

Issue Brief

See Appendix A at the end of this brief for detailed Health Reform Implementation Time Line.

FEDERAL ISSUE BRIEF • MARCH 29, 2010

KEY POINTS

- The bills will extend health coverage to 32 million people.
- Changes in H.R. 4872 include the following.
 - increased tax credits to help people buy insurance by increasing the eligibility levels under Medicaid
 - more federal funding to states for Medicaid, thereby rescinding H.R. 3590's favorable treatment for Nebraska (but still allowing additional monies for Louisiana)
 - closure of the Medicare prescription-drug donut hole for seniors
 - expansion of the Medicare payroll tax for higher-paid Americans

Congress Passes Massive Health Care Reform Using Two Bills

Congress has passed the most sweeping health care reform measures since the enactment of Medicare in 1965 using two separate bills — the Senate's **Patient Protection and Affordable Care Act** (H.R. 3590) from December 2009 and the House's recent **Health Care and Education Affordability Reconciliation Act of 2010** (H.R. 4872). H.R. 4872 modifies several provisions in H.R. 3590. President Obama signed H.R. 3590 into law March 23, and it is now Public Law 111-148. Together, the bills will extend health coverage to 32 million people. The Congressional Budget Office estimates that the legislation will cost approximately \$940 billion throughout 10 years while reducing the federal deficit.

Changes in H.R. 4872 include the following.

- increased tax credits to help people buy insurance by increasing the eligibility levels under Medicaid
- more federal funding to states for Medicaid, thereby rescinding H.R. 3590's favorable treatment for Nebraska (but still allowing additional monies for Louisiana)
- closure of the Medicare prescription-drug donut hole for seniors
- expansion of the Medicare payroll tax for higher-paid Americans. It significantly reduces the Senate's 40 percent excise tax on high cost premiums because of a later effective date and increased thresholds. This reduces the revenue it could have raised to a total of only \$32 billion throughout the decade,

leaving a \$116 billion hole that has been filled by extending the Medicare payroll tax on unearned income for joint filers earning \$250,000 or more and individuals making \$200,000 or more.

According to CBO, the bills will, among other things:

- establish a mandate for most U.S. residents to obtain health insurance
- establish insurance exchanges in which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage
- significantly expand eligibility for Medicaid
- substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law)
- impose an excise tax on insurance plans with relatively high premiums
- make various other changes to the federal tax code, Medicare, Medicaid and other programs.

CHANGES TO H.R. 3590 CONTAINED IN H.R. 4872

The reconciliation bill makes various changes to H.R. 3590. The changes with the largest budgetary effects during the 2010–2019 period include the following.

- increasing the subsidies for premiums and cost sharing that would be offered through the new insurance exchanges

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- increasing the penalties for employers who do not offer health insurance and modifying the penalties for individuals who do not obtain insurance
- changing eligibility for Medicaid in a way that effectively increases the income threshold from 133 percent of the federal poverty level to 138 percent for certain individuals
- increasing the federal share of spending for certain Medicaid beneficiaries
- reducing overall payments to insurance plans under the Medicare Advantage program
- expanding Medicare’s drug benefit by phasing out the “donut hole” in that benefit throughout 10 years
- modifying the design and delaying the implementation of the excise tax on insurance plans with relatively high premiums
- increasing the rate and expanding the scope of a tax that would be charged to higher-income households

nonelderly people who are uninsured by nearly 32 million, leaving nearly 23 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under the legislation, the share of legal nonelderly residents with insurance coverage will rise from the current 83 percent to 94 percent.

Approximately 24 million people will purchase their own coverage through the new insurance exchanges, and there will be roughly 16 million more enrollees in Medicaid and the Children’s Health Insurance Program than the number projected under current law. Relative to currently projected levels, the number of people purchasing individual coverage outside the exchanges will decline by 5 million.

Under the legislation, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges. Approximately 5 million people will obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to 29 million.

EFFECTS OF THE LEGISLATION ON INSURANCE COVERAGE

CBO estimates that by 2019, the combined effect of enacting H.R. 3590 and H.R. 4872 will be to reduce the number of

COSTS

Below are a number of significant cost items as scored by CBO during the next 10 years.

Coverage Provisions

Medicaid & CHIP Expansion Outlays (increased enrollment)	\$434 billion
Exchange Subsidies and Related Spending	\$464 billion
Small Employer Tax Credits	\$40 billion
Penalty Payments by Uninsured Individuals	\$-17 billion*
Penalty Payments by Employers	\$-52 billion*
Excise Tax on High-Premium Insurance Plans	\$-32 billion*
Other Effects on Tax Revenues and Outlays	\$-48 billion*

* Negative amounts reduce the cost to the government.

Outlays

Revision of certain marketbasket updates and incorporation of services productivity improvements into marketbasket updates for providers who do not already incorporate such improvements	\$-156.6 billion
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Savings from the establishment of an Independent Payment Advisory Board	\$-15.5 billion
Savings from changes to Medicare and Medicaid Disproportionate Share payments	\$-36.1 billion
Reductions in Medicare Advantage Plans	\$-135.6 billion
Medicaid Prescription Drug Coverage	\$-38.1 billion
Payment Adjustments to Home Health	\$-39.7 billion
Community Living Assistance Services and Supports	\$-70.2 billion

COMMENT

It is necessary to review the interactions of both bills simultaneously to understand the changes being made. At this stage, there is not a single codified document reflecting the two bills. As of this writing, H.R. 4872 has not been signed by President Obama and has not been assigned a public law number.

There has been much debate, confusion and uncertainty about health care reform. Many changes are still several years away, and it should come as no surprise to find many changes being made in the years ahead.

One thing, however, seems certain, and that is a need to reduce and control overall federal spending on Medicare and Medicaid.

IMPLEMENTATION TIME FRAMES

The following time lines reflect the effective dates of various provisions. The list is not all inclusive but identifies major issues. Some items are repeated in different years because portions of changes have different effective dates.

2010

Medicare Providers

Hospital Inpatient and Outpatient Marketbasket Rates of Increase –

Reduces the marketbasket rates of increases as follows. Updates, especially when coupled with a productivity adjustment that is applicable in later years, can result in payments being less than in the previous year.

- Fiscal Year 2010-2011 marketbasket update reduced by 0.25 percent
- FY 2012-2013 marketbasket update reduced by 0.10 percent
- FY 2014 marketbasket update reduced by 0.30 percent
- FY 2015-2016 marketbasket update reduced by 0.20 percent
- FY 2017-2019 marketbasket update reduced by 0.75 percent

Inpatient Rehabilitation Facilities

Marketbasket Rates of Increase –

Reduces the marketbasket rates of increases as follows. Updates can result in payments being less than in the previous year.

- FY 2010-2011 marketbasket update reduced by 0.25 percent
- FY 2012-2013 marketbasket update reduced by 0.10 percent
- FY 2014 marketbasket update reduced by 0.30 percent
- FY 2015-2016 marketbasket update reduced by 0.20 percent
- FY 2017-2019 marketbasket update reduced by 0.75 percent

Long-Term Care Hospitals (LTCHs)

Marketbasket Rates of Increase –

Reduces the marketbasket rates of increases as follows. Updates can result in payments being less than in the previous year.

- Rate year 2010 marketbasket update reduced by 0.25 percent
- Rate year 2011 marketbasket update reduced by 0.50 percent
- Rate years 2012-2013 marketbasket update reduced by 0.10 percent

- Rate year 2014 marketbasket update reduced by 0.30 percent
- Rate years 2015-2016 marketbasket update reduced by 0.20 percent
- Rate years 2017-2019 marketbasket update reduced by 0.75 percent

MMSEA section 114(c) and (d) are extended for one year.

COMMENT

Changes made to marketbasket updates as previously noted are effective April 2010.

Home Health – Establishes a provider-specific cap of 10 percent of revenues that may be reimbursed from outlier payments, and provides for a 3 percent add-on payment for rural agencies, from April 1, 2010, to Jan. 1, 2016.

Outpatient Therapy – Extends the outpatient therapy caps exceptions process through Dec. 31, 2010.

Extends Payment Protections for Rural Providers – Extends Medicare payment protections to small rural hospitals, including hospital outpatient services, laboratory services and facilities that have a low volume of Medicare patients but play an important role in their communities.

Imaging – Physicians must disclose ownership interest in imaging equipment to their patients.

Medicare/Other

Cracking Down on Health Care Fraud – Requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system by adding \$250 million throughout 10 years.

Physician Self-Referral (Specialty Hospitals) – Prohibits new/expanded physician ownership in hospitals, grandfathered physician-owned hospitals in operation as of Dec. 31, 2010.

Medicare Part D (Prescription Drug Benefit) – Provides a \$250 rebate for

Part D enrollees who exceed the donut hole in 2010.

Strengthening the Quality

Infrastructure – Provides additional resources to U.S. Department of Health & Human Services to develop a national quality strategy and support quality measure development and endorsement for the Medicare, Medicaid and CHIP quality improvement programs.

Medicaid

Medicaid Prescription Drug Coverage – Increases the Medicaid drug rebate from 15.1 percent to 23.1 percent of the average manufacturers price, increases the drug rebate for generic drugs from 11 percent to 13 percent and extends the drug rebate to include Medicaid managed care organizations.

Insurance Changes

Immediate Access to Insurance for Uninsured Individuals With a Pre-Existing Condition – Provides eligible individuals access to coverage that does not impose any coverage exclusions for pre-existing health conditions. This provision ends when exchanges are operational, effective 90 days from enactment.

Eliminating Pre-Existing Condition Exclusions for Children – Bars health insurance companies from imposing pre-existing condition exclusions on children's coverage, effective six months from enactment.

Prohibiting Rescissions — Prohibits abusive practices whereby health insurance companies rescind existing health insurance policies when a person gets sick as a way to avoid covering the costs of enrollee's health care needs, effective six months from enactment.

Eliminating Lifetime Limits and Restricting Use of Annual Limits – Prohibits lifetime limits on benefits in all group health plans and in the individual

continued

market; prohibits the use of restrictive annual limits, effective six months from enactment.

Covering Preventive Health Services – All new group health plans and plans in the individual market must provide first dollar coverage for preventive services, effective six months from enactment.

Extending Dependent Coverage – Requires any group health plan or plan in the individual market that provides dependent coverage for children to continue to make that coverage available up to age 26, effective six months after enactment.

Bringing Down the Cost of Health Care Coverage – Health plans, including grandfathered plans, must annually report on the share of premium dollars spent on medical care and provide consumer rebates for medical loss ratios in excess of 85 percent.

Reducing the Cost of Covering Early Retirees – Creates a new temporary reinsurance program to help companies that provide early retiree health benefits for those ages 55-64 to offset the expensive cost of that coverage.

Improving Consumer Assistance – Requires that any new group health plan or new plan in the individual market implement an effective appeals process for coverage determinations and claims.

Tax and Revenue Provisions

Small Business Tax Credit – Initiates the first phase of the small business tax credit for qualified small employers for contributions to purchase health insurance for employees. The credit covers as much as 35 percent of the employer's contribution to provide health insurance for employees. Small nonprofit organizations can receive a credit that does not exceed 25 percent.

Special Deduction for Blue Cross Blue Shield – Requires that nonprofit BCBS

organizations have a medical loss ratio of 85 percent or higher to take advantage of the special tax benefits provided to them under Internal Revenue Code Section 833, including the deduction for 25 percent of claims and expenses and 100 percent of unearned premium reserves.

Nonprofit Hospitals – Establishes new requirements applicable to nonprofit hospitals beginning in 2010, including conducting community needs assessments every three years; implements a financial assistance policy; limits charges to certain patients to amounts generally billed to insured patients; and follows certain debt collection practices.

Tax Relief for Health Professionals With State Loan Repayment – Excludes from gross income payments made under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after Dec. 31, 2008.

Other

Strengthening Community Health Centers and the Primary Care Workforce – Provides funds to build new and expand existing community health centers; expands funding for scholarships and loan repayments for primary care practitioners working in underserved areas.

Encouraging Investment in New Therapies – Authorizes a two-year temporary credit subject to an overall cap of \$1 billion, to encourage investments in new therapies to prevent, diagnose and treat acute and chronic diseases. The credit would be available for qualifying investments made in 2009 and 2010.

Establishing a Patient-Centered Outcomes Research Institute – Establishes a private, nonprofit institute to

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identify national priorities and provide for research to compare the effectiveness of health treatments and strategies.

Ensuring Medicaid Flexibility for States

– Creates a new option allowing states to cover parents and childless adults up to 133 percent of the federal poverty level and to receive the current law’s Federal Medical Assistance Percentage.

2011

Medicare Providers

Ambulatory Surgical Centers – Full productivity adjustment incorporated into annual update, and HHS will submit a value-based purchasing program plan to Congress by Jan. 1, 2011.

Clinical Laboratory Services – Payments reduced 1.75 percent from 2011-2015.

Durable Medical Equipment – Productivity adjustment incorporated into the annual update.

Home Health – Marketbasket update reduced 1 percent for 2011-2013, and HHS will submit a value-based purchasing implementation program to Congress by Oct. 1, 2011.

Imaging – Increases the utilization rate assumption for calculating the payment for advanced imaging equipment from 50 percent to 75 percent.

Medicare/Other

Improving Health Care Quality and Efficiency – Establishes a new Centers for Medicare & Medicaid Innovation to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals.

Transitioning to Reformed Payments in Medicare Advantage – Freezes 2011 Medicare Advantage payment benchmarks at 2010 levels to begin transition. Reduces

Medicare Advantage benchmarks in subsequent years relative to current levels. Benchmarks will vary from 95 percent of Medicare spending in high-cost areas to 115 percent of Medicare spending in low-cost areas. Changes are phased-in through a three, five or seven year period, depending on the level of payment reductions.

Discounts in the Part D “Donut Hole”

– Provides a 50 percent discount on all brand-name drugs in the donut hole and begins phasing in additional discounts on brand-name and generic drugs to completely close the donut hole by 2020 for all Part D enrollees.

Increasing Training Support for Primary Care – Establishes a Graduate Medical Education policy allowing unused training slots to be re-distributed for purposes of increasing primary care training at other sites.

Improving Preventive Health Coverage – Provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries, and requires new plans to cover preventive services with little to no cost sharing. Creates incentives for state Medicaid programs to cover evidence-based preventive services with no cost-sharing, and requires coverage of tobacco cessation services for pregnant women.

Improving Transitional Care for Medicare Beneficiaries – Establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries.

Expanding Primary Care, Nursing and Public Health Workforce – Increases access to primary care by adjusting the Medicare Graduate Medical Education program. Primary care and nurse training programs also are expanded to increase the size of the primary care and nursing workforce.

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Medicaid

Increasing Access to Home and Community-Based Services – The new Community First Choice Option, which allows states to offer home and community-based services to disabled individuals through Medicaid rather than institutional care, takes effect Oct. 1, 2011.

Insurance Changes

Improving Consumer Assistance – Requires the HHS Secretary to award grants to states to establish health insurance consumer assistance or ombudsman programs that receive and respond to inquiries and complaints on health insurance coverage.

Tax and Revenue Provisions

Reporting Health Coverage Costs on Form W-2 – Requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

Standardizing the Definition of Qualified Medical Expenses – Conforms the definition of qualified medical expenses for health savings accounts, flexible savings accounts, and health retirement accounts to the definition used for the itemized deduction. An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.

Increasing Additional Tax for Withdrawals From Health Savings Accounts and Archer Medical Savings Account Funds for Nonqualified Medical Expenses – Increases the additional tax for HSA withdrawals before age 65 that are not used for qualified medical expenses from 10 percent to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses will increase from 15 percent to 20 percent.

Cafeteria Plan Changes – Creates a

Simple Cafeteria Plan to provide a vehicle in which small businesses can provide tax-free benefits to their employees.

Pharmaceutical Manufacturers Fee – Imposes an annual, nondeductible fee on the pharmaceutical manufacturing industry allocated according to market share and not applying to companies with sales of branded pharmaceuticals of \$5 million or less 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.

2012

Medicare Providers

Hospitals (Inpatient and Outpatient) – Full productivity reduction applies to annual update.

Skilled Nursing Facilities – Productivity adjustment incorporated into annual update, HHS will develop and submit a value-based purchasing implementation program to Congress by Oct. 1, 2011; implementation of the RUG-IV classification system may not occur before Oct. 1, 2011.

Long-Term Care Hospitals – Productivity adjustment incorporated into annual update.

End Stage Renal Disease – Productivity adjustment incorporated into annual update; GAO to study the effects of including specified oral drugs in the bundled ESRD PPS on Medicare beneficiary access to high-quality dialysis services

Inpatient Rehabilitation Facilities – Productivity adjustment incorporated into annual update.

Medicare/Other

Encouraging Integrated Health Systems – Implements physician payment reforms that enhance payment for primary care services and encourage physicians to join

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together to form “accountable care organizations” to gain efficiencies and improve quality.

Linking Payment to Quality

Outcomes – Establishes a hospital value-based purchasing program to incentivize enhanced quality outcomes for acute care hospitals. Also, requires the HHS Secretary to submit a plan to Congress by 2012 on how to move home health and nursing home providers into a value-based purchasing payment system.

Reducing Avoidable Hospital

Readmissions – Directs the CMS to track hospital readmission rates for certain high-volume or high-cost conditions and uses new financial incentives to encourage hospitals to undertake reforms needed to reduce preventable readmissions, which will improve care for beneficiaries and rein in unnecessary health care spending.

2013

Medicare Providers

Hospital Inpatient – Inpatient hospital value-based purchasing program would transition from pay-for-reporting to pay-for-performance; reduced payments to hospitals with high readmission rates begins. Under this program, a percentage of hospital payments would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care.

Hospice – FY 2013-2019 marketbasket update reduced 0.3 percent; productivity adjustment incorporated into annual update; and HHS, in consultation with MedPAC, to revise the payment system.

Encouraging Provider Collaboration – Establishes a national pilot program on payment bundling to encourage hospitals, doctors and post-acute care providers to work together to achieve savings for Medicare through increased collaboration and improved coordination of patient care.

Insurance Changes

Administrative Simplification – Health plans must adopt and implement uniform standards and business rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.

Tax and Revenue Provisions

Limiting Health Flexible Savings

Account Contributions – Limits the amount of contributions to health FSAs to \$2,500 per year, indexed by Consumer Price Index for subsequent years.

Eliminating Deduction for Employer

Part D Subsidy – Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

Increasing Threshold for Claiming Itemized Deduction for Medical

Expenses – Increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 to 10 percent. Individuals 65 and older would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

Additional Hospital Insurance Tax for High Wage Workers

– Increases the hospital insurance tax rate by 0.9 percentage points on an individual taxpayer earning more than \$200,000 (\$250,000 for married filing jointly); and expands the taxable base to include net investment income in the case of taxpayers earning more than \$200,000 (\$250,000 for joint returns).

Medical Device Excise Tax – Establishes a 2.9 percent excise tax on the first sale for use of a medical device. Excepted from the tax are Class I devices, eye glasses, contact lenses, hearing aids and any device that is generally purchased by the public at retail for individual use.

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Limiting Executive Compensation

– Limits the deductibility of executive compensation under Section 162(m) for insurance providers if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements. The deduction is limited to \$500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services, for or on behalf of, a covered health insurance provider. This provision is effective beginning in 2013 with respect to services performed after 2009.

2014

Medicare Providers

Quality Reporting for Certain Providers

– Places certain providers – including ambulatory surgical centers, long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, prospective payment system-exempt cancer hospitals and hospice providers – on a path toward value-based purchasing by requiring the Secretary of HHS to implement quality measure reporting programs in these areas and also to pilot test value-based purchasing for each of these providers in subsequent years (See the following).

Home Health – Directs HHS to rebase payments, with a four-year transition with payment reductions limited to 3.5 percent annually

Hospice – Establishes quality reporting program with a 2 percent penalty for failing to report.

Long-Term Care Hospitals – Establishes quality reporting program with a 2 percent penalty for failing to report.

Inpatient Rehabilitation Facilities – Establishes quality reporting program with a 2 percent penalty for failing to report.

Medicare DSH Payments – Reduces Medicare DSH payments as the number of uninsured patients is reduced.

Medicare Advantage – Requires an 85 percent Medical Loss Ratio for MA plans (failure to achieve will result in a rebate paid to HHS).

Medicaid

Increasing Access to Medicaid – Medicaid eligibility will increase to 133 percent of poverty for all nonelderly individuals to ensure that people obtain affordable health care in the most efficient, appropriate manner. States will receive increased federal funding to cover these new populations; strikes the provision for a permanent 100 percent federal matching rate for Nebraska for the Medicaid costs of newly eligible individuals. Provides federal Medicaid matching payments for the costs of services to newly eligible individuals at the following rates in all states except expansion states.

- 100 percent in 2014, 2015 and 2016
- 95 percent in 2017
- 94 percent in 2018
- 93 percent in 2019
- 90 percent thereafter

Insurance Changes *(2014 is the real start of expanding coverage)*

Establishing Health Insurance

Exchanges – Opens health insurance exchanges in each state to individuals and small employers. This new venue will enable people to comparison shop for standardized health packages. It facilitates enrollment and administers tax credits so that people of all incomes can obtain affordable coverage.

Reforming Health Insurance

Regulations – Implements strong health insurance reforms that prohibit insurance companies from engaging in discriminatory practices that enable them to refuse to sell or renew policies due to

an individual's health status. Health plans can no longer exclude coverage for treatments based on pre-existing health conditions. It also limits the ability of insurance companies to charge higher rates because of health status, gender or other factors. Premiums can vary only based on age (no more than 3:1), geography, family size and tobacco use.

Eliminating Annual Limits – Prohibits health plans from imposing annual limits on the amount of coverage an individual may receive.

Ensuring Coverage for Individuals Participating in Clinical Trials – Prohibits new health plans from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial; Applies to all clinical trials that treat cancer or other life-threatening diseases.

Ensuring Choice Through a Multistate Option – Provides a choice of coverage through a multistate plan, available from nationwide health plans under the supervision of the Office of Personnel Management.

Tax and Revenue Provisions

Promoting Individual Responsibility – Requires most individuals to obtain acceptable health insurance coverage or pay a penalty of \$95 for 2014, \$325 for 2015, \$695 for 2016 (or, as much as 2.5 percent of income in 2016), with a cap of the national average bronze plan premium. Families will pay half the amount for children, with a cap of \$2,250 per family. After 2016, dollar amounts are indexed. If affordable coverage is not available to an individual, they will not be penalized.

Promoting Employer Responsibility – Requires employers with 50 or more employees who do not offer coverage to their employees to pay \$2,000 annually for each full-time employee over the

first 30 as long as one of their employees receives a tax credit. Precludes waiting periods more than 90 days to become eligible for care. Requires employers who offer coverage but whose employees receive tax credits to pay \$3,000 for each worker receiving a tax credit to a maximum aggregate cap of \$2000 per full-time employee.

Providing Health Care Tax Credits – Makes premium tax credits available through the exchange to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty who are not eligible for or offered other acceptable coverage. Credits apply to both premiums and cost-sharing to ensure that no family faces bankruptcy because of medical expenses.

Ensuring Choice Through Free Choice Vouchers – Workers who qualify for an affordability exemption to the individual responsibility policy but do not qualify for tax credits can take their employer contribution and join an exchange plan.

Small Business Tax Credit – Continues the second phase of the small business tax credit for qualified small employers.

Health Insurance Provider Fee – Imposes an annual, nondeductible fee on the health insurance sector allocated across the industry according to market share. The fee does not apply to companies whose net premiums are \$25 million or less.

2015

Medicare Providers

Hospital Inpatient – Hospitals in the top 25th percentile of rates of hospital-acquired conditions for certain high-cost and common conditions would be subject to a payment penalty.

Home Health – Productivity adjustment incorporated into annual update.

continued

Continuing Innovation and Lower Health Costs – Establishes an Independent Payment Advisory Board to develop and submit proposals to Congress and the private sector aimed at extending the solvency of Medicare, lowering health care costs, improving health outcomes for patients, promoting quality and efficiency, and expanding access to evidence-based care. Commission proposals will be automatically implemented unless Congress acts in opposition.

Paying Physicians Based on Value, Not Volume – Creates a physician value-based payment program to promote increased quality of care for Medicare beneficiaries.

2016

Medicare Providers

Hospice – Pilot testing for value-based purchasing to occur no later than Jan. 1, 2016.

Long-Term Care Hospitals – Pilot testing for value-based purchasing to occur no later than Jan. 1, 2016.

Inpatient Rehabilitation Facilities – Pilot testing for value-based purchasing to occur no later than Jan. 1, 2016.

2018

Tax and Revenue Provisions

Excise Tax – Excise tax on high cost (Cadillac) employer-provided health plans becomes effective. Tax is on the cost of coverage in excess of \$27,500 (family coverage) and \$10,200 (single coverage), increased to \$30,950 (family) and \$11,850 (single) for retirees and employees in high-risk professions. The dollar thresholds are indexed with inflation, and employers with higher costs because of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.

*Analysis provided for MHA
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Appendix A

Health Reform Implementation Time Line

President Obama signed comprehensive health reform into law March 23. This time line of key provisions contained in the health reform law incorporates modifications included in reconciliation “fixes.” The majority of health insurance-related provisions would begin Jan. 1, 2014.

IMPLEMENTATION DATE	PROVISION
Jan. 1, 2010	<ul style="list-style-type: none"> • Modify definition of qualified medical expenses for taxable years beginning after Dec. 31, 2009 • Imaging self-referral sunshine • Expansion of 340b drug program
July 1, 2010	<ul style="list-style-type: none"> • 10 percent tax on indoor tanning services
Dec. 31, 2010	<ul style="list-style-type: none"> • Limitation on Medicare exception to the prohibition of certain physician referrals for hospitals • Extend Recovery Audit Contractor program to Medicare Parts C and D, as well as Medicaid
2010	<ul style="list-style-type: none"> • Increase Medicaid rebate percentage for brand-name drugs from 15.1 percent to 23.1 percent • Increase Medicaid rebate for generic drugs to 13 percent of average manufacturer’s price • Extend Medicaid rebates to managed care organizations • Marketbasket minus 0.25 percent for long-term care hospitals • New requirements applicable to not-for-profit hospitals apply for taxable years beginning after enactment of the act.
2010-2011	<ul style="list-style-type: none"> • Marketbasket minus 0.25 percent for inpatient and outpatient hospitals, inpatient psych and IRFs
2010-2013	<ul style="list-style-type: none"> • Phase I small business tax credit available
2010-2015	<ul style="list-style-type: none"> • Home health rural add-on payment
Jan. 1, 2011	<ul style="list-style-type: none"> • Increase utilization rate assumption for advanced imaging equipment to 75 percent • Pharmaceutical manufacturer excise tax • Transition to new Medicare Advantage benchmarks (Phase in until 2013, when benchmarks are based on plan bids.) • Part D drug discount program (50 percent discount on brand-name drugs for those in coverage gap) • Full productivity adjustment for ASCs, DME and clinical labs • Medical loss ratio floor of 85 percent for large group market and 80 percent for individual/small group market • Employer W-2 reporting of value of health benefits • Increase tax on nonqualified health savings account distributions to 20 percent for tax years starting after Dec. 31, 2010 • Changes in cafeteria plans for small employers for taxable years beginning after Dec. 31, 2010 • States given option to begin covering nonelderly, nonpregnant adults through Medicaid. • Establish CMS Innovation Center • 10 percent bonus for primary care/general surgery codes for five years (50 percent funded by reduction in other codes) • Eliminate deduction for expenses allocated to Medicare Part D subsidy for tax years after Dec. 31, 2010 • Provider-specific annual cap of 10 percent of revenues on home health agency outlier reimbursements • Physician payment sunshine
April 1, 2011	<ul style="list-style-type: none"> • Excise tax applies to tax-exempt hospital failures to meet hospital exemption requirements occurring after the date of the enactment of the act.
July 1, 2011	<ul style="list-style-type: none"> • Prohibit federal payments to states for Medicaid services related to health care-acquired conditions

IMPLEMENTATION DATE	PROVISION
September 30, 2011	<ul style="list-style-type: none"> • Extension of authority to conduct gainsharing demonstration
October 1, 2011	<ul style="list-style-type: none"> • Increase access to home and community-based services for disabled individuals • Implementation of RUG-IV for skilled nursing facilities • Due date for Medicare home health and SNF value-based purchasing plan for consideration
2011	<ul style="list-style-type: none"> • Increase training support for primary care; expand primary care, nursing and public health workforce • Expand Round Two of DME competitive bidding program to 100 largest MSAs • Marketbasket minus 0.5 percent for LTCHs
2011-2013	<ul style="list-style-type: none"> • Marketbasket minus 1 percent for home health
2011-2015	<ul style="list-style-type: none"> • Clinical lab fee schedule reduction by 1.75 percent
2011-2019	<ul style="list-style-type: none"> • Freeze current income thresholds for income-related premium for Medicare Part B
Jan. 1, 2012	<ul style="list-style-type: none"> • Full productivity adjustments for inpt. and outpt. hospitals, inpatient psych, IRFs, LTCHs, nursing homes and ESRD • Medicaid bundled payment demo in as many as eight states • Require utilization management to reduce waste in dispensing meds in LTC facilities • Corporate information reporting requirements for tax years beginning after Dec. 31, 2011 • Allow Medicare Advantage plans to grandfather extra benefits for current enrollees in certain areas • Transitional benefits for current MA enrollees that experience significant reduction in extra benefits • Eligible accountable care organizations can qualify for incentive bonus.
April 1, 2012	<ul style="list-style-type: none"> • Not-for-profit hospitals must perform community health needs assessment every three years, effective with taxable years beginning after March 31, 2012.
October 1, 2012	<ul style="list-style-type: none"> • Congress should authorize a program for collection of user fees for follow on biologics
2012-2013	<ul style="list-style-type: none"> • Marketbasket minus 0.1 percent for inpt. and outpt. hospitals, inpatient psych, IRFs and LTCHs
Jan. 1, 2013	<ul style="list-style-type: none"> • Repeal business deduction for federal subsidies for certain retiree prescription drug plans for tax years after Dec. 31, 2012 • Limit flexible spending in cafeteria plans to \$2,500 per year for tax years starting after Dec. 31, 2012 • Medical device manufacturer excise tax • Medicare Advantage benchmarks based on plan bids and bonus payments for meeting benchmarks • Full productivity adjustment for hospice providers • Increase in the income threshold for itemized deductions for medical expenses from 7.5 percent to 10 percent • Increase the hospital insurance tax rate to 3.8 percent on investment income or earnings more than \$200,000 (\$250,000 for couples) • Increase utilization rate assumption for advanced imaging equipment from 65 percent to 70 percent • Health plans must implement uniform standards and rules for administrative simplification. • National voluntary pilot program on payment bundling • Hospital readmissions above certain threshold subject to payment penalties
2013	<ul style="list-style-type: none"> • Value-based purchasing programs for physicians, hospitals and ambulatory surgical centers
2013-2015	<ul style="list-style-type: none"> • Extend funding of Children's Health Insurance Program from 2013 to 2015

IMPLEMENTATION DATE	PROVISION
2013-2019	<ul style="list-style-type: none"> • Marketbasket minus 0.3 percent for hospice
Jan. 1, 2014	<ul style="list-style-type: none"> • Marketbasket minus 0.3 percent for inpt. and outpt. hospitals, inpatient psych, IRFs and LTCHs • Annual health insurance provider fee • Insurance reform in individual market – compliance with changes in rating rules and benefit options • Insurance reform in the small group market – up to five-year phase in beginning Jan. 1, 2014 • Individual insurance coverage mandate and phase in of excise taxes for those without insurance • Employer fee for employees receiving affordability credits • Affordability tax credits for individuals and families between 100 and 400 percent of poverty • Cost sharing subsidies for individuals and families between 100 and 200 percent of poverty • Free choice vouchers for certain workers to use employer contribution to join an exchange plan • Office of Personnel Management contracts with private plans with at least two multistate plans (one not-for-profit) in each state exchange. • Congressional employees required to purchase coverage through exchange • Phase II small business tax credit begins with tax years ending after Dec. 31, 2013 • Medical loss ratio floor calculated based on average ratio of premium costs and total premium revenue for previous three years • Prohibit insurers from imposing annual limits • Establish 133 percent of poverty as new mandatory minimum Medicaid eligibility level for all nonelderly • 100 percent FMAP assistance to states for newly eligible Medicaid beneficiaries • Permit all hospitals that participate in Medicaid to make presumptive eligibility determinations • Rescind funds available in the Medicaid Improvement Fund for FY 2014-2018 • States receive 0.23 percent increase in CHIP match rate, subject to cap of 100 percent (continues until FY 2019). • Rebasing home health payments (phased in until CY 2017) • Quality reporting for LTCHs, IRFs, PPS-exempt cancer hospitals and hospice • Elimination of 2014 add-on payment for DME
Jan. 15, 2014	<ul style="list-style-type: none"> • Medicare commission proposal to reduce excess cost growth by 0.5 percent with higher target in future years
Jan. 1, 2015	<ul style="list-style-type: none"> • Marketbasket minus 0.2 percent for inpt. and outpt. hospitals, inpatient psych, IRFs and LTCHs • Hospitals in top quartile of national hospital-acquired condition rates receive 99 percent of Medicare pay • Full productivity adjustment for home health providers • States must allow small businesses, with as many as 100 employees, to purchase coverage through exchange
Jan. 1, 2016	<ul style="list-style-type: none"> • Marketbasket minus 0.2 percent for inpt. and outpt. hospitals, inpatient psychs, IRFs and LTCHs • Health care choice compacts allowed to take effect.
Jan. 1, 2017	<ul style="list-style-type: none"> • 95 percent FMAP assistance to states for newly eligible (as of 2014) Medicaid beneficiaries • Marketbasket minus 0.75 percent for inpt. and outpt. hospitals, inpatient psych, IRFs and LTCHs • States may allow businesses with more than 100 employees to purchase coverage through exchange.
Jan. 1, 2018	<ul style="list-style-type: none"> • High cost insurance excise tax for taxable years beginning after Dec. 31, 2017 • 94 percent FMAP assistance to states for newly eligible (as of 2014) Medicaid beneficiaries • Marketbasket minus 0.75 percent for inpt. and outpt. hospitals, inpatient psych, IRFs and LTCHs
Jan. 1, 2019	<ul style="list-style-type: none"> • 93 percent FMAP assistance to states for newly eligible (as of 2014) Medicaid beneficiaries • Marketbasket minus 0.75 percent for inpt. and outpt. hospitals, inpatient psych, IRFs and LTCHs
Jan. 1, 2020	<ul style="list-style-type: none"> • 90 percent FMAP assistance to states for newly eligible (as of 2014) Medicaid beneficiaries