

## **Health Reform Summary**

### **March 23, 2010**

On Sunday March 21, 2010 the U.S. House of Representatives passed H.R. 3590, “The Patient Protection and Affordable Care Act,” by a vote of 219 to 212. The Senate passed the same bill on Christmas Eve 2009. President Obama signed the bill into law on March 23, 2010.

The bill garnered enough votes for passage once Rep. Bart Stupak (D-MI) and a group of anti-abortion Democrats agreed to support the bill in exchange for an executive order that prohibits the use of federal funds for abortions. 34 Democrats and all 178 Republicans voted against the bill.

H.R. 4872, the reconciliation bill amending H.R. 3590, also passed the House on March 21 by a vote of 220-211. The Senate still has to vote on H.R. 4872, which eliminates much of the funding that favors individual states, increases subsidies for those who purchase health coverage through the national insurance exchange, and lowers the excise tax on high-cost insurance plans. The Senate is expected to vote on the reconciliation bill the week of March 22, 2010.

The health reform overhaul is expected to provide coverage to 32 million Americans. The Congressional Budget Office’s analysis of both H.R. 3590 and H.R. 4872 states that the reform package will cost \$871 billion and will reduce the federal deficit by \$138 billion over the next ten years. The physician payment fix is not included in the bill. Congress promised the AMA that they will not allow a scheduled 21% cut to be implemented. This fix will cost at least \$240 billion over the next ten years.

Major provisions of the final health reform plan include:

**Mandated Health Care:** Starting in 2014, individuals who do not have minimum health coverage will have to pay a \$95 penalty. This penalty will increase to the higher amount of \$750 or 2% of income in 2016, and will incur a cost-of-living increase each year thereafter. Those who object to coverage based on religion, those below the poverty line, and Indian tribe members are among those exempt from the penalty.

Employers that do not offer coverage and employ more than 50 employees would be required to pay a \$750 fine for each employee who receives a tax credit for health insurance through a state exchange. Employers of that size requiring a waiting period before an employee can enroll in health care coverage would pay \$600 per employee for a 60-90 day waiting period. Employers of that size offering coverage but with at least one full-time employee receiving the premium assistance tax credit would pay the lesser of \$3,000 per employee receiving a tax credit, or \$750 per full-time employee. The bill would ensure that no employer would discharge or discriminate against an employee on the basis of the employee receiving a premium tax credit.

The bill would also require group health plans and health insurance issuers to provide coverage of, and not impose any cost-sharing requirements for, additional preventive care and screening for women. It would bar the U.S. Preventive Service Task Force’s most recent recommendations

on breast cancer screening, mammography and prevention from being used for coverage determinations.

**Creation of State Insurance Exchanges:** Individuals who do not have health coverage through their employer would be able to purchase coverage through state-based insurance exchanges by 2014. Federal subsidies would be provided to those who meet poverty level requirements. The subsidies will be funded by fines on employers who have 50 or more full-time workers and do not provide health coverage.

**Tax Credits and Subsidies:** Available in 2010 to help buy coverage on the exchange, is a tax credit to subsidize the cost of premiums. People with incomes between 100 percent and 400 percent of the federal poverty level (or \$22,050 for a single person to \$88,000 for a family of four) would be eligible. Most people who are offered coverage by their employer would not be eligible for the tax credit. If an employee was offered unaffordable coverage (9.8 percent or more of his income) by his employer, they could be eligible for an affordability waiver.

The bill would provide a sliding scale tax credit for a qualified small employer for contributions to purchase health insurance for its employees. A “qualified small employer” would be an employer with no more than 25 full-time-equivalent employees employed during the taxable year, and whose employees have annual wages that average no more than \$50,000.

#### **Taxes and Revenue Raisers:**

**Insurance provider user fees –** A fee is established on any U.S. health insurance provider, based on each provider’s relative market share. The fee is \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, and \$14.3 billion in 2018. In 2019, these fees would be adjusted by the same rate as the growth in health insurance premiums.

**Prescription Drug Industry User Fee –** An annual fee on brand name prescription drug manufacturers as follows: \$2.5 billion in 2011, \$3 billion in 2012-2016, \$3.5 billion in 2017, \$4.2 billion in 2018, and \$2.8 billion in 2019 and beyond.

**In 2011: Qualified Medical Expenses -** The cost of over-the-counter medicines may not be reimbursed through a health FSA or HRA, a health savings account, or an Archer MSA. The tax on distributions from an HSA or Archer MSA that are not used for qualified medical expenses is raised to 20%.

**In 2013: Flexible Spending Accounts (FSAs)** contributions are capped at \$2,500 annually, (indexed to CPI-U).

**Individual Income Taxes -** Increases the hospital insurance payroll tax by 0.9% on individuals earning over \$200,000 and joint filers earning over \$250,000, effective 2013 (income amount not indexed to inflation).

A 3.8% Medicare tax is applied on investment income from interest, dividends, royalties, rents, gross income from a trade or business, and net gain from disposition of property for individuals

earning over \$200,000 and joint filers earning \$250,000 (income amount not indexed to inflation)

Medical Device Industry Excise Tax - 2.3% excise tax on medical devices sold in the U.S.

Medical Expense Deduction - increases the threshold for claiming the itemized deduction for medical expenses from 7.5% to 10%

Tax Deduction for Part D Expenses - eliminates the deduction for the employer subsidy for employers who provide prescription drug coverage to employees eligible for Medicare Part D

In 2018: Excise "Cadillac" Tax on High-Cost Health Insurance - a 40% excise tax on health coverage that exceeds \$10,200 for an individual and \$27,500 for families (annually indexed to All Urban Consumers + 1%).

**Insurance Reforms:** Effective 90 days from enactment, HHS will establish a temporary insurance program for uninsured people denied coverage due to pre-existing conditions until the creation of the insurance exchanges in 2014.

Six months after enactment: Health insurance plans are prohibited from excluding children on the basis of a pre-existing condition, prohibited from rescinding coverage, except in cases of fraud or intentional misrepresentation. Small and large group plans may not impose lifetime limits on coverage and insurers that offer dependent coverage are required to allow uninsured and unmarried children to remain on their parents' health insurance up until age 26. All plans must provide coverage, without cost-sharing, for preventive services and immunizations recommended by the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force.

In 2014: The bill prohibits group health plans from excluding patients on the basis of pre-existing conditions. Small and large group plans are prohibited from establishing annual or lifetime limits. Plans in the individual or small group market must provide the essential health benefits package. Insurers are prohibited from discriminating based on health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, or any factor determined appropriate by HHS. It would prohibit group health plans from establishing any eligibility rules for health care coverage that have the effect of discriminating in favor of higher wage employees.

The bill accelerates the adoption of uniform standards and rules for electronic transactions between providers and health plans. It requires health plans to certify compliance or face penalties of up to \$20 per covered patient life or \$40 per covered life if the plan knowingly provided inaccurate information.

**Medicare:** Require Medicare to cover 100 percent of most preventive services and would waive beneficiary co-insurance requirements. It would authorize the HHS secretary to adjust the coverage of preventive services to the extent the change is consistent with recommendation of the U.S. Preventive Services Task Force.

**Medicare Sustainability:** Revises certain market basket updates and incorporation of services used to determine the reimbursement for certain services under Medicare Part A. Generally, market baskets are used to adjust payments each year based on projected changes in indexes that are used to measure how much more or less it would cost to buy the same goods and services. The measure would incorporate “productivity adjustments” — adjustments based on gains in productivity — into several market baskets used under Part A that do not currently incorporate such provisions. The adjustments would be phased in during different years for different types of providers, and would affect inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospitals. There is also a temporary adjustment to the calculation of Part B premiums.

The bill would create a 15-member Independent Medicare Advisory Board that would be charged with reducing the per capita growth rate in Medicare spending. Members would be appointed by the president and subject to Senate confirmation. The board would make recommendations on how to limit the growth rate of Medicare spending if spending were projected to exceed certain targets. Beginning in 2014, the board would submit a proposal to the president for years in which spending would exceed the targets, which would be required by Jan. 15 each year. The president would submit the proposal to Congress. The board’s recommendations would be implemented by the HHS secretary on Aug. 15 unless Congress enacted legislation containing an alternate method for reducing costs.

Improving payment accuracy for Disproportionate Share Hospitals, home health, and imaging services – The measure would require a reduction in federal matching payments in fiscal 2014 through fiscal 2019 to states for Medicaid DSH payments, which are additional reimbursements for hospitals that serve a disproportionate share of low-income individuals. Beginning in 2013, home health payments will be rebased to reflect the number and mix of home health services and the average cost of providing care. It would establish a 10 percent cap on the reimbursement a provider could receive from outlier payments and would reinstate an add-on payment for rural home-health providers from April 1, 2010, through 2015. The bill increases the utilization rate assumption for calculating the payment for advanced imaging equipment from 50 percent to 65 percent for 2010 through 2012, to 70 percent in 2013 and to 75 percent beginning in 2014. These three reforms are estimated to save \$65 billion.

Savings for the aforementioned programs to are estimated be \$250 billion over 10 years.

**Medicare Advantage:** Require that Medicare Advantage (MA) payments be based on the average of the bids from MA plans that participate in a market providing bonus performance payments based on certain criteria. The bill creates a four-year transition, beginning in 2011, for new benchmarks. In addition, the amount that MA plans can spend on administrative costs is limited to 15 percent. Savings are expected to be \$200 billion over ten years.

**Medicare Part D (Prescription Drug Benefit):** Under the 2003 law that created Part D, after a beneficiary meets his or her deductible for the year, a beneficiary will have 75 percent of his or her drug costs covered by the government up until a set dollar amount, which was initially set at \$2,250, but has increased to \$2,830 in 2010 as a result of inflationary increases permitted

beginning in 2007. After that dollar amount has been reached, the beneficiary is responsible for 100 percent of the cost of prescriptions up to another dollar amount, known as the catastrophic threshold, or the “doughnut hole,” which is \$6,440 in 2010. The federal government is responsible for 95 percent of the costs above that upper limit for the rest of the year.

The bill provides a one-time, \$250 rebate for beneficiaries who fall into the “doughnut hole” in 2010 and phases out the “doughnut hole” over 10 years. Starting in 2011, the measure creates a discount of 50 percent on brand-name drugs for beneficiaries who fall into the “doughnut hole,” and this discount increases to 75 percent by 2020, with the government paying the rest of the cost of the drugs.

**Medicare Waste, Fraud, and Abuse:** Requires all providers and suppliers to implement compliance programs including core elements developed by HHS. Increases funding for the Health Care Fraud and Abuse Control Fund. Requires HHS to screen all providers and suppliers, including advanced screening procedures for certain types of at-risk providers and suppliers and permits the IRS and HHS to share data to screen and identify fraudulent providers.

**Medicaid:** By 2014, states are required to cover parents and childless adults at or below 133% of the federal poverty level who are not eligible for Medicare. The federal government is to pay 100% of the cost of Medicaid expansion in 2014-2016, 95% of the cost in 2017, 94% of the cost in 2018, 93% of the cost in 2019, and 90% of the cost in 2020 and beyond. The measure requires a reduction in federal matching payments to states for Medicaid DSH payments, which are additional reimbursements for hospitals that serve a disproportionate share of low-income individuals. Specifically, it would require a reduction in DSH payments by \$14.1 billion, over the period of fiscal 2014 through fiscal 2019. It expands the current option under Medicaid that allows states to cover services to include certain preventive services recommended by the U.S. Preventive Services Task Force as well as certain immunizations for adults that are recommended by the Advisory Committee on Immunization Practices. It permits hospitals to make “presumptive eligibility” decisions for all Medicaid eligible populations.

**Health Care Quality:** The law requires the HHS secretary to establish and update, on an annual basis, a national strategy to improve the delivery of health care services, patient health outcomes and population health. It also would create an interagency working group on health care quality.

**CLASS Program:** The bill would create a new voluntary insurance program to help individuals with functional limitations purchase community living assistance services and supports (CLASS). The CLASS Independence Benefit Plan, as the program would be known, would be funded by premiums paid by program beneficiaries. Active workers would generally purchase coverage through their employer, who would deduct amounts from their paycheck.

**Health Care Workforce:** The bill would establish a national commission to review the health care workforce and its projected needs. It would establish competitive grants for state partnerships to complete workforce planning and create health care workforce development strategies.