of new revenue include:

- Increasing the Medicare payroll tax by 0.9 percent points for single taxpayers earning more than $200,000 and couples earning more than $250,000, and by making investment income for these wealthy taxpayers subject to taxation. These tax increases will generate an estimated $210 billion over ten years.
- Charging new fees on insurance companies, drug manufacturers and medical device manufacturers in exchange for adding millions of new customers as more Americans have and use health insurance. The new fees are expected to generate about $107 billion over 10 years.
- Adding an excise tax to high-cost health plans beginning in 2018 will generate an estimated $32 billion during 2018 and 2019. The excise tax will apply to insurance companies that sell policies that exceed $10,200 for a single

20 Stuart Guterman, Karen Davis and Kristof Stremikis, *How Health Care Reform Will Affect Medicare Beneficiaries*, Commonwealth Fund (March 2010). Accessed April 2, 2011 at www.commonwealthfund.org .

policy and $27,500 for a family policy. These thresholds are increased to $11,850 for an individual and $30,950 for family coverage for retirees and employees who work in high risk jobs, such as miners, police and firefighters. Costs in excess of these limits will be subject to a 40-percent tax.

- Charging penalties to individuals and employers who don't comply with their responsibilities under the Act, which are projected to generate $17 billion from individuals and $52 billion from businesses.

CHAPTER 6

Conclusion

> *"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."*
>
> — Reverend Martin Luther King, Jr.

The Affordable Care Act is a remarkable piece of legislation that warrants the description "historic." No legislation since the adoption of Medicare and Medicaid 45 years ago will have as much impact on the health care of the American people as Affordable Care Act will have: 32 million additional Americans will have health insurance; comprehensive reforms will be made in the health insurance industry; significant steps will be taken to control costs, particularly in Medicare; and major investments will be made in prevention, primary care and public health. All of these are monumental achievements that will impact the health and financial security of our nation.

In addition, the Affordable Care Act removes the single largest barrier to entrepreneurship in America today: access to health insurance. Beginning in 2014, every American, including sole proprietors, will be guaranteed access to health care. People locked in jobs because of health insurance will be able to start their own businesses or move to new jobs with the security of knowing that they will have access to coverage.

Another benefit of health reform is a change in how insurance companies compete for business. For the last half century, insurance companies have competed on the basis of price and their ability to shift costs to someone else, principally government, but also to other insurance companies. That ends in 2014. They will no longer be able to set premiums based on someone's health status. And, if the risk adjustment mechanisms work, there will be no financial incentive to attract only healthy people. After 2014, insurance companies will compete on the basis of price and quality. Those that hold down cost and offer effective chronic disease management programs or patient-center medical homes are very likely to be the most successful.

There are, however, very legitimate concerns with the ACA. Will there be enough primary care providers available to deliver services to the 32 million newly insured Americans? The ACA does take some steps to increase the number of primary care providers. But West Virginia needs to examine the "scope of practice" for nurse practitioners, physician assistants, and others to ensure that these primary care providers are allowed to practice to their full potential.

Provider capacity is not the only legitimate concern. Does West Virginia state government have the capacity to implement the Affordable Care Act? For example, can our Medicaid agency actually enroll and manage the care of 122,000 to 157,000 new, low-income beneficiaries? Is the Offices of the Insurance Commissioner adequately staffed and have sufficient authority to enforce the complex insurance reforms in the Act?

A key decision needs to be made by the health insurance exchange board, the Governor and the legislature about the health exchanges. What is the mission of the health exchange? Is it merely a website and an 800 call center that dutifully posts the increases in insurance company premiums? Or will the health exchange be operated for the benefit of consumers and require insurance companies to offer better quality while containing cost? WVAHC will work diligently to ensure that the health exchange is operated by and for the benefit of consumers.

Beyond the issues involved with state implementation, does the new legislation go far enough? What about the 23 million Americans who are expected to fall between the cracks of the Affordable Care Act? Will the tax incentives for small businesses, limited to two years beginning in 2014,

be enough to spur more small employers to purchase health coverage for their employees? Will the exchanges be robust enough to rein in spiraling costs?

Controlling cost is probably where the shortcomings of Affordable Care Act are most evident: Does the Act do enough to control costs in the private insurance market, where almost 160 million Americans receive their health insurance?

There are efforts to control insurance company administrative costs. Establishing health exchanges and requiring rebates to businesses and other consumers when health insurance companies spend too much on administrative costs will undoubtedly restrain the administrative costs of insurance companies and force them to be more effective. Having greater resources in the Offices of the Insurance Commissioner to thoroughly review premium increases, and specifically allowing states to deny insurance companies access to the health exchanges if they adopt unreasonable premium increases, will likely dampen future premium increases. But this process leaves it to private insurance companies to control the underlying increases in medical costs, and so far insurance companies have been ineffective at controlling the medical rate of inflation.

Comparative effectiveness, portrayed by some as rationing of health care, actually holds great promise in understanding what drugs and procedures will produce the best patient outcomes, and therefore reduce cost. But the results of this research are years away, and implementation of the findings are severely hampered in the ACA in order to avoid the “r” word — rationing.

One possible strategy is to have private insurance companies and government payers collaborate. Both the public payers and the private payers should be partners in payment reforms. If accountable care organizations or patient-centered medical homes are successful in improving patient outcomes for Medicare patients, they also are likely to be successful in improving patient outcomes for Blue Cross Blue Shield patients. It should not just be the public payers that do experiments to determine what works and what doesn’t. It should be a combined effort by all payers.

Ultimately, we should pool the resources of both private and public payers (Blue Cross Blue Shield, Carelink, Medicare, Medicaid, etc.) in order to negotiate reimbursements with doctors, hospitals, and pharmaceutical companies. This is similar to the Wellness Funds used in Germany and other countries to effectively control cost. Over time, reimbursement rates paid to doctors and hospitals by Medicaid and Medicare could be equalized to the reimbursement rates paid by private insurance companies, or at least the huge disparity could be reduced.

This proposal would face certain opposition from providers and pharmaceutical companies. One of the prices paid by the Obama Administration for the pharmaceutical companies’ support of health care reform was the decision not to allow Medicare to negotiate prices for drugs. Combining Medicare, Medicaid and private insurance companies would surely be unacceptable to the pharmaceutical industry as well as many hospitals and doctors.

However, the current rate of medical inflation is unsustainable. Left unchecked, the nation’s expenditures on health care are expected to more than double from $1.4 trillion in 2001 to $3.1 trillion by 2012. During the same period, the percentage of our gross national product consumed by health care will rise from 14.1 percent to 18 percent, leaving in its wake shrinking resources for education and other urgent national priorities. At some point we will be forced to rein in health care costs or accept a diminished standard of living and overall quality of life.

Even with its shortcomings, the Affordable Care Act is a huge step in the right direction. The foundation for meaningful reform has been laid by this landmark legislation, and now the hard work of implementation begins. We hope this booklet will help inform consumers and businesses of the new opportunities contained in the Act so that they can take advantage of them. West Virginians for Affordable Health Care will closely monitor and report new developments on our website, as well as advocate for additional policies that will assure every resident in the United States access to quality, affordable health care.

APPENDIX A

Health Insurance Tax Credits

The three charts below show the effect that tax credits for individuals and families in the Affordable Care Act will have on premiums, cost sharing (the amount paid in deductibles and copayments) expressed as an actuarial value, and out-of-pocket maximums. An actuarial value is the percentage that the insurance company pays of the claims for the average consumer. For example, a 94 percent actuarial value means that the insurance company will pay 94 percent of the claims and the patient will pay 6 percent in copayments and deductibles. An out-of-pocket maximum is the most that an individual or family has to pay in deductibles and copayments. After the individual or family reaches the out-of-pocket maximum, the insurance company pays 100 percent of all additional legitimate claims for the year. The protection in out-of-pocket maximums is based on a percentage of the deductible allowed in a high deductible plan, called a health savings account (HSA). The values shown in the out-of-pocket maximum are the 2010 amounts. In 2014, when they become effective, these amounts are expected to be higher.

Tax Credits to Subsidize Insurance Premiums

Income as a percentage of the federal poverty level	Percent of income paid by an individual or family in premiums
Up to 133% of FPL	2% of income
133 - 150% of FPL	3 - 4% of income
150 - 200% of FPL	4 - 6.3% of income
200 - 250% of FPL	6.3 - 8.05% of income
250 - 300% of FPL	8.05 - 9.5% of income
300 - 400% of FPL	9.5% of income

Tax Credits to Assist with Deductibles, Copayments and Co-insurances

Income as % of federal poverty level	Actuarial value (percentage that insurance company pays)	Consumer share of insurance cost
100 - 150% of FPL	94%	6%
150 - 200% of FPL	87%	13%
200 - 250% of FPL	73%	27%
250 - 400% of FPL	70%	30%

Out-of-Pocket Maximums

Based on highest deductible allowed in a health savings account (HSA)

Income as % of federal poverty level	% of HSA deductible limit	Individual (for 2010)	Family (for 2010)
100 - 200% of FPL	1/3	$1,963	$3,967
200 - 300% of FPL	1/2	$2,975	$5,950
300 - 400% of FPL	2/3	$3,927	$7,933
400% and above	100%	$5,950	$11,900

APPENDIX B

Federal Poverty Levels

Federal Poverty Levels (FPL)* for 2010

Family Size	100% of FPL	133% of FPL	200% of FPL	250% of FPL	300% of FPL	350% of FPL	400% of FPL
1	$10,830	$14,440	$21,660	$27,075	$32,490	$37,905	$43,320
2	$14,570	$19,378	$29,140	$36,425	$43,710	$50,995	$58,280
3	$18,410	$24,352	$36,620	$45,775	$54,930	$64,435	$73,240
4	$22,050	$29,326	$44,100	$55,125	$66,150	$77,175	$88,200

* Poverty levels are re-calculated every year. By the time, the proposed reforms take effect in 2014, actual incomes will be higher.

APPENDIX C

Monthly Premiums and Subsidies

for Individuals and Families Who Purchase Insurance in the Health Exchanges by Income and by Age

The chart below provides the amount a single person will pay per month in health insurance premiums and the amount of tax credits. For example, a 20-year old who makes $16,245 a year (150 percent of the federal poverty level) will pay $58 a month in premiums and the tax credit will be $225 a month.

Annual Income (and as a % of FPL)	Monthly Premiums / Tax Credits by Age		
	20 Years Old	40 Years Old	60 Years Old
$10,830 (100%)	Medicaid	Medicaid	Medicaid
$16,245 (150%)	$58 / $225	$58 / $318	$58 / $790
$21,660 (200%)	$121 / $162	$121 / $254	$121 / $727
$32,490 (300%)	$273 / $9	$273 / $102	$273 / $574
$43,320 (400%)	$283 / $0	$364 / $11	$364 / $483
$43,320+ (400%+)	$283 / $0	$375 / $0	$848 / $0

The chart below provides the amount a family of four will pay per month in health insurance premiums and the amount of tax credits. For example, a 20 year old policy holder in a family of four with income of $33,075 a year (150 percent of the federal poverty level) will pay $117 a month in premiums and the tax credit will be $645 a month.

Annual Income (and as a % of FPL)	Monthly Premiums / Tax Credits by Age		
	20 Years Old	40 Years Old	60 Years Old
$22,050 (100%)	Medicaid	Medicaid	Medicaid
$33,075 (150%)	$117 / $645	$117 / $894	$117 / $1,886
$44,100 (200%)	$246 / $516	$246 / $765	$246 / $1,758
$66,150 (300%)	$556 / $205	$556 / $454	$556 / $1,447
$88,200 (400%)	$742 / $20	$742 / $269	$742 / $1,262
$88,200+ (400%+)	$762 / $0	$1,011 / $0	$2,004 / $0

Source: Kaiser Family Foundation calculator at: http://healthreform.kff.org/SubsidyCalculator.aspx

APPENDIX D

Preventive Services Required Under the Affordable Care Act

If you have a *new* health insurance plan or insurance policy beginning on or after September 23, 2010, the following preventive services must be covered without having to pay a copayment or coinsurance or meet your deductible, when these services are delivered by a network provider.

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults — doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breast Feeding** interventions to support and promote breast feeding
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Folic Acid** supplements for women who may become pregnant
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Osteoporosis** screening for women over age 60 depending on risk factors

- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Syphilis** screening for all pregnant women or other women at increased risk

Covered Preventive Services for Children

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Cervical Dysplasia** screening for sexually active females
- **Congenital Hypothyroidism** screening for newborns
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight and Body Mass Index** measurements for children
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

APPENDIX E

Medicare Prescription Drug Changes

Phasing Out the Doughnut Hole for Brand-Name Drugs

Year	Drug Manufacturer's Discount	Federal Government's Contribution	Consumer's Responsibility
2011	50%	0	50%
2012	50%	0	50%
2013	50%	2.5%	47.5%
2014	50%	2.5%	47.5%
2015	50%	5%	45%
2016	50%	5%	45%
2017	50%	10%	40%
2018	50%	15%	35%
2019	50%	20%	30%
2020	50%	25%	25%

Phasing Out the Doughnut Hole for Generics Drugs

Year	Federal Government's Contribution	Consumer's Responsibility
2011	7%	93%
2012	14%	86%
2013	21%	79%
2014	28%	72%
2015	35%	65%
2016	42%	58%
2017	49%	51%
2018	56%	44%
2019	63%	37%
2020	75%	25%

Source: Medicare Rights Center, *Health Reform and Medicare: Closing the Doughnut Hole* (April 1, 2010), as modified by WVAHC.

Acronyms Used in this Guide

ACO - Accountable Care Organization
Affordable Care Act (ACA) – Patient Protection and Affordable Care Act
CBO - Congressional Budget Office
CDC - Centers for Disease Control and Prevention
CHIP – Children's Health Insurance Program
CO-OP - Consumer Operated and Oriented Plan
CPI - Consumer Price Index
ERISA - Employee Retirement Income Security Act
FMAP - Federal Medical Assistance Percentage
FPL – Federal Poverty Level
HSA - Health Savings Account
HHS – U.S. Department of Health and Human Services
OIC - The West Virginia Offices of the Insurance Commissioner
Secretary - Secretary of the U.S. Department of Health and Human Services

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Guiding Principles of West Virginians for Affordable Health Care

- Health care should be a right of citizenship or residency rather than a privilege of employment.
- Our health care system should use limited resources wisely.
- Health care cost containment is essential.
- Communities, providers, and individuals all have important responsibilities to promote and protect health.
- Quality health care depends on the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

For more information about our work, please visit our website:
www.wvahc.org and www.healthreform.org

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