

Key Provisions of Federal Health Care Reform

This document incorporate details of both the Patient Protection and Affordable Care Act and the Reconciliation Bill. Both are now law. This is not meant to capture all the provisions of the new laws, but key provisions of interest to employers, brokers and members. HealthPartners will continue to make adjustments as our understandings of both laws expand. For the most up-to-date information, please visit healthpartners.com/employer.

Patient Protection and Affordable Care Act and Reconciliation Bill	
Estimated Coverage	Expands coverage to 32 million Americans. Estimated 94% of Americans will have health care coverage. 23 million will still be left uninsured by 2019.
Estimated Cost	\$938 billion over 10 years
Estimated Deficit Reduction	\$132 billion over 10 years
Insurance Market Reforms	
Small Business Tax Credits (Employer Supports)	<p>Small business tax credits beginning in 2010 for small business to offer coverage to employees. Small business is 25 or fewer employees and average wages up to \$50,000.</p> <p>In 2010, tax credit (if the employer pays at least 50% of premium) is:</p> <ul style="list-style-type: none"> ○ For small non-profits, 25% of employer's contribution* ○ For small for profits, 35% of employer's contribution* <p>*Credit is phased out if the employer has over 10 employees or average wages over \$25K</p> <p>Expanded in 2014 to higher percentages (up to 50% for small for-profits)</p>
High Risk Pool	<p>By 6/23/2010</p> <p>Temporary high risk program established at the federal level. Some states have chosen to administer, including Wisconsin.</p> <p>Lasts until the Exchange is up and running</p>
Reinsurance for Early Retirees	<p>Beginning 6/1/2010</p> <p>Creates a temporary reinsurance program for employers providing health insurance to retirees over age 55 who are not eligible for Medicare at the federal level. Total funds available are \$5B and the program ends when funds are exhausted.</p> <p>Reimburse employers or insurers 80% of retiree claims between \$15,000 and \$90,000. Reinsurance payments to be used to lower costs for enrollees in the plan.</p> <p>Employers must submit an application to be eligible to submit claims. Applications and claims paid on a first come, first served basis.</p>

Rescissions	9/23/2010, only for fraud or intentional misrepresentation, including Grandfathered plans
Medical Loss Ratio Requirements	1/1/ 2011 <ul style="list-style-type: none"> ○ Large group market 85% ○ Small group and individual market 80% ○ Medicare Advantage plans 85% Rebates to enrollees required if medical loss ratios are above these levels
Guaranteed Issue	1/1/2014
Individual Mandate	1/1/2014 Must have minimum essential coverage or pay penalty unless in an excepted/exempted category: <ul style="list-style-type: none"> ○ religious objections, ○ incarcerated individuals, ○ those who can't afford coverage, ○ members of Indian tribes, and others.
Individual Responsibility (penalty for not complying with the individual mandate)	1/1/2014 Penalty – graduated over time, tax penalty per individual for the greater of: <ul style="list-style-type: none"> ○ 2014: \$95 or 1.0% of household income ○ 2015: \$325 or 2.0% of household income ○ 2016: \$695 or 2.5% of household income ○ COLA increases after 2016 ○ Penalty for children is half of the individual penalty to a \$2,250 cap Hardship exemption for individuals for whom the lowest cost premium exceeds 8% of income
Employer Responsibility (penalty for employers who have employees accessing subsidies in the Exchange)	1/1/2014: “back door” mandate For employers with 50 or more full-time equivalent employees <p>If employer <u>does not offer</u> coverage and has one or more employees receiving premium assistance, the first 30 employees are exempt from calculation, then the fee is \$2000 per FT employee.</p> <p>For employers who <u>do offer</u> coverage, the employer must pay a fee of \$3000 per employee for each FT employee who receives a premium tax credit, or \$2000 per FT employee (after exempting the first 30 employees), whichever is less.</p> Starting in 2014, employers who do offer coverage must offer free choice vouchers to purchase through the Exchange to employees for whom

	contribution would be between 8% and 9.8% of income.
Market Size/Structure	<p>Small group market defined as 1 to 100 States can choose to define as under 51 until 2016.</p> <p>Study on self-insured groups and the impact of any adverse selection in the large group market due to reforms.</p>
Exchange	<p>Short term – Immediate internet portal to facilitate shopping for individuals and small employers; portal under development for 7/1/2010 launch with basic information on products in the individual and small group markets. As of 10/1/2010, benefit and pricing information added.</p> <p>1/1/2014 - States must establish an Exchange which is run by government or a non-profit States may form regional exchanges OPM to administer at least two plans in the exchange, one of which must be non-profit (see below)</p> <p>Eligible to purchase through Exchange:</p> <ul style="list-style-type: none"> ○ 2014-2016: Individuals and small groups ○ 2017: Large groups may participate at state discretion <p>Products in the Exchange must meet standardized affordability, essential benefit and consumer protection requirements.</p> <p>In addition, the Exchange must provide information on their operations and product offerings to Treasury and others.</p>
Public Option/ Multi-State Plans	<p>No public option</p> <p>Instead, Multi-state qualified plans to be offered in the Exchange overseen by OPM</p> <ul style="list-style-type: none"> ○ Must comply with Exchange plan requirements and FEHPB requirements ○ One must be non-profit ○ Initially, must be offered in at least 60% of states and must be national by year 4
CO-OP Plans	\$6B fund to support creation of non-profit, member-governed co-ops to be offered in the Exchange. Can be offered in 2014.
Interstate and Nationwide Plan Sales	<p>Health Care Choice Compacts created to allow two or more states to enter into an agreement under which an insurer can sell individual products across state lines</p> <ul style="list-style-type: none"> • NAIC to advise and regulations to be issued by 7/1/2013 <p>Nationwide plans allowed but states may opt out</p>

Rating	<p>1/1/2014 for new business, adjusted community rating for individual and small employer groups and in Exchange</p> <ul style="list-style-type: none"> ○ Age (3 : 1) ○ Geographic area ○ Family size ○ Tobacco use (1.5 : 1) <p>States have new authority to strengthen rate review</p>								
Taxes that affect rates: Insurance Industry Fee	<p>1/1/2014, annual fee on health plan fully insured net premiums.</p> <table border="0"> <tr> <td>2014</td> <td>\$8B</td> </tr> <tr> <td>2015-2016</td> <td>\$11.3B</td> </tr> <tr> <td>2017</td> <td>\$13.9B</td> </tr> <tr> <td>2018 – on</td> <td>\$14.3B</td> </tr> </table> <p>Excludes self-insured or government entities or non-profits which have 80% of gross revenues from Medicare, Medicaid or CHIP and meets certain lobbying requirements. Only 50% of premiums of plans/carriers which are tax exempt entities are included in the calculation of the fee.</p>	2014	\$8B	2015-2016	\$11.3B	2017	\$13.9B	2018 – on	\$14.3B
2014	\$8B								
2015-2016	\$11.3B								
2017	\$13.9B								
2018 – on	\$14.3B								
Excise Tax on High Cost Plans (Cadillac tax)	<p>Starting in plan years 1/1/2018 and beyond, 40% excise tax on value of employer sponsored plans exceeding \$10,200 single and \$27,500 family. Increased thresholds for additional factors, including employee age or gender. Dental and vision plans excluded.</p>								
Comparative Effectiveness Fee	<p>\$2 per enrollee fee on fully insured and self-insured insurers to pay for comparative effectiveness research; decreases to \$1 per enrollee from 2013-2019</p>								
Product Design Reforms									
Lifetime Maximums	<p>Starting 9/23/2010 as contracts renew</p> <p>Lifetime limits prohibited on essential benefits in group and individual plans, including Grandfathered plans</p> <p>Could have lifetime limits on benefits outside of the essential benefit set (scope of essential benefit set as yet undefined)</p>								
Annual Maximums	<p>Starting 9/23/2010 as contracts renew</p> <p>Unreasonable annual limits* restricted on essential benefit set, including Grandfathered plans</p> <p>2014 Annual limits on essential benefit set eliminated</p> <p>Could have annual limits on benefits outside of the essential benefit set (scope of essential benefit set as yet undefined)</p>								

Pre-existing Conditions Exclusions	Starting 9/23/2010 as contracts renew No pre-ex for children in new individual and group plans including Grandfathered <u>group</u> plans 1/1/2014, no pre-ex for anyone including Grandfathered plans
Dependent Coverage	Starting 9/23/2010 as contracts renew, expanded to dependents to age 26, including Grandfathered plans From 2010 until 2014, adult dependents in grandfathered groups may be added if they are not eligible to enroll in other group coverage.
Imputed Income	Starting after March 31, 2010, the IRC is changed to remove <u>federal</u> issues associated with imputed income for adult children not otherwise meeting the dependent definition under the tax code who have not yet turned 27 by the end of the tax year. Neither Minnesota nor Wisconsin legislatures passed conforming tax legislation this past session, so imputed income issues remain at the state level. Does not remove other imputed income implications for others not meeting tax dependent requirement such as domestic partners.
Preventive Health Services	Starting 9/23/2010 as contracts renew, new group and individual plans must provide for preventive services with no cost sharing. Preventive services are spelled out specifically to include at a minimum: <ul style="list-style-type: none"> ○ A & B services in the current USPSTF recommendations ○ Immunizations ○ Evidence-informed care and screening for infants, children and adolescents (HRSA-supported guidelines) ○ Additional care and screenings for women (included in HRSA-supported guidelines) <ul style="list-style-type: none"> ○ Specifically does not include any breast cancer, mammography or prevention guidelines from USPSTF from 11/2009
Emergency Services Coverage	Starting 9/23/2010 as contracts renew, plans may not require prior authorization for emergency services Coverage must be provided at in-network cost sharing levels (prudent layperson standard).
Limits Health Savings Accounts	1/1/2011, Penalty for nonqualified HSA payments increased from 10% to 20% 1/1/2011, no more reimbursement for OTC meds; preserves reimbursement for prescription drugs and insulin
Limits on Flexible Spending Accounts	1/1/2011, no more reimbursement for OTC meds; preserves reimbursement for prescription drugs and insulin 1/1/2013, contributions are limited to \$2,500 per year (indexed to CPI-U over time)
Clinical Trials Mandate	1/1/2014 Coverage for routine care for those on clinical trials for cancer and life-threatening conditions

Essential Benefit Set	<p>1/1/2014, Benefits - Four core benefit sets to be offered in the Exchange</p> <ul style="list-style-type: none"> ○ Bronze (60% actuarial value) ○ Silver (70% actuarial value) ○ Gold (80% actuarial value) ○ Platinum (90% actuarial value); plus ○ “young invincibles” plan (catastrophic plus 3 primary care visits) for those under 30 or meet the individual mandate hardship exemption <p>Must include preventive (covered at 100%), primary care, emergency, imaging, hospitalization, outpatient care, pediatric care, drugs, children’s dental and mh/cd coverage.</p> <p>Cost sharing limited to HSA limits (\$5950 indiv)</p> <p>States can require additional mandated benefits but must offset the costs related to those mandates</p>
Clinical Trials Mandate	<p>1/1/2014 Coverage for routine care for those on clinical trials for cancer and life-threatening conditions</p>
Eligibility/Affordability (Covering more People)	
CHIP enrollment transfer	<p>CHIP preserved until 2019 and federal matching rate increased. Extends current reauthorization for two years</p>
Medicaid expansion	<p>1/1/2014, Medicaid eligibility expanded to all adults up to 133% FPL States may voluntarily move earlier (4/2010) but state would be required to pay its standard contribution of about 50% of the cost. For newly eligibles 100% FMAP through 2014-2016; 95% for 2017; 94% for 2018; 93% for 2019; 90% for 2020-on Increased assistance for “expansion states”</p>
Affordability Credits (Premium Subsidies)	<p>1/1/2014, administered through Exchange</p> <p>Available for non-Medicaid individuals and those not enrolled in affordable ER sponsored coverage with incomes between 100% - 400%FPL Credits act to offset premium expense and to offset cost sharing</p> <p>Sliding scale based on premium paid and income</p>

	<ul style="list-style-type: none"> ○ 100-133% FPL pay no more than 2% of income ○ 133-150% FPL pay between 3% -4% of income ○ 150-200% FPL pay between 4-6.3% of income ○ 200-250% FPL pay between 6.3-8.05% of inc. ○ 250-300% FPL pay between 8.05% -9.5% ○ 300-400% FPL pay 9.5% of income <p>Cost sharing credits on a different sliding scale</p>
Medicare	
Cost Contract Extension	Extends reasonable cost contracts from 1/1/2010 to 1/1/2013 regardless of any other MA plans service the area.
Special Needs Plan Extension	Extends SNP authority through 12/31/2013 SNPs must be approved by NCQA in order to serve targeted populations starting in 2012.
Medicare Advantage Payment Changes	Restructure payments to MA plans by setting payments to different percentages of FFS, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phase-in revised payments over 3 years beginning in 2011 in most areas with payments phased-in over longer periods (4 or 6 years) in certain areas. Cap total payments, including bonuses, at current payment levels.
Part D Coverage Gap (Donut Hole)	1/1/2010 Provide a \$250 rebate to beneficiaries who reach the coverage gap Eliminates the gap by phasing down the coinsurance rate in the coverage gap from 100% to 25%. Phasing begins in 2013 and ends in 2020. Between 2014 and 2019, reduce the OOP amount that qualifies a beneficiary for catastrophic coverage. Require pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the coverage gap beginning in 2011. Provide phased in federal subsidies of the generic drug cost. Phase in starts in 2011 and reaches 75% by 2020.
Part D Premium Subsidy	1/1/2011

	Reduces the Medicare Part D premium subsidy for beneficiaries with high incomes (\$85,000 individual; \$170,000 couples)
Employer Part D Subsidy	1/1/2011 Eliminates the tax deductibility of the federal subsidy for employers who offer qualifying drug coverage to their Part D eligible retirees
Hospital Payment changes	<p><u>Market basket updates</u> Cuts will occur for PPS hospitals starting in 2010 (0.25% reduction in 2010-2011, 0.1% reduction for 2012-2013, 0.3% reduction in 2014, 0.2% reduction in 2015, and 0.75% reduction in 2017-2019) No provision for adjustment if the uninsured rate does not drop</p> <p><u>Value Based Purchasing</u> Expansion of Value Based Purchasing for PPS hospitals funded by withholds across all DRGs on low performing hospitals</p> <p><u>Hospital Acquired Conditions (HAC)</u> 1% cut to top quartile of hospitals for risk adjusted HAC rates.</p> <p><u>Readmission rates</u> Applies to PPS hospitals on or after 10/1/2012 Begins with three conditions (heart attack, heart failure and pneumonia) Cut on all payments to poor performing hospitals Readmission rates will be published on Hospital Compare</p> <p><u>Bundling</u> - Voluntary pilots programs by 1/1/2013 which HHS can expand if they are found to improve quality and reduce costs</p> <p><u>Global Payment</u> – 5 state demo for payment to safety net providers</p>
Physician Payment changes	<p>No SGR fix and <u>no</u> Physician Payment fix in these acts.</p> <p>Value based purchasing - Incentive for Physicians to report; penalty for non-reporting</p> <p>HHS to apply a Value based payment modifier to the physician fee schedule</p> <p>10% bonus for certain E&M codes performed primary care and major surgical procedures performed by rural general surgeons from 2011 to 2015</p>
Home Health Payment Changes	0.1% market basket reduction for home health agencies in 2011-2013
Hospice Payment Changes	0.3% market basket reduction for hospice in 2011-2013 unless the uninsured rate drops less than projected

Geographic Inequities	<p>Value based payment modifier for physicians based on quality of care compared to cost</p> <p>Also provides an additional \$400M in supplemental payments under IPPS to hospitals located in counties in the bottom quartile ranked by risk adjusted spending</p>
Accountable Care Organizations	<p>1/1/2012, providers can be recognized as ACOs and be eligible to share in cost savings above a threshold</p> <p>Includes Part A and Part B services</p> <p>Preference to providers working on ACO with private payers</p>
Medicare DSH payments	<p>Beginning in 2014, reduces Medicare DSH payments by \$22B over ten years.</p> <p>Some redistribution depending on amount of uncompensated care provided</p>
National Oversight	<p><u>Independent Payment Advisory Board</u></p> <p>Establishes a new board and requires board to submit proposal with recommendations for reducing Medicare spending, if per capita growth rates exceed targets, beginning in January 2014</p> <p><u>Center for Medicare and Medicaid Innovation</u></p> <p>Establishes a new center to test payment and service delivery pilots by 1/1/2011</p> <p>Focus on programs to reduce cost while preserving/enhancing quality.</p> <p>Testing may be limited to certain geographic areas and may be expanded nationally without Congressional authorization.</p> <p><u>Federal Coordinated Health Care Office</u></p> <p>Establishes center to improve care coordination for dual eligibles effective March 1, 2010.</p>
Medicaid	
Medicaid Early State Option	<p>States can cover adult \leq 133% FPL starting 4/1/2010</p>
CHIP	<p>Extends reauthorization to September 2015</p> <p>Preserves CHIP program and requires maintenance of eligibility to 2019</p> <p>Provides for a 23% increase in CHIP matching rates for 2016 -2019</p>
Hospital Payment Changes	<p>Medicare Hospital Acquired Conditions nonpayment policy extended to Medicaid effective 7/1/2011</p> <p>Bundling pilots in 8 states by 1/1/2012</p>

Physician Payment Changes	Increases fee for service and Medicaid managed care payments for primary care services by certain providers to no less than 100% of Medicare part B rates in 2013 and 2014. Feds pay 100% of the increased payments.
Medicaid DSH payments	Reduces Medicaid DSH payments by an aggregate \$500M in 2014; \$500M in 2015 and 2016; \$1.8B in 2017; \$5B in 2018; \$5.6B in 2019 and \$4B in 2020. Adds additional requirements as well.
Drug Rebates	Increase in minimum percent rebate on brand drugs to 23.1% AWP and 13% for other drugs Strikes exemption for new formulations of orphan drugs.
Accountable Care Organizations	Pediatric ACO demos beginning 1/1/2010 Providers eligible for incentives based on cost and quality
Medicare	
Hospital Charge Disclosure	All hospitals must publicly disclose annually a list of the hospital's standard charges, including for Medicare DRGs
Tax-Exempt Hospitals	Charitable hospitals limited in what can be charged for emergencies or medically necessary care to the amount generally billed to those who have insurance. New requirements: <ul style="list-style-type: none"> ○ Community needs assessment done and publicly reported at least every 3 years ○ Establish and widely publicize a financial assistance policy ○ Uninsureds can't be charged more than insureds ○ Additional 990 reporting ○ IRS review similar to SEC oversight
Dental	Demonstration program for 15 entities to establish training programs for alternative dental care providers, including DPDH, DT and others
340B Program	Expanded to include children's hospitals, critical access hospitals and others in both outpatient programs; excludes orphan drugs.
Physician Sunshine Act	Beginning 3/31/2011, drug and device manufacturer must report annually on payments and gifts to physicians and teaching hospitals payments over \$10 (or less than \$10 if totals \$100 or more). Other disclosure also required.
Pharmacy Benefit Managers	PBMs must disclose information (mail order vs. retail; price concessions and rebates)

Biogenerics	FDA pathway created with 12 year exclusivity granted with further extensions in certain cases
Workforce	Variety of physician and other provider type workforce initiatives to increase access to care/services for underserved populations
Graduate Medical Education	
Medicare Slot Redistribution	65% of unused residency slots redistributed with focus on primary care and general surgery. Of the pool of redistributed slots, 70% for hospitals in states with low resident to population ratios.
Medicare Counting Time	Time spent in training counted toward direct GME for cost reports on or after 7/1/09 and for IME on or after 10/1/2001, but have to appeal to open settled cost reports. Flexibility in counting time in non-hospital settings toward direct GME and IME effective 7/1/2010.
Wellness	
Employers	Beginning 2011, grants for businesses with 100 employees or less and no existing wellness program Premium discounts or other incentives allowed up to 30% of the cost of employee only coverage for participation in wellness programs
Restaurant Labeling Requirements	Restaurant nutritional content, including calories, disclosure provisions For restaurants that are part of a chain with 20 or more locations
Shared Decision Making	Provisions included around facilitating patient decision aids for preference sensitive care
Legal Considerations	
Anti-trust Exemption Elimination	Not included
Anti-Kickback Intent Standard	“Intent” standard amended to allow that a person can violate anti-kickback without actual knowledge of or specific intent to violate.
False Claims Act	Expanded to include payments made by, through or with the Exchange including federal funds

	Change to permit a person who has independent knowledge that materially adds to the publicly disclosed allegations to serve as an original source.
Fraud and Abuse	Funding for Fraud, Abuse and Control Fund and for the Medicaid Integrity Program
Stark exception	Self-referral disclosure requirement for diagnostic imaging starting 1/1/2010 Medicare self referral disclosure protocol to be developed by 2011
Tort Reform	State demonstration grants for developing and implementing tort litigation alternatives
Other Pay-fors	
Device Tax	1/1/2013 2.3% excise tax on all taxable medical devices (a few exceptions)
Pharmaceutical Industry Fee	2011 Annual fee on branded drug manufacturers, increasing over time \$2.5B in 2011; \$2.8B in 2012-2013; \$3.0B in 2014-2016; \$4.0B in 2017; \$4.1B in 2018; \$2.8B in 2019 and on going.
Taxes on high income individuals	2013 0.9% hospital insurance tax for high wage workers (over \$200,000 single; over \$250,000 married filing jointly) adds a category for married filing singly of \$125,000 Adds 3.8% surtax on the lesser of net investment income or the excess of modified adjusted gross income over \$200,000 single; over \$250,000 married filing jointly or \$125,000 married filing separately

Sources

- H.R. 3590
- H.R. 4872
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- Comparison of Health Reform Legislation – Medicare and Medicaid Improvements, Health Policy Alternatives for ACHP on January 6, 2010
- Summary of Key Medicare Provisions in White House Proposal and House and Senate Health Reform Bills, Kaiser Family Foundation on March 15, 2010
- Side-by-Side Comparison of Major Health Care Reform Proposals, Kaiser Family Foundation on March 22, 2010
- Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under the Patient Protection and Affordable Care Act (issued on 5/13/2010 by Department of the Treasury, Department of Labor and Department of Health and Human Services)
- Interim Final Rules for Early Retiree Reinsurance Program issued on May 5, 2010 by Department of Health and Human Services