

President Signs Health Care Reform

Highlights

- ✓ Employer mandate for health insurance
- ✓ Small employer tax credit
- ✓ Individual mandate for health insurance
- ✓ Tax on high-cost insurance
- ✓ Insurance market reforms
- ✓ Medicare payments and quality outcomes
- ✓ Expansion of Medicaid eligibility
- ✓ Value-based purchasing for Medicare providers
- ✓ Medicare and Medicaid program integrity improvements
- ✓ Impact of the Health Care and Education Act

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President Obama, on March 23, 2010, signed the massive health care reform package approved by the House on March 21, 2010. In a series of votes, the House passed both 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 Reconciliation Act). The Affordable Care Act had been approved by the Senate on December 24, 2009. The Reconciliation Act serves as a “sidecar” bill to move changes made by the House to the Affordable Care Act to the Senate under the budget reconciliation rules that require only 51 votes to pass in the Senate, rather than a super-majority of 60 votes. The Reconciliation Act would strike out or modify a number of provisions in the Senate’s Patient Protection Act to which the House objected.

The Senate is expected to shortly take up the “sidecar” Reconciliation Act, and Senate Democrats have the goal of sending a final package to the White House before its scheduled April recess begins on March 29.

Employers

Employer responsibility. Employers are not required to provide health insurance coverage under the Affordable Care Act. However, automatic enrollment in health insurance plans sponsored by large employers is mandated.

In addition, “large employers” (generally those with 50 or more employees) that fail to offer minimum essential coverage during any month for which a full-time employee has enrolled in a qualified plan and receives a premium assistance tax credit or cost-sharing reductions will be liable for an additional tax. That penalty will equal the product of the applicable payment amount (defined as, with respect to any month, 1/12 of \$750) and the number of full-time employees employed by the employer during such month.

Large employers offering coverage to employees who qualify for premium assistance tax credits or cost-sharing reductions also will be liable for an additional tax equal to the product of the number of full-time employees for the month and 400 percent of the applicable payment amount. Large employers with extended enrollment waiting periods (generally those exceeding 90 days) will be liable for an additional tax of \$600 for each full-time employee for whom the extended waiting period applies. Special rules would apply to construction employers.

Comment: *The Reconciliation Act would improve the transition to the employer responsibility policy for employers with 50 or more full-time equivalent workers by subtracting the first 30 full time employees from the payment calculation (e.g., a firm with 51 workers that does not offer coverage will*

Core Concepts

The core concepts that have emerged in the Affordable Care Act will fundamentally alter the health care landscape for individuals and employers.

- All individuals will be required to obtain health care coverage or pay penalties. Employer-provided coverage will generally satisfy the universal-coverage requirement. Lower-income individuals will receive a credit or voucher to help pay for health insurance.
- Employers currently offering health insurance can elect to continue offering coverage as long as their plans meet certain acceptable minimum requirements. Employers electing not to offer qualifying coverage will be subject to additional taxes to help finance the health care coverage for their employees. Exceptions will be made for small business.

pay an amount equal to 51 minus 30, or 21 times the applicable per employee payment amount). The provision would also change the applicable payment amount for firms with more than 50 full-time workers that do not offer coverage up to \$2,000 per full-time employee. It would also eliminate the assessment for workers in a waiting period, while maintaining the 90-day limit on the length of any waiting period beginning in 2014.

Treatment of small businesses. A small employer credit is provided in the Affordable Care Act. Starting in 2010, qualified small businesses will be eligible for tax credits up to 35 percent. The credit will reach 50 percent by 2014. Salary-reduction contributions are not counted. A qualified small employer has 25 or fewer employees and pays average annual wages of \$40,000 or less. The amount of the credit is reduced for employers with 10 to 25 employees and average annual wages of \$20,000 to \$40,000 per employee. The wage threshold is indexed for inflation beginning in 2014. Tax-exempt employers would receive a 35 percent credit.

Comment: *Qualified small businesses will be able to purchase insurance for their employees through state-based web portals to be known as Small Business Health*

Options Programs (SHOP). These programs would allow small businesses to pool together to spread their financial risk.

Comment: *Generally, small employers will be required to contribute at least 50 percent of the total premium cost.*

Information returns. Employers and other entities providing minimum essential coverage will be required to file information returns with the IRS identifying the individual, the coverage and the amount of premium, if any, paid by the individual. Penalties will be imposed for failure to file an information return.

Flexible spending arrangements. Flexible spending arrangements (FSAs) contributions are capped at \$2,500 (indexed for inflation). The use of FSA funds for over-the-counter medications is not allowed. These changes apply to distributions and reimbursements for taxable years beginning after December 31, 2010.

Comment: *The Reconciliation Act would delay the implementation of the limitations on FSAs until December 31, 2012. To prevent an end-run around the new FSA restrictions using cafeteria plan rules, the Affordable Care Act provides that, if a benefit is available under a cafeteria plan through employer provided contributions to a health FSA, the benefit will not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to the arrangement.*

Health savings accounts. Individuals under age 65 must pay an additional tax for nonqualified distributions from a health savings account (HSA) and increases the additional tax from 10 percent to 20 percent. (The additional tax on Archer medical savings accounts would increase from 15 to 20 percent.)

Cafeteria plans. The cafeteria plan rules are relaxed under the Affordable Care Act to encourage more small employers to offer tax-free benefits to employees, including those related to health insurance coverage. A safe harbor is carved out from the nondiscrimination requirements for cafeteria plans for qualified small employers.

Executive compensation. Code Sec. 162(m) is amended by the Affordable Care Act as it applies to remuneration paid by health insurance providers to high-level executives. If only 35 percent of the plans providing premium income to the insurer meet coverage requirements under the Act, no Code Sec. 162(m)

deduction will be allowed to the extent the remuneration exceeds \$500,000, with a special provision for deferred compensation.

Individuals

Health insurance exchanges. For individuals who are not currently covered by their employer (and some small businesses), a new Health Insurance Exchanges is established in which consumers can comparison shop among health plans.

Individual responsibility. Individuals will be required under the Affordable Care Act to maintain minimum essential coverage beginning after 2013. Individuals who fail to maintain minimum essential coverage will be liable for a penalty. A formula is used to calculate the penalty taking into account the taxpayer's household income and a flat dollar amount. Generally, the penalty will start at \$95 for 2014, \$495 for 2015 and \$750 for 2016 (with indexing for inflation for tax years after 2016).

Individuals with Medicare and other qualified government coverage will also satisfy the minimum essential coverage requirement.

Qualified individuals will be provided with premium assistance tax credits and have reduced cost sharing. The amount of the premium assistance tax credit will be tied to the relation of the individual's income to the federal poverty limit and will be adjusted for inflation. Generally, individuals who fall within 100 percent to 400 percent of the federal poverty limit will be eligible for premium assistance. Premium assistance tax credits will be disregarded for federal or federally-assisted programs.

Certain exclusions from the individual minimum coverage requirement are provided. Those exclude include undocumented individuals in the U.S. from coverage and provides special rules for children under age 18 and incarcerated individuals. Additionally, individuals who cannot afford coverage (generally where the individual's required contribution would exceed eight percent of household income for the taxable year), individuals with taxable income under 100 percent of the federal poverty limit, qualified members of Native American tribes, and certain hardship cases would be exempt.

Comment: *The Reconciliation Act would modify the assessment that individuals who choose to remain uninsured pay in three ways: (a) exempts income below the filing threshold, (b) lowers the flat payment from \$495 to \$325 in 2015 and from \$750 to \$695 in 2016 and (c) raises the percent of income that is an alternative payment amount from 0.5 to 1.0% in 2014, 1.0 to*

2.0% in 2015, and 2.0 to 2.5% for 2016 and subsequent years to make the assessment more progressive.

Comment: *The financing for premiums and cost sharing for individuals with incomes up to 400% of the federal poverty level would also change under the Reconciliation Act. The Act improves tax credits to make premiums more affordable as a percent of income; and improves support for cost sharing, focusing on those with incomes below 250% of the federal poverty level. Starting in 2019, the Act constrains the growth in tax credits if premiums are growing faster than the consumer price index, unless spending is more than 10% below current Congressional Budget Office projections.*

Funding Mechanisms

Both a (1) new tax on high-cost group insurance and (2) an additional Medicare payroll tax on high-income taxpayers are imposed by the Affordable Care Act. Annual nondeductible fees on various health-related industries are also imposed, as well as a 10 percent tax on the amount paid for indoor tanning services.

Tax on high-cost insurance. A 40 percent nonrefundable excise tax is imposed by the Affordable Care Act on group insurers if the aggregate value of applicable employer-sponsored health coverage exceeds an inflation-adjusted \$23,000 for family coverage (\$8,500 for individual coverage) beginning in 2013. Designed principally to limit so-called "Cadillac plans," the excise tax for these high-end policies would be imposed pro rata on issuers. For self-insured plans, the plan administrator (including employers that act as plan administrators) would pay the excise tax. Transition relief would be available for coverage in 17 high-cost states for 2013, 2014, and 2015. The excise tax is estimated to generate approximately \$200 billion over ten years. Penalties would apply for failure to properly calculate the excess benefit, barring certain exceptions.

Comment: *The Reconciliation Act would modify the amount of coverage from \$23,000 to \$27,500 for family coverage and from \$8,500 to \$10,200 for individual coverage. The application of the excise tax would be delay from 2013 to 2018 to give plans "time to implement and realize the cost savings of reform." Because of this delay, however, the Reconciliation Act eliminates the three-year transition relief that had been available in the Affordable Care Act for coverage in the 17 high-cost states.*

Additional Medicare tax. There is an additional 0.9 percent Medicare payroll tax on individual earned income over \$200,000 (\$250,000 for joint filers). Self-employed individuals are also liable for the additional tax. The payroll tax is projected to raise \$53 billion in additional revenue over ten years.

Comment: *The Reconciliation Act would modify the Medicare tax to include net investment income in the taxable base. The tax on net investment income would not apply if modified adjusted gross income is less than \$250,000 in the case of a joint return, or \$200,000 in the case of a single return. Net investment income would consist of interest, dividends, royalties, rents, gross income from trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business). Net investment income would be reduced by properly allocable deductions to such income.*

Market Reforms

For plan years beginning on or after January 1, 2014, new requirements include the following:

- elimination of preexisting condition exclusions;
- premium rating allowed by individual or family coverage, geographic area, age (limited to a 3-1 ratio), and tobacco use (limited to a 1.5-1 ratio);
- guaranteed issue and renewability; and
- blanket prohibition against discrimination because of health status.

Benefit explanations. Group health plans are required to provide accurate summaries of benefits and coverage information that do not exceed four pages in length, and utilize terminology understandable by the average enrollee. The Department of Health and Human Services will have one year from enactment to develop standards for the summary, and benefit plans would have one year after that to provide the new summaries to participants.

Medicare and Medicaid

The Affordable Care Act adds several provisions related to the link between quality outcomes and payments under Medicare. It also adjusts reimbursement for most types of Medicare providers to improve payment accuracy. It adjusts Medicare Advantage payments to be more in line with Medicare fee-for-service payments. The Affordable Care Act makes a variety of changes in Medicare Part

D, including an attempt to close the “donut hole” for prescription drug coverage.

The Affordable Care Act expands both access to Medicaid, as well as the types of services that are covered under Medicaid, including preventive services and long-term care. Additional revenue is allocated for specific maternal and child health services.

Provisions to increase the program integrity of both Medicare and Medicaid are also included. Below are highlights of the Medicare and Medicaid portions of the Act.

Medicare

Value-based purchasing. The Affordable Care Act establishes a value-based purchasing (VBP) program for hospitals starting 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. The Secretary of HHS will be required to develop a VBP plan by 2012 on moving skilled nursing facilities and home health agencies into a value-based purchasing payment system. By 2016, VBP pilot programs should be implemented for psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals, and hospice programs.

Quality reporting. The Secretary of HHS will be required to develop quality measure reporting programs for long-term care hospitals, rehabilitation hospitals, hospice programs, and PPS-exempt cancer hospitals.

Hospital-acquired conditions. 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.

Key Offsets

To help finance health care reform, the Affordable Care Act includes:

- a 40 percent excise tax on high-dollar insurance plans to begin in 2013, which would be delayed until 2018 under the Reconciliation Act;
- an increase in Medicare payroll taxes starting in 2013 on taxpayers in the \$200,000 plus income category (\$250,000 for joint filers); and
- new fees on certain health-related industries.

Readmissions reduction. Beginning in fiscal year 2012, CMS will adjust payments paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of preventable Medicare readmissions for acute myocardial infarction, heart failure, and pneumonia patients.

Ambulatory surgical centers. The Affordable Care Act calls for the development of a plan to implement a value-based purchasing program for payments under the Medicare program for ambulatory surgical centers.

Medicare payments for frontier states. 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.

Comment: According to the Congressional Budget Office, five states qualify as frontier states: Montana, North Dakota, South Dakota, Utah and Wyoming.

Rural healthcare. The Affordable Care Act extends several existing statutes related to improving Medicare payments to providers in rural areas. The existing "hold harmless" provisions relating to adjustments that offset the effect of the outpatient prospective payment system on rural hospitals and sole community hospitals with more than 100 beds will be extended through the end of fiscal year 2010. The Rural community Hospital Demonstration Program and the Medicare-dependent hospital program will both be extended. The temporary adjustment to inpatient payments to low-volume hospitals will extend through FY 2012.

Payment accuracy. Home health payments will be rebased starting in 2013 based on an analysis of the current mix of services and intensity of care provided to home health patients. Hospice claim forms and cost reports will have to be updated by 2011. The Secretary of HHS will be required to regularly review the physician fee schedule for services paid by Medicare, with a particular emphasis on services that have experienced high growth rates. The legislation modifies the equipment utilization factor for advanced imaging services. It also extends hospital wage index reclassifications through the end of FY 2010.

Independent Medicare Advisory Board. This board will be required to present Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. The Board's proposals will automatically take effect unless Congress approves legislation with similar savings.

Medicare Part B

Part B payments. The floor on geographic adjustments to the work portion of the physician fee schedule is extended to the end of 2010. The exceptions process for Medicare therapy caps is extended to December 31, 2010. The following items are also extended: payments for the technical component of certain physician pathology services; bonus payments for ambulance services in rural areas; and the physician fee schedule mental health add-on. The payment rate for certified nurse midwives for covered services is extended to the full rate that a physician would receive for performing the same service.

Comment: The Reconciliation Act would set the assumed utilization rate at 75 percent for the practice expense portion of advanced diagnostic imaging services.

Comment: The Senate bill as introduced included a provision to replace the scheduled 21 percent payment reduction under the physician fee schedule for 2010 with a 0.5 percent increase. This provision was removed before the Senate took its final vote. However, the physician pay cut was delayed until March 1, 2010, under a provision included in the defense appropriations bill for 2010, and again delayed until March 31, 2010, under a provision of the Temporary Extension Act of 2010.

Physician quality reporting initiative. The PQRI program, which provides financial incentives to physicians who report quality data to CMS, will be extended through 2014. The Secretary of HHS also will be required to develop and implement a system that will adjust Medicare physician payments based on the quality and cost of the care they deliver.

Prevention services. The Affordable Care Act provides coverage, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. It also will waive beneficiary coinsurance requirements for most preventive services.

Comment: A report cited by the Senate Finance Committee noted that elderly patients are price-sensitive and that a \$10 co-payment increase led to a 20 percent decline in physician office visits.

Part B premiums. For beneficiaries who pay a higher Part B premium, income thresholds are frozen at 2010 levels until 2019.

Medicare Part C

Payments. The Affordable Care Act sets Medicare Advantage payments based on the average of the bids from MA plans in each market, rather than on a statutorily set benchmark rate.

Comment: *Using plan bids to set MA plan rates will encourage plans to compete more directly on the basis of price and quality rather than on the level of extra benefits offered to enrollees. Further, since plan bids are usually lower than benchmark rates, this change will provide cost savings to the Medicare program.*

Comment: *The Reconciliation Act would freeze Medicare Advantage payments in 2011. Beginning in 2012, Medicare Advantage benchmarks would be reduced relative to their current levels. Benchmarks would vary from 95 percent of Medicare spending in high-cost areas to 115 percent of Medicare spending in low-cost areas. The phase-in period of these changes would depend on the level of payment reductions. An incentive system would be created to increase payments to high-quality plans by at least 5 percent, and would also extend CMS authority to adjust risk scores in Medicare Advantage for observed differences in coding patterns relative to fee-for-service.*

Benefit protection. MA plans will be prohibited from charging beneficiaries cost sharing that is greater than what is charged under Medicare fee-for-service.

Annual enrollment. The annual enrollment periods for beneficiaries will be simplified; MA enrollees will be allowed to disenroll and return to fee-for-service Medicare each year from January 1 to March 15.

Special needs plans. MA special needs plans for dual eligible, frail individuals will be extended through 2013.

Savings on administrative costs. The Reconciliation Act would require Medicare Advantage plans to spend at least 85 percent of revenue on medical costs or activities that improve quality of care, rather than profit and overhead.

Medicare Part D

“Donut hole” fix. Drug manufacturers are required to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. The initial coverage limit in the standard Part D benefit will be increased by \$500 for 2010.

Comment: *The Reconciliation Act would change the date from July 1, 2010 to 2011 on which drug manufacturers*

would be required to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap. Drug manufacturers would further be required to provide a 75 percent discount on brand-name and generic drugs by 2020. All Part D enrollees who enter the donut hole in 2010 would receive a \$250 rebate.

Comment: *The donut hole was put in place when Medicare Part D was created in 2003. Its purpose was political, not practical. Congress had to make the legislation that enacted Medicare Part D budget neutral and requiring a large “gap” in prescription drug coverage, where the government paid nothing and the beneficiary shouldered the entire cost of prescription drugs, was one of the ways that the legislation could pass scrutiny by the Congressional Budget Office.*

Part D premium subsidy and cost sharing. Part D premium subsidy for beneficiaries with incomes above the Part B income threshold is removed. Cost sharing for beneficiaries receiving care under a home- and community-based waiver is eliminated. Several changes are made in the determination of the low-income subsidy.

Medicaid

Expanded eligibility. States will have the option starting in 2014 to expand Medicaid eligibility to non-elderly, 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 can provide more home- and community-based services through a state plan amendment rather than a waiver. The current state option to provide certain diagnostic and preventive services will be expanded to include specific clinical preventive services and immunizations.

Comment: States that provide additional preventive services and vaccines will receive an increased federal medical assistance percentage of one percentage point for these services.

Comment: In the case of expansion state, the state share of the costs of covering non-pregnant childless adults would be reduced under the Reconciliation Act by 50 percent in 2014, 60 percent in 2015, 70 percent in 2016, and 80 percent in 2017. In 2019 and thereafter, expansion states would bear the same state share of the costs of covering non-pregnant childless adults as non-expansion states (e.g. 7 percent in 2019, 10 percent thereafter).

Prescription drug rebate. The flat rebate for single source and innovator multiple source outpatient prescription drugs will increase from 15.1 percent to 23.1 percent. The basic rebate for multi-source, non-innovator drugs will increase from 11 percent to 13 percent.

DSH payments. A state's disproportionate share hospital allotment will be reduced by 50 percent once its rate of uninsurance decreases by 45 percent.

Health care quality. The Secretary of HHS will be required to develop a set of quality measures for Medicaid eligible adults that is similar to the quality measures under CHIP. The Secretary also will be required to develop a list of healthcare-acquired conditions for which Medicaid will not reimburse providers.

Comment: The definition of healthcare-acquired condition under Medicaid will be similar to the existing definition of hospital-acquired condition under Medicare, but the Medicaid definition will not be limited to conditions acquired in a hospital.

Medicare and Medicaid

Dual eligibles. The Secretary of HHS will establish a federal Coordinated Health Care Office responsible for better coordinating health care for individuals who are eligible for both Medicare and Medicaid.

Center for Medicare and Medicaid Innovation. The Affordable Care Act will establish within CMS a new Center for Medicare and Medicaid Innovation responsible for research, development, testing, and implementation of innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to Medicare and Medicaid patients.

Accountable Care Organizations. ACOs comprised of groups of health care providers that meet designated quality of care targets and reduce the cost of their

patients health care spending will be rewarded with a share of the Medicare savings they achieve.

Medicare demonstration projects. Several demonstration projects relate to Medicare, including projects:

- to test a payment incentive and service delivery system that uses physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes;
- to extend the gainsharing demonstration project aimed at evaluating arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries;
- to improve the demonstration project designed to allow rural health care providers to test new models for the delivery of health care;
- to allow patients who are eligible for hospice care to receive all other Medicare covered services at the same time;
- to increase graduate nurse education training;
- to implement a national independent monitoring program to conduct oversight of interstate and large intrastate nursing home chains;
- to conduct facility-based projects on culture change and the use of information technology in nursing homes;
- to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries;
- to test the impact of direct payments for certain complex laboratory tests.

Medicaid demonstration projects. The demonstration projects related to Medicaid, include projects:

- to allow states to adjust their current pay structure for safety net hospitals from a fee-for-service model to a global capitated payment structure;
- to study the use of bundled payments for hospital and physician services;
- to allow qualified pediatric providers to receive payments as accountable health organizations
- to establish a Medicaid emergency psychiatric demonstration project;
- to develop a comprehensive model for reducing childhood obesity;
- to provide access to comprehensive health care services to the uninsured at reduced fees.

Program Integrity

Program integrity. Physician-owned hospitals that do not have a provider agreement prior to February 1, 2010, are

prohibited from participating in Medicare. Drug, medical device, biological, and medical supply manufacturers are required to report transfers of value made to any physician, medical practice, group practice, or teaching hospital.

Nursing home integrity. Skilled nursing facilities and nursing homes are required to disclose specific ownership information. The Secretary of HHS is required to modify cost reports for SNFs to require reporting of expenditures on wages and benefits for direct care staff.

Civil money penalties. Civil money penalties are reduced by 50 percent for certain facilities that self-report and promptly correct deficiencies within 10 calendar days of imposition.

Provider screening. Screening and disclosure requirements apply to providers and suppliers participating in Medicare, Medicaid, and CHIP.

National fraud and abuse data collection. HHS is required to maintain a national health care fraud and abuse data collection program for reporting specific adverse actions taken against health care providers, suppliers, and practitioners. The Healthcare Integrity and Protection Databank is terminated and its information transferred to the National Practitioner Data Bank.

Claims submission. Beginning January 2010, the maximum period for submission of Medicare claims is reduced to not more than 12 months.

Expansion of RAC program. The recovery audit contractor program is expanded to state Medicaid programs.

Prevention

National council and public health fund. A national council consisting of representatives from the departments of HHS, Agriculture, Education, Labor, Transportation and others, is charged with establishing a national prevention and health promotion strategy. It also establishes a prevention and public health investment fund to provide national investment in prevention and public health programs to improve health and restrain the rate of growth in health care spending.

Clinical preventive services. The Affordable Care Act authorizes a grant program for the development of school-based health clinics. It establishes an oral healthcare prevention education program.

Chronic disease. The Affordable Care Act provides for the award of grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. The Centers for Disease Control and Prevention will provide grants

to states and local health departments to conduct pilot programs on the 55-to-64 year old population to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease receive clinical treatment to reduce risk.

Nutrition labeling on menus. Restaurants that are part of chains of 20 or more restaurants will be required to disclose calories on the menu board and, in written form, available to customers upon request, additional nutritional information.

Healthcare Workforce

National healthcare workforce commission.

This commission would be charged with providing comprehensive, unbiased information to Congress and the President on how to align federal healthcare resources with national needs. States would be eligible for grants to develop a healthcare workforce at the local level.

Student loan programs. The Affordable Care Act modifies existing federally supported student loan programs for medical students; increases loan amounts and updates the years for nursing schools to establish and maintain student loan funds; establishes a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services in underserved areas; offers loan repayment for public health students who work for at least three years at a federal, state, local, or tribal public health agency; and offers loan repayment for allied health professionals employed at public health agencies in underserved areas.

Training. The Affordable Care Act provides for training in family medicine, general internal medicine, general pediatrics, and physician assistantship. Funding also is provided to establish new training opportunities for direct care workers providing long-term care. The legislation authorizes funding for geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools and family caregivers. It also provides grants for mental and behavioral health education; advanced nursing education; nurse training and retention; and community health workforce promotion.

Comment: *As noted above, the legislation directs more federal funding toward primary care and preventive services, while expanding the number of people who will have health insurance from public or private sources.*

More primary care providers – doctors, nurses, physician assistants, etc. – are necessary to make sure that there are adequate resources for providing basic primary and preventive care.

Miscellaneous Provisions

Biologics Price Competition and Innovation Act. The Secretary of HHS will be required to establish a process to license a biological product that is biosimilar to or interchangeable with a licensed biologic product.

Community Living Assistance. The Affordable Care Act establishes a national voluntary insurance program for purchasing community living assistance services and support, i.e., long-term care assistance.

Indian healthcare. Cost sharing for Indians enrolled in a qualified health benefit plan obtained through an Exchange is prohibited. The Affordable Care Act also authorizes appropriations for the Indian Health Care Improvement Act for 2010 and beyond. The text of S. 1790, the “Indian Health Care Improvement Reauthorization and Extension Act of 2009” is incorporated. Among other things, this legislation requires a federal health care program to accept an Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization entity as a provider eligible to receive payment under the program for services furnished to an Indian on the same basis as any other qualified provider.

Demonstration projects. The Affordable Care Act includes several demonstration projects relating to public health, preventive services, tort reform, and other health care issues, including projects:

- to give grants to academic institutions to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals’ clinical education;
- to provide at-risk populations who utilize community health centers with a comprehensive risk-factor assessment and an individualized wellness plan designed to reduce risk factors for preventable conditions;
- to award grants to establish training programs for alternative dental health care providers to increase dental health services in underserved areas;
- to provide aid and supportive services to low-income individuals for health care education and training, in particular for occupations that are likely to experience labor shortages;
- to develop alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.

Studies. A number of federal agencies are required to conduct studies on different aspects of the Medicare and Medicaid programs, including:

- an HHS study on whether certain urban hospitals should qualify for the Medicare dependent hospital program;
- a MedPAC study on the adequacy of Medicare payments for health care providers serving in rural areas;
- an HHS study whether existing cancer hospitals that are exempt from the inpatient prospective payment system have costs under the outpatient prospective payment system (OPPS) that exceed costs of other hospitals, and to make an appropriate payment adjustment under OPPS based on that analysis;
- an HHS study on the need for additional Medicare payments for certain urban Medicare-dependent hospitals paid under the inpatient prospective payment system;
- an HHS OIG study comparing prescription drug prices paid under the Medicare Part D program to those paid under state Medicaid programs;
- a Government Accountability Office study on the utilization of and payment for Medicare covered preventive services, the use of health information technology in coordinating such services, and whether there are barriers to the utilization of such services;
- a GAO study and report to Congress on coverage of vaccines under Medicare Part D and the impact on access to those vaccines;
- a GAO study on the Five-Star Quality Rating System for nursing homes which would include an analysis of the systems implementation and any potential improvements to the system.

Reconciliation Act Changes

Impact of Reconciliation Act. Other changes to the Patient Protection and Affordable Care Act by the Reconciliation Act (H.R. 4872) would include the following:

- extend the prohibition of lifetime limits and prohibition on rescissions to grandfathered plans;
- place limitations on excessive waiting periods;
- extend the requirement of coverage for non-dependent children up to age 27 to all existing health insurance plans starting six months after enactment;
- for grandfathered group health plans, prohibit pre-existing condition exclusions in 2014, restrict annual limits beginning six months after enactment, and prohibits them starting in 2014. For coverage of non-dependent children prior to 2014, the requirement on

- grandfathered group health plans would be limited to those adult children without an employer offer of coverage;
- repeal the underlying 340B expansion to inpatient drugs and exemptions to GPO exclusion. Exempts orphan drugs from required discounts for new 340B entities;
 - increase mandatory funding for community health centers to \$11 billion over five years (FY 2011 – FY 2015);
 - require Federal Medicaid matching payments be made for the costs of services to newly eligible individuals at the following rates in all state except expansion state. 100 percent in 2014, 2015, and 2016; 95 percent in 2017; 94 percent in 2018; 93 percent in 2019; and 90 percent thereafter;
 - reduce federal Medicaid DSH payments from \$18.1 billion to \$14.1 billion and the reductions would begin in fiscal year 2014;
 - apply new requirements to community mental health centers that provide Medicare partial hospitalization services in order to prevent fraud and abuse;
 - streamline procedures to conduct Medicare prepayment reviews to facilitate additional reviews designed to reduce fraud and abuse;
 - authorize the Secretary of Treasury to share IRS data with HHS employees to help screen and identify fraudulent providers with tax debts, and to help recover such debts;
 - increase funding for the Health Care Fraud and Abuse Control Fund by \$250 million over the next decade;
 - require a 90-day period to withhold payment and conduct enhanced oversight in cases where the HHS Secretary identifies a significant risk of fraud among DME suppliers.

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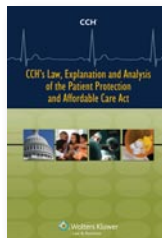
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