Senate Research Office
AT ISSUE
Special Federal Healthcare Edition 1 State of Georgia May 2010

An Overview of the Major Provisions of Federal Health Care Reform

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On March 23, 2010, President Barack Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act. Shortly thereafter, on March 30, the President signed H.R. 4872, the Health Care and Education Reconciliation Act of 2010, which amended and added to the provisions of H.R. 3590. The enactment of these two bills completed an arduous legislative process in Congress and ushered in one of the most sweeping developments to U.S. domestic policy in recent history. The primary intention of these reforms is to provide health care coverage to an additional 32 million Americans via an expansion of public programs and market reforms, but they also include numerous other health care related measures. Listed below are the major provisions of the legislation that was ultimately enacted (hereinafter referred to as "the Act"). Subsequent briefs will explore these provisions in greater detail.

Individual Mandates

Beginning in 2014, most individuals will be required to have health insurance. Those who do not have coverage will be charged an annual financial penalty, to be phased in over three years as follows:

- In 2014, the penalty will be $95 per person or one percent of household income, whichever is greater.

- In 2015, the penalty will be increased to the greater of $325 per person or two percent of household income.
- By 2016, the penalty will be the greater of $695 per person or 2.5 percent of income (up to a maximum of $2,085 per family).

Exceptions to the individual mandate include persons given a waiver for financial hardship or religious objections, Indian tribe members, persons who have been uninsured for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost health plan exceeds eight percent of their income, and individuals who have income below the tax filing threshold. It is also worth noting that the Act expressly prohibits the federal government from prosecuting persons who fail to pay an imposed penalty or from placing a lien on or levying a taxpayer's property for nonpayment of a penalty.

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Medicaid and CHIP

The Act expands Medicaid in all states to cover all individuals under the age of 65 with incomes up to 133 percent of the federal poverty level (FPL) based on modified adjusted gross income, effective 2014. The Act also requires Medicaid coverage for former foster children under the age of 26. As with current law, undocumented immigrants are ineligible for Medicaid.

Beginning in 2014, the federal government will provide 100 percent funding for the costs of newly eligible individuals for three years, after which the federal funding will gradually decline to 90 percent for 2020 and subsequent years.

States that already extend Medicaid eligibility to adults with incomes up to 100 percent of the FPL (known as "expansion states") will see increased federal funding for the coverage of these individuals. In 2014, the expansion states' share for the costs of covering nonpregnant, childless adults will be reduced by 50 percent; by 2018, their costs will be reduced by 90 percent. By 2019, expansion states will receive the same federal financing as other states.

The Act also requires states to maintain their current levels of income eligibility for children in Medicaid and in the Children's Health Insurance Program (CHIP) until 2019. The Act also extends CHIP funding through 2015. Beginning in 2015, states will receive a 23 percent point increase in the CHIP match rate up to a cap of 100 percent. The CHIP benefit and cost-sharing rules will continue as under current law.

Year	Federal Match
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020	90%

Health Insurance Exchanges

To make the purchasing of insurance more affordable and accessible, the Act creates two different state-based exchanges. The American Health Benefit Exchange will allow U.S. citizens and legal immigrants who do not receive employer-based insurance or who do not qualify for public assistance to purchase an individual policy, beginning in 2014. The Small Business Health Options Program (SHOP) Exchange will allow small businesses with up to 100 employees to purchase coverage beginning in 2014, with states having the option of allowing businesses with more than 100 employees to purchase coverage through the SHOP exchange beginning in 2017. Plans sold through an exchange must meet certain requirements, and insurers are to offer four levels of coverage that vary based on premiums, out-of-pocket expenses, and benefits beyond the minimum required plus a catastrophic coverage plan.

The Office of Personnel Management is to contract with private insurers to offer at least two multi-state plans in each exchange, including at least one offered by a non-profit organization. Additionally, federal funding will be available to establish non-profit, member-run health insurance Co-Ops in each state.

Persons with incomes between 133 to 400 percent of the FPL will be eligible to receive premiums subsidies to help them purchase coverage through an exchange. The subsidies will be on a sliding scale. Such persons may also be able to receive cost-sharing subsidies to limit out-of-pocket spending.

Temporary Programs Prior to the Exchange

To assist individuals with pre-existing conditions that make insurance prohibitively expensive, the Act establishes a temporary national high-risk pool. (Effective 90 days after enactment.) To be eligible, an individual must be a U.S. citizen or legal immigrant with a pre-existing condition who has been uninsured for at least six months. Premiums for the pool will be established for a standard population and may vary by no more than a four to one ratio

due to age. The national high-risk pool will end in 2014, when individuals with pre-existing conditions will be able to buy insurance through an exchange.

Another temporary program designed to bridge the gap until the exchanges begin to operate is a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days after enactment) Employer-sponsored plans that provide such coverage may apply to the U.S. Department of Health and Human Services to participate in the program. If approved, these employer sponsored plans will receive reimbursement for up to 80 percent of costs for health benefits between $15,000 and $90,000. This program ends in 2014, when such early retirees will be able to purchase coverage through an exchange.

New Rules for Health Insurers

The Act also imposes several new requirements on private insurers, including prohibiting several practices that have been commonplace in the insurance industry such as lifetime limits on coverage; this prohibition will go into effect within six months after enactment. Moreover, by 2014, the use of annual limits will be prohibited as well. In addition, effective six months from the enactment of this legislation, health insurers are prohibited from denying coverage to children based on a preexisting condition; in 2014, this prohibition will apply to all persons. Insurers will also be barred from rescinding coverage except for cases of fraud.

Other notable requirements for health insurers include, but are not limited to, the following:

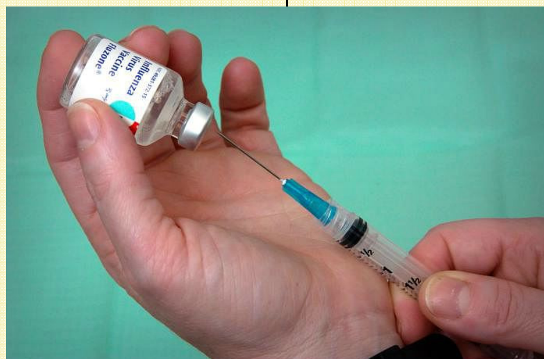
- New insurance plans are required to cover preventative services, with no out-of-pocket cost to the patient, effective six months after enactment. In 2018, this requirement will apply to all plans.
- The Act requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs. Insurers that do not meet certain thresholds for spending premium dollars on medical services must provide rebates to policy holders. (Effective Date: January 1, 2011)
- Effective six months from enactment, insurers must allow adult children to remain on their parent's policy up to their 26th birthday, regardless of the child's marital status.
- The Act establishes a process for reviewing increases in health plan premiums and requires plans to justify any increases. (Effective beginning plan year 2010)

Employer Requirements

While the Act technically does not have an employer mandate, it establishes a "pay or play" system in which employers with more than 50 employees must offer coverage to their employees or pay fees for employees who receive federal subsidies for health insurance. Beginning in 2014, employers with more than 50 employees who do not offer health insurance and who have at least one employee receiving a premium credit through an Exchange will be assessed a fee of $2,000 per full-time employee (not counting the employer's first 30 employees). Employers that do offer coverage but have at least one employee receiving a

premium credit through an Exchange must pay the lesser of $3,000 for each employee who receives a premium credit or $2,000 for each full-time employee. Employers who offer coverage will be required to provide a voucher to employees with incomes below 400 percent of the FPL and whose share of the premium cost is greater than eight percent but less than 9.8 percent of the employee's income. The voucher is to be equal to what the employer would have paid for the employee's coverage under the employer's plan. The voucher is to be used to purchase insurance through an Exchange.

Employers with more than 200 employees will be required to automatically enroll employees into the employer's lowest cost premium plan, unless the employees sign up for coverage on their own or opt out of coverage.



Medicare
The Act includes many provisions that will affect seniors on Medicare. Among the most notable, the Act will close the Medicare Part D coverage gap (known as the Medicare prescription drug donut hole) by 2020. In the meantime, beginning 2010, Medicare beneficiaries who hit the donut hole will receive a $250 rebate. In 2011, seniors who are in the donut hole will receive a 50 percent discount on brand name drugs. Other provisions related to consumer costs under Medicare include eliminating co-payments for preventative services and exempts preventative services from deductibles under the Medicare program (beginning in 2011) and providing for full-benefit dual eligible beneficiaries receiving home and community-based care services to have the same Part D cost-sharing equal to those who receive institutional care (Effective 2012).

Prevention and Wellness
Many of the Act's provisions seek to promote preventative services and wellness programs. In addition to eliminating cost-sharing for preventative services in Medicare, the Act provides that Medicare beneficiaries will receive coverage for an annual wellness visit that includes a comprehensive risk assessment and a personalized prevention plan. (Risk assessment model to be developed 18 months after enactment.) Likewise, the Act requires qualified health plans sold through the Exchange to cover, without cost-sharing, preventative services rated A or B by the U.S. Preventative Services Task Force (USPSTF), recommended immunizations, preventative care for infants, children, and adolescents, and additional preventative services for women. (Effective six months after enactment.) Additionally, states that provide Medicaid coverage, without cost-sharing, of the preventative services recommended by USPSTF and the recommended immunizations will receive a one percentage point increase in the FMAP for these services. (Effective January 1, 2011)

The Act also provides grant funding for small employers that establish wellness programs. Employers may offer employee rewards (such as premium discounts or waiver of cost-sharing requirements) of up to 30 percent (or 50 percent in some cases) for participating in a wellness program and meeting certain health standards. However, employers must offer alternative standards for employers for whom it is unreasonably difficult to meet the original standard. (Effective January 1, 2014)

CLASS Program
The Act establishes the Community Living Assistance Services and Supports (CLASS) program, a national insurance program for long-term care, effective January 1, 2011. Following a five-year vesting period, program beneficiaries with functional limitations will receive a cash benefit of at least $50 per day to purchase non-medical services and supports necessary to maintain community residence. Participation in the CLASS program is optional, but all working adults will be automatically enrolled in the program unless they choose to opt out. The program will be self-funded, financed through voluntary payroll deductions.

Health Workforce

The Act includes several provisions to strengthen several different sectors of the nation's health workforce, especially the primary care workforce, including a 10 percent Medicare bonus for primary care services provided by primary care physicians through 2016. Moreover in order to attract more primary care providers to the Medicaid program, Medicaid payments to primary care doctors for primary care services will be increased to 100 percent of Medicare payment rates in 2013 and 2014 with 100 percent federal funding. Other measures intended to strengthen the health care workforce and access to primary care include the following:

- The number of Graduate Medical Education (GME) training positions will be increased by redistributing unused residency slots to programs that agree to train more primary care physicians and general physicians.
- The Act also creates Teaching Health Centers, which are community-based, ambulatory patient care centers that are eligible for Medicare dollars for primary care residency centers (Initial appropriation in fiscal year 2010).
- The Act earmarks $11 billion over five years for community health centers and provides $1.5 billion in mandatory spending for the National Health Services Corps to be used to attract primary care providers to health shortage areas. (Effective fiscal year 2011.)
- The Act includes several provisions to attract health care workers through scholarships and loans, funds for state grants to providers in medically underserved areas, strengthened grant programs for oral health professionals, and support for the development of interdisciplinary mental and behavioral health training programs (Effective dates vary.)

Other Provisions

Some of the other provisions of the Act include, but are not limited to, the following:

Nutritional Information

Under the Act, chain restaurants and sellers of food from vending machines must disclose the nutritional content of each item (proposed regulations to be issued within one year following enactment).

Generic Drugs

The Act authorizes the Food and Drug Administration to approve generic forms of biologic drugs and grants biologics manufacturers an exclusive use period of 12 years before generics can be developed (effective upon enactment).

Non-Profit Hospitals

The Act provides several new requirements for non-profit hospitals. Non-profit hospitals must conduct a community needs assessment every three years and adopt a strategy to meet identified needs. Such hospitals must also adopt and publicize a financial assistance program policy indicating whether free or discounted care is available and how to apply for such assistance. Charges to patients who qualify for financial assistance must be limited to the amount generally billed to insured patients, and the hospital must make reasonable attempts to determine eligibility for financial assistance before taking extraordinary collection actions against a patient. Non-Profit hospitals who fail to meet these requirements will be subject to a tax of $50,000 per year (Effective for taxable years following enactment).

Trauma Care

The Act creates a new trauma program aimed at strengthening trauma center capacity and provides funding for research on emergency medicine (appropriations begin in fiscal year 2011).

American Indians

The Act reauthorizes the Indian Health Care Improvement Act, with amendments (effective upon enactment).

Paying for Health Care Reform

To pay for health care reform, the Act provides for approximately $500 billion in Medicare cuts over the next ten years, including cuts to the Medicare Advantage program. The Act also

includes several new taxes, as well as cuts to some current tax deductions. Taxes that will be become effective this year include a 10 percent excise tax on tanning bed services. (Effective Date: July 1, 2010) Other tax provisions will take effect much later, including the much debated tax on “Cadillac plans,” which will go into effect in 2018. Under this provision, insurance companies and plan administrators of employer-sponsored health plans with aggregate values that exceed the thresholds of $10,200 for individual coverage and $27,500 for family coverage will have to pay an excise tax equal to 40 percent of the plan’s value that exceeds the thresholds. The Act also increases the Medicare Part A tax rate on wages by 0.9 percent (from 1.45 percent to 2.35 percent) on earnings over $200,000 for individual taxpayers and $250,000 for married couples. The Act also imposes a 3.8 percent tax on the unearned income of these same individuals and couples. (Effective Date: January 1, 2013)

Beginning in 2011, the cost for over-the-counter drugs will be excluded from reimbursement through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. The Act also increases the tax on distributions from a HSA or an Archer MSA that are not used for qualified medical expenses to 20 percent (from 10 percent for HSAs and from 15 percent for Archer MSAs) of the disbursed amount. (Effective Date: January 1, 2011) The Act will cap the amount of contributions to a flexible spending account for medical expenses to $2,500 per year, increased annually by the cost of living adjustment. (Effective Date: January 1, 2013)

Other taxes imposed by the Act include, but are not limited to an annual fee on the pharmaceutical manufacturers (Effective Date: January 1, 2011), a 2.3 percent excise tax on the sale of a medical device (Effective Date: January 1, 2012), and an annual fee on the health insurance sector (Effective Date: January 1, 2014).

Coverage and Cost Estimates

The Congressional Budget Office (CBO) has estimated that this legislation will reduce the number of uninsured by 32 million by 2019. Approximately 24 million people will obtain insurance through an exchange (including some who previously purchased their own insurance in the individual market). Another 16 million people are estimated to enroll in Medicaid or the Children’s Health Insurance Program. For Georgia, nearly 774,000 residents are expected to be newly eligible for Medicaid, according to estimates by the Urban Institute. The U.S. Department of Health and Human Services has estimated that approximately 1.7 million Georgia residents who do not have health insurance and 387,000 residents who have nongroup insurance will be able to buy coverage through the health insurance exchange.

However, even the strongest proponents of the Act acknowledge that it will not completely achieve universal coverage. After all provisions have taken effect, it has been estimated that up to 23 million individuals would still remain uninsured. This number includes approximately seven million illegal immigrants, persons who still could not afford to purchase coverage, and persons who violate the individual mandate to have insurance.

CBO estimates the cost to be $938 billion over the next ten years. Moreover, according to CBO, the health care components of the legislation will reduce the deficit by $124 billion over ten years. If the health care components and student loan components are added together, the legislation is said to reduce the deficit by $143 billion over ten years.

Information for this brief was obtained from the Kaiser Family Foundation, the National Conference of State Legislatures, the Urban Institute, and the Office of the U.S. House Speaker.