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## House Passes Legislation that will Fundamentally Transform America's Health Care System

Yesterday, the House of Representatives passed two pieces of legislation that will fundamentally transform America's health care system. First, it passed the Senate's Patient Protection and Affordable Care Act (H.R. 3590), a comprehensive reform bill that will go to the president for his signature. Second, it passed the Health Care & Education Affordability Reconciliation Act (H.R. 4872). This second bill makes some amendments to the underlying bill and must now be considered by the Senate. Together, the provisions in these bills will impact providers, insurers, employers, individuals, states and localities.

Generally, this legislative package makes incremental changes to the health insurance marketplace in order to expand coverage. By 2014, an individual requirement to have health insurance coverage will go into place. The legislation includes insurance market reforms with national rules administered at the state level; subsidies for low-income individuals who do not have workplace coverage to purchase coverage; Medicaid expansion; and employer responsibilities to offer coverage or potentially pay a penalty if any of their full-time workers are eligible for, and receive, insurance subsidies. The bills raises significant new revenues – through new taxes, efficiencies and spending cuts (particularly to Medicare Advantage) – in order to finance an anticipated 15 million additional Americans receiving Medicaid coverage and 15 million receiving subsidies to purchase private health insurance coverage.

The following is a roadmap and brief summary of the various changes, based on the dates of implementation. We will be providing more information over the next few weeks summarizing the various requirements of this new law.

### 2010

**Insurance Reforms:** Extends the prohibition of lifetime limits, prohibitions on rescissions, limitations on excessive waiting periods, and a requirement to provide coverage for non-dependent children up to age 26 to all existing health insurance plans starting six months after enactment. Prior to 2014, the requirement on group health plans for coverage of non-dependent children is limited to those adult children without an employer offer of coverage.

**Restriction on Annual Limits:** Restricts annual limits for group health plans six months after enactment.

**False Claims Act:** Narrows the application of the False Claims Act's public disclosure bar.

**Small Employer Tax Credit:** The legislation provides a sliding scale tax credit to small employers with fewer than 25 employees and average.

## 2011

**Fee on Manufacturers and Importers of Branded Drugs:** \$2.5 billion for 2011; \$3.0 billion per year for 2012-2016; \$3.5 billion for 2017; \$4.2 billion for 2018; and \$2.8 billion thereafter.

**Physician Ownership Referral:** Physician ownership of hospitals to which they self-refer is prohibited. There is a limited exception to the growth restrictions for grandfathered physician owned hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).

**Enhanced Oversight for Initial Claims of DME Suppliers:** Requires 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.

**Funding to Fight Waste, Fraud and Abuse:** Increases funding for the Health Care Fraud and Abuse Control Fund by \$250 million over 10 years. Indexes funds to fight Medicaid fraud based on the increase in the CPI.

**Market Basket and Productivity Adjustments:** With varying effective dates, reduces annual market basket for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers. Also includes productivity adjustments.

## 2012

**Medicare Advantage (MA):** MA payments are frozen for 2011. Beginning in 2012, a new system of blended benchmarks will be phased-in. Payments will be linked to county benchmarks, but they will vary based on the county's fee-for-service costs. Bonuses will be available to high-performing plans. The changes in the combined Senate bill and reconciliation package represent.

## 2013

**FSA Limits:** Limits health FSA arrangements to \$2,500; indexed to CPI-U after 2013.

**Medical Device Tax:** 2.9 percent excise tax on manufacturers and importers of certain medical devices.

**Elimination of Deduction for Part D Subsidy:** The House Reconciliation legislation delays the elimination of this deduction by two years (the Senate bill eliminated it in 2011).

**Broadening of Medicare Hospital Insurance Tax Base:** Imposes additional surtax of 0.9 percent on earned income in excess of \$200,000/\$250,000 (unindexed) and a 3.8 percent surtax on investment income for taxpayers with AGI in excess of \$200,000/\$250,000 (unindexed).

**Medicaid Reimbursements to Primary Care Physicians:** Requires that Medicaid payment rates to primary care physicians for furnishing primary care services to be no less than 100 percent of Medicare payment rates in 2013 and 2014. Provides 100 percent federal funding for the incremental costs to states of meeting this requirement.

**2014**

**Health Insurance Exchanges:** States must establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses. Qualified individuals (individuals who are not incarcerated and who are lawfully residing in a state) can enroll in a qualified health plan through a State Exchange. Small employers can offer a choice of plans to their employees through the Exchange.

**Individual Obligation:** Other than individuals who meet a hardship exemption, individuals will be required to carry eligible health coverage. The House reconciliation bill modifies the penalty for not having health insurance from \$750 or 2 percent of income to \$695 or 2.5 percent of income.

**Employer Obligation:** Employers with 50 or more employees face a number of coverage obligations under the combined legislation. Those that do not provide health coverage would be assessed \$2,000 for each full-time employee in its workforce. These employers would not be assessed a penalty for the first 30 full-time employees. Employers that provide coverage that is deemed unaffordable would be assessed \$3,000 for each full-time employee who obtains a premium credit in a health insurance exchange. Mitigating these obligations, employers would be permitted to have waiting periods of up to 90 days without being subject to penalties. Furthermore, part-time employees would be considered solely for the purpose of calculating if an employer has the 50 or more employees (by adding together full time employees and full-time equivalents) that subject the employer to coverage responsibility requirements. Penalties, however, would be assessed only on behalf of full-time employees who work 30 or more hours per week.

**Annual Fee on Health Insurance Providers:** \$8 billion in 2014; \$11.3 billion in 2015 and 2016; \$13.9 billion in 2017; \$14.3 billion in 2018; and indexed to medical cost growth thereafter.

**Pre-existing condition exclusions:** Prohibits pre-existing condition exclusions for group health plans.

**Prohibition on Annual Limits:** Prohibits annual limits for group health plans.

**Medicare DSH Cuts:** Reductions in Medicare DSH payments begin, rather than a 2015 implementation in the Senate bill. DSH payments are initially reduced by 75 percent and then subsequently increased based on the size of the uninsured population and the amount of uncompensated care.

**Medicaid DSH Cuts:** Reductions in DSH allotments by \$0.5 billion in 2014, \$.6 billion in 2015, \$0.6 billion in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020.

**2015**

**IPAB:** Establishes an Independent Payment Advisory Board (IPAB), charged with recommending reductions in Medicare spending. Congress must either adopt the IPAB's proposed cuts or pass an alternative with equivalent savings. The IPAB will first propose cuts in 2014 for implementation in 2015.

**2016**

**Interstate Health Choice Compacts:** Under these compacts, qualified health plans could be offered in all participating States, but insurers would still be subject to the consumer protection laws of the purchaser's state.

**2017**

**Large Employer Participation in Exchanges:** States may allow large employers to offer coverage to their employees through the Exchanges.

**2018**

**High premium excise tax:** 40 percent excise tax on health coverage in excess of \$10,200/\$27,500 and increased thresholds of \$1,650/\$3,540 for over age 55 retirees or certain high-risk professions, both indexed for inflation by CPI-U plus one percent; adjustment based on age and gender profile of employees; vision and dental excluded from excise tax

**2019/2020**

**Indexing of Premium Subsidies:** In order to make coverage more affordable, the House reconciliation bill increases subsidies offered in the exchanges. To slow the growth of these premium subsidies, beginning in 2019, the indexing of these subsidies is adjusted if premiums are growing faster than CPI.

**Indexing of High Premium Tax Thresholds:** Beginning in 2020, the thresholds for the high premium tax will be reindexed to the general rate of inflation.

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