

# HEALTH CARE HELPER

## REFORM ISSUE

The Patient Protection & Affordable Care Act (PPACA) and The Education Affordability Reconciliation Act of 2010 is now the law of the land. This by far is the most comprehensive and sweeping piece of legislation dealing with our broken health care system in decades. Therefore, this issue of Health Care Helper will be entirely dedicated to summarizing the issues that will affect our members the most. This historic legislation will lead to the coverage of 32 million Americans who are currently uninsured, including millions of kids who will no longer have to show up to school unready to learn because of treatable medical conditions. Reform has also succeeded in achieving key insurance market reforms, including measures to push insurance companies to keep premiums down, preventing lifetime caps on the dollar amount of benefits, restricting the way annual benefit limits can be applied, and prohibiting the cancellation of policies when people get sick. Many of the provisions depend on the states to establish criteria and regulations that meet the standards. Over the next few months, and years, we will be working closely with NEA and other states to ensure the successful enactment of the Acts.

### 1st Year

#### HEALTH CARE REFORM



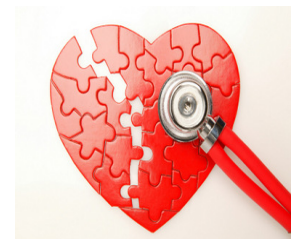
- ◆ Ninety days after enactment, people that are uninsured due to pre-existing conditions will have access to coverage through a temporary high-risk pool
- ◆ Temporary re-insurance will be provided to employers that have early retiree programs from ages 55 until Medicare eligible
- ◆ After six months, dependent children will be able to stay on their parent's health plan until their 26<sup>th</sup> birthday
- ◆ Insurers will be prohibited from denying coverage to children with pre-existing conditions
- ◆ Insurers prohibited from rescinding coverage when people get sick

- ◆ Insurers prohibited from applying lifetime caps
- ◆ Insurers required to pay first-dollar coverage for preventive care
- ◆ Insurers required to offer minimum benefits and limit out-of-pocket costs to consumers
- ◆ Beginning January 2011, large group plans required to spend 85% of premiums on medical services. Small groups required to spend 80%. If they do not meet this threshold, participants will be entitled to rebates
- ◆ Resources provided to establish a National Quality Strategy
- ◆ Insurers required to offer minimum benefits and limit out-of-pocket costs to consumers to about \$6,000 annually for individuals and \$12,000 for families
- ◆ A 10% tax applied to indoor tanning services

### The 2nd Year & Beyond

- ◆ In 2012, there will be incentives for primary care doctors to integrate with other physicians

- ◆ Rewards for quality outcomes and penalties for those hospitals with high readmission rates
- ◆ By 2014, no one will be denied coverage based on a pre-existing condition
- ◆ States required to establish regulations and Insurance Exchanges that will allow people to have access to affordable insurance
- ◆ Subsidies available for individuals that can't afford insurance
- ◆ Penalties for individuals that do not obtain health coverage
- ◆ Employers with more than 50 employees will be required to offer coverage or face penalties



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- ◆ A higher Medicare Tax will be applied to individuals making more than \$200,000 or \$250,000 for couples
- ◆ In 2015, payments to providers will be calculated on evidence-based medicine Quality Strategy and additional prevention promotion will be implemented

### Medicare Impacts



- ◆ A one-time rebate of \$250 for Medicare recipients who have exhausted the first part of their drug benefit and are paying 100% of the cost of their medication. The following year, low-income and middle-income seniors would begin getting a 50% discount on brand-name drugs.
- ◆ Steps will be taken to prevent fraud and waste in the system
- ◆ Cost sharing for covered preventive care services will be prohibited under Medicare and eventually all plans
- ◆ The bill reduces unnecessary and expensive subsidies made to private insurers who offer Medicare Advantage plans and limits the cost sharing requirements imposed by these plans

### Excise Tax

Members, staff, and many other labor organizations from around the Nation fought vigorously against the High Cost Plan Excise Tax. Through our efforts, we were not able to eliminate this portion of The Act.



However, we gained significant improvements. The application of this tax to insurers was delayed until 2018 and the threshold levels were raised to \$10,200 for single coverage and \$27,500 for family coverage (\$11,850 and \$30,950 for retirees). These steps are meant to allow the other cost saving measures to take effect and also reduces the revenue generation from this tax by 80%. In addition, dental and vision coverage is excluded and the dollar thresholds will increase based on inflation when calculating the tax starting now. The costs to employers may also be reduced in the event the demographics of the covered population is not representative of the average age and gender of the national risk pool.

As we move forward to implement these historic reforms, the hope is there will be large cost savings in existing plans by providing access to more people so we are not supplementing expensive emergency room visits by the uninsured with our premium dollars. We should also see reductions in costs through quality improvement measures, wellness promotion, and encouragement of preventative care. At this time, there are still many unanswered questions. NODD will be working closely with NEA and other departments within CTA to help shape and define many of these provisions in order to maximize the benefit to our members.

### California Can Do Better



In 2017, prior to the Excise Tax going into effect, states will have the ability to apply for Alternatives to the exchanges that could create a single payer system in individual states. This will allow California to funnel federal dollars into the system and continue our efforts to pass SB 810 and completely remove the profit from health care system.