

HEALTHCARE REFORM LEGISLATION

After including a budget reconciliation process, the House of Representatives passed H.R. 3590, the Patient Protection and Affordable Care Act (the Affordable Care Act), and H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (the Health Care Reconciliation Act).

The Affordable Care Act, previously approved by the Senate on December 24, 2009, was signed into law by President Obama on March 23, 2010. The Health Care Reconciliation Act strikes out or modifies a number of tax and revenue provisions in the Senate's Affordable Care Act. Under budget reconciliation rules, the House Health Care Reconciliation Act now goes to the Senate for approval, possibly by a 51 vote majority not subject to filibuster delay. If the Senate makes any changes, however, the House and the Senate versions could end up in a House-Senate conference committee, with any final agreement requiring a majority approval by the two chambers under strict rules that set a timetable for action and that prohibit any amendments. Assuming passage of this conference committee agreement, it would then be sent to the President for his signature.

The president's signature to H.R. 4872 will put into effect the provisions of the Affordable Care Act, as amended by the Health Care Reconciliation Act.

These provisions include, but are not limited to, the following:

Employer Responsibilities. Beginning on January 1, 2014, assesses a penalty of \$2000 annually per full-time employee for employers with more than 50 employees who do not offer health insurance with at least one full-time employee who receives a premium tax credit. Employers with more than 50 employees that do offer coverage will pay a \$3000 annual penalty for each full-time employee that receives a premium tax credit. In calculating these penalties, the bill subtracts 30 workers from the size of a large employer's workforce. Employers with 50 or fewer employees are exempt from penalties. (Effective January 1, 2014).

Also effective in 2014, employers that offer coverage would be required to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange.

Employers with more than 200 employees must automatically enroll employees coverage offered by the employer. Employees may opt out of coverage.

Individual Responsibilities. The Act generally requires that all individuals either obtain health insurance or pay a penalty on their federal tax return beginning in 2014. To avoid the penalty, individuals will need to obtain and maintain “minimum essential coverage” for themselves and their dependents. “Minimum essential coverage” includes coverage under any employer-provided plan, governmental programs (for example, Medicare and Medicaid), and any plan offered in the individual market. Coverage under grandfathered plans - those in effect on the date of enactment that are not required to be amended to comply with the Act - also qualifies. There are virtually no specific benefit requirements for a plan’s coverage to be considered minimum essential coverage, so long as the plan primarily covers medical benefits.

Those without coverage pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: \$95 in 2014, \$325 in 2015, and \$695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. After 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for those for whom the lowest cost plan option exceeds 8% of an individual’s income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples).

Health Benefit Exchanges. Requires each state to establish an American Health Benefit Exchange and Small Business Health Options Program (SHOP) Exchange, to be administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. States are permitted to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. Funding is available for states to establish Exchanges within one year of enactment and until January 1, 2015.

Each plan participating in an Exchange must meet standardized affordability, essential benefit, and consumer protection requirements. Exchange plans must also meet state benefits requirements, but states must defray premium and cost-sharing costs related to additional benefits for subsidized individuals.

Individual subsidies. Refundable and advance premium credits are made available to eligible individuals and families with incomes between 133 and 400% of the federal poverty level to purchase insurance through the Health Insurance Exchanges. The premium cred-

its will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale.

Employer subsidies. Small employers with no more than 25 employees and average annual wages of less than \$40,000 that purchase health insurance for employees are provided with a tax credit.

For 2010 through 2013, a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium is provided if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium.

For 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, a tax credit is provided of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000.

Effective 90 days after enactment and extending until Jan. 1, 2014, a temporary reinsurance program is established for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program will reimburse employers or insurers for 80% of retiree claims between \$15,000 and \$90,000.

Financing of health reform. Beginning in 2014, a tax on individuals without qualifying coverage is imposed that is the greater of \$695 per year up to a maximum of three times that amount or 2.5% of household income.

Beginning in 2018, an excise tax is imposed on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage.

Benefit design. Beginning in 2014, an essential health benefits package is established that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950 for individual and \$11,900 for family in 2010), and is not more extensive than the typical employer plan. Requires the Secretary to define and annually update the benefit package through a transparent and public process. All qualified health benefits plans, including

those offered through the Exchanges and those offered in the individual and small group markets (except grandfathered plans) are required to offer at least an essential health benefits package.

Private Insurance. Effective within 90 days of enactment and extending through Jan. 1, 2014, a temporary national high-risk pool is established to provide health coverage to individuals with pre-existing medical conditions. Individuals who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit (\$5,950/individual and \$11,900/family in 2010).

Beginning in 2010, health insurance plans are required to report the proportion of premium dollars spent on clinical services, quality, and other costs. Effective in 2011, insurers must provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. A process is established for reviewing increases in health plan premiums and requiring plans to justify increases. States are required to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases.

Effective six months after enactment, all individual and group policies must provide dependent coverage for children through age 26; individual and group health plans are prohibited from placing lifetime limits on the dollar value of coverage and insurers are prohibited from rescinding coverage except in cases of fraud; plans are prohibited from imposing pre-existing condition exclusions for children.

As of January 2014, individual and group health plans are prohibited from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary.

Six months following enactment, grandfathered plans are required to extend dependent coverage to age 26, prohibit rescissions of coverage, eliminate waiting periods for coverage of greater than 90 days, and eliminate pre-existing condition exclusions for children. Beginning in 2014, grandfathered group plans must eliminate lifetime limits on coverage and eliminate annual limits on coverage.

Beginning in 2014, waiting periods for coverage are limited to 90 days and states have the option of merging the individual and small group markets.

Cost. The Congressional Budget Office estimates the cost of the coverage components of the reconciliation bill in combination with the Patient Protection and Affordable Care Act

to be \$940 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which CBO estimates will raise \$32 billion over ten years. CBO estimates the proposal will reduce the deficit by \$143 billion over ten years.

Additional Medicare tax. A 40 percent excise tax will be imposed on high-dollar insurance plans and an increase in Medicare payroll taxes on taxpayers in the \$200,000 plus income category (\$250,000 for joint filers), beginning in 2013.

MEDICARE

Several provisions link quality outcomes and payments under Medicare. Quality measure reporting programs, already in place for inpatient acute hospitals, will be developed for long-term care hospitals, rehabilitation hospitals, hospice programs, and PPS-exempt cancer hospitals.

Starting in fiscal year 2015, hospitals in the top 25th percentile of rates of hospital-acquired conditions for certain high-cost procedures will be subject to a payment penalty. A value-based purchasing (VBP) program for hospitals will be implemented in 2013. A portion of a hospital's Medicare payment will be linked to the hospital's performance on quality measures related to common and high-cost conditions, such as cardiac, surgical, and pneumonia care. Similar programs will be introduced for other health care providers as well.

Reimbursement for most types of Medicare providers will be adjusted to improve payment accuracy. Medicare Advantage payments will be adjusted to be more in line with Medicare fee-for-service payments.

Physician fee schedule. Payments would increase by 0.5 percent increase over 2009 rates.

Rural health care. Medicare payments will increase to providers in any state where at least 50 percent of the counties are "frontier counties," those having a population density less than six people per square mile. Several existing statutes related to improving Medicare payments to providers in rural areas are extended.

Prescription drugs. Changes to Medicare Part D, prescription drug reimbursement, includes an attempt to close the "donut hole" for prescription drug coverage.

MEDICAID

Access to Medicaid, as well as the types of services that are covered under Medicaid is expanded, including preventive services and long-term care. Additional revenue is allocated for specific maternal and child health services.

Expanded eligibility. States will have the option starting in 2014 to expand Medicaid eligibility to nonelderly, non-pregnant individuals who are not otherwise eligible for Medicare, with incomes up to 133 percent of the federal poverty level (FPL). From 2014 through 2016, the federal government will pay 100 percent of the cost of covering newly eligible individuals.

Children's Health Insurance Program. States are required to maintain income eligibility levels for CHIP through the end of fiscal year 2019. Enrollment changes. Individuals may apply for or enroll in Medicaid, CHIP, or an insurance plan offered by one of the new state-based Exchanges through one state-run website. Hospitals are allowed to provide Medicaid services during a period of presumptive eligibility of all Medicaid eligibility categories.

Expansion of services. Medicaid will cover services provided by free-standing birth centers. States will have the option of offering community-based attendant services to disabled Medicaid beneficiaries who would otherwise need institutional care. State also may provide more home- and community-based services through a state plan amendment rather than a waiver.

Fraud prevention. Provisions to prevent fraud in federal healthcare programs and to increase the program integrity of both Medicare and Medicaid will be implemented.