[PROVISIONS]

Health Care Overhaul's Key Parts

After year of debate, changes begin to take effect later in 2010

By Marian Jarlenski and Richard Rubin

The landmark health care bill that President Obama signed into law March 23 (PL 111-148) is the most sweeping change to federal health care policy since the enactment of Medicare in 1965. The new law was a huge victory for Obama and the culmination of decades of work, especially by liberal Democrats, to ensure that all Americans have health insurance.

The law requires most Americans to obtain health insurance and significantly expands coverage under Medicaid. It creates state-run "exchanges" that will allow people without employer-provided coverage, or who cannot afford their employer's plan, to buy health insurance, with federal subsidies to those who cannot afford the premiums. It also places new requirements on private insurance companies, including a prohibition on denying coverage because of a pre-existing condition, and it imposes a tax on many employers that do not offer health insurance plans.

Work on the overhaul consumed much of lawmakers' energy last year, spilling into the first three months of 2010. After weeks of behind-the-scenes negotiations, hearings and committee markups in both chambers, the House acted first, passing its version of the bill (HR 3962) on a 220-215 vote Nov. 7, 2009, with just one Republican in support. Seven weeks later, on Dec. 24, the Senate passed its version (HR 3590) on a party-line vote of 60-39. On March 21 of this year, the House cleared the Senate bill, 219-212.

The same day, the House passed a bill that made modifications insisted on by House members who were unhappy over some of the Senate's provisions. After the Senate made some slight changes, the House cleared the second bill, 220-207, on March 25. Obama signed it March 30 (HR 4872 — PL 111-152).

Democrats passed the modifications under expedited budget reconciliation rules, which allowed them to move forward with a simple majority in the Senate, instead of the 60 votes usually needed to limit debate. That became crucial when Republican Scott P. Brown won a Jan. 19 special election in Massachusetts, giving the GOP the 41 votes necessary to block attempts to change the Senate bill.

The law and the earlier House version both include the requirement that most U.S. citizens and legal residents obtain insurance, but there also were major differences.

For example, the law creates state-based health insurance exchanges, rather than the national exchange the House wanted. It does not have a "public option," a plan that had staunch backing among many House liberals. It also provides lower levels of subsidies to assist low- and moderate-income households in buying health coverage, although the levels were raised slightly in the reconciliation bill. It includes a 40 percent excise tax on high-cost health insurance plans, a provision that was modified in the reconciliation bill so as to kick in later. The law also contains abortion restrictions that are viewed as weaker than those in the House bill.

Under the combined health care laws, the expansion of health care coverage is forecast to cost $938 billion over the next decade, according to the Congressional Budget Office and the Joint Committee on Taxation. The tax on high-cost health insurance plans covers part of the cost. The law also reduces federal payments to private Medicare Advantage plans. The reconciliation bill increases Medicare payroll taxes on high-income earners and adds a new tax on their investment income. Other major revenue sources include fees on the health insurance and pharmaceutical industries and a new tax on medical devices.

Below are the main provisions of the health care overhaul, as modified by the reconciliation law.

EXPANSION OF COVERAGE

EXCHANGES

■ **State-run exchanges.** By 2014, states are required to create "American Health Benefit Exchanges" that offer different health insurance plans to certain individuals and small businesses. Such exchanges can be administered by either a governmental agency or a nonprofit entity established by the state. The new law provides federal funding for states to create the exchanges but requires that the exchanges be financially self-sustaining by 2015.

If a state does not create an exchange by Jan. 1, 2014, the Department of Health and Human Services (HHS) will create and operate one, either directly or through an agreement with a not-for-profit organization.

Health plans offered through the exchanges must meet a number of requirements, including offering a "sufficient choice of providers," serving medically underserved communities, and meeting certain clinical access and quality standards. The details of the requirements will be finalized in rulemaking by HHS.

The Office of Personnel Management will contract with health insurers to offer at least two multistate plans in each new state health insurance exchange. The health plans must provide both individual and employer health plans. One of the two multistate plans required in each exchange must be run by a nonprofit organization, and one plan must not offer abortion services coverage beyond the specifications of the Hyde Amendment, which is only in cases where a woman's life is in danger or in cases of rape or incest.

In addition, the law creates a new Consumer Operated and Oriented Plan (CO-OP) program intended to encourage the development of nonprofit entities to provide health insurance coverage. The measure appropriates $6 billion for federal loans grants to help finance the CO-OP program, which will be awarded by July 1, 2013.

Two or more states can enter into agreements to operate multistate

or regional exchanges, as long as HHS approves the arrangements and as long as such exchanges cover a "distinct geographic area."

■ **Eligibility for exchanges.** Citizens and legal residents who are not incarcerated can obtain coverage through the new health insurance exchanges. Starting in 2014, employers with 100 or fewer employees will be allowed to purchase coverage through the new state exchanges. Starting in 2017, businesses with more than 100 employees can purchase health insurance through the exchanges. Any individual who applies for coverage in a state exchange must also be screened for eligibility for Medicaid, the federal-state health insurance program for low-income and disabled people, or for the federal-state Children's Health Insurance Program (CHIP) and be enrolled if eligible. Children who meet income-eligibility guidelines for CHIP but are unable to enroll because a state with budget constraints has frozen enrollment can receive tax credits to help pay premiums for health insurance through the new exchanges. Starting in fiscal 2016, states will have the option of transitioning CHIP-eligible children into a health insurance exchange, instead of CHIP, as long as HHS approves the transition.

■ **'Essential benefits package.'** All qualified health benefits plans in the exchanges are required to provide coverage that meets or exceeds the standards of an "essential benefits package." At a minimum, the essential benefits must include outpatient services; emergency services; hospitalization; maternity and newborn care; mental health services, including behavioral health treatment; prescription drugs; laboratory services; preventive and wellness services; chronic disease management; rehabilitative services; and pediatric services, including dental and vision care.

■ **Benefit structure.** The new law creates five tiers of health benefits to be offered in the health insurance exchanges. The Bronze Plan, which represents the minimum level of health coverage available through the exchanges, will cover 60 percent of the costs of the medical benefits provided. The Silver Plan will cover 70 percent of the costs of the medical benefits provided. The Gold Plan will cover 80 percent. The Platinum Plan, which is the most generous health insurance coverage available through the exchanges, will cover 90 percent of the costs of medical benefits. Finally, the Catastrophic Plan will be available only to individuals age 30 or younger who are exempt from the law's requirement to purchase health insurance, and it will cover only medically catastrophic events, such as injuries sustained in a major car accident, with the maximum amount of cost-sharing permitted under the law. The Catastrophic Plan will be available to individuals only, not to employers.

■ **'Basic Health Plan.'** States will be permitted to create a "Basic Health Plan" that provides coverage to uninsured individuals with annual household incomes of 133 percent to 200 percent of the federal poverty level (currently $14,404-$21,600 for an individual or $29,327-$44,100 for a family of four). States will contract with private insurers to provide at least the essential benefits package required by the measure.

■ **Tax credits for lower-income households.** The government will provide tax credits for part of the cost of premiums, starting in 2014, for those with household incomes of 100 percent to 400 percent of the federal poverty level (currently an annual income of $22,050-$88,200 for a family of four). Within each income bracket, the tax credits will be determined on a sliding scale that limits the premiums families pay to a percentage of their income, as follows:

- Households with incomes of 133 percent to 150 percent of the federal poverty level would pay 3 percent to 4 percent of their incomes for premiums.
- Those with incomes of 150 percent to 200 percent of the federal poverty level will pay 4 percent to 6.3 percent of their incomes.
- Those with incomes of 200 percent to 250 percent of the federal poverty level will pay 6.3 percent to 8.05 percent of their incomes.
- Those with incomes of 250 percent to 300 percent of the federal poverty level will pay 8.05 percent to 9.5 percent of their incomes.
- Those with incomes of 300 percent to 400 percent of the federal poverty level will pay 9.5 percent of their incomes for premiums.

Starting in 2015, the premium tax credits will be adjusted to reflect year-to-year premium growth in the health plans.

The credits will be reduced if any member of a household is illegally residing in the United States. For example, if four people are supported by one income, and one family member is an illegal immigrant, the family income will be counted as supporting only three people.

The Congressional Budget Office projects that in 2015, the average federal premium tax credit will be $5,200 per household.

■ **Limit on out-of-pocket costs.** Lower-income households will have to spend only a certain percentage of their incomes when purchasing health care coverage through the new exchanges. The percentage of a plan's cost that a household must pay out of pocket will be limited to:

- 6 percent for households with incomes of 100 percent to 150 percent of the federal poverty level.
- 13 percent for households with incomes of 150 percent to 200 percent of the federal poverty level.
- 27 percent for households with incomes of 200 percent to 250 percent of the federal poverty level.
- 30 percent for households with incomes of 250 percent to 400 percent of the federal poverty level.

■ **Tax credits for small businesses.** Starting in 2010, employers with 25 or fewer employees who have annual average incomes of less than $50,000 will be eligible for new tax credits phased in over the course of several years. In tax years 2010 through 2013, qualifying small employers will receive a tax credit of 35 percent of the employer contribution to health insurance premiums, as long as the employer contributes at least 50 percent of the total premium costs, on an aggregate basis. In tax years 2014 and after, the law provides a tax credit of 50 percent for qualified employers for the first two years in which they purchase health insurance through a state exchange, provided they contribute at least 50 percent of total premium costs. Tax-exempt small businesses, such as religious organizations, that meet all the other requirements will be eligible for tax credits of up to 35 percent of their contributions to employees' health insurance premiums.

■ **Abortion coverage.** In administering the new health insurance exchanges, states may prohibit coverage of abortion services. The new law does not pre-empt state laws pertaining to abortion services. Health insurers in an exchange cannot discriminate against health providers who are unwilling to provide abortion services or to refer patients to providers who do provide abortion services.

Health plans in a state exchange that cover abortion services beyond those needed to save a woman's life or in the case of rape or incest must segregate payments for abortion coverage into a separate account for those enrollees who receive premium tax credits. To get the abortion coverage, an enrollee would have to make two premium payments: one for regular benefits and one for abortion services. The enrollee could not receive federal tax credits for the premium for abortion services.

■ **Temporary high-risk pool.** Within 90 days of enactment, HHS is required to create a temporary, national high-risk insurance pool program to provide health care benefits to individuals who have a

pre-existing condition, until the health insurance exchanges created by the law are functioning in 2014. States that already have their own high-risk pools are required to continue operating them. To be eligible for the high-risk pool, an individual cannot be eligible for Medicare, Medicaid or an employer-based plan, and cannot have had insurance during the six-month period before applying. Illegal immigrants cannot receive coverage through the pool. The law appropriates $5 billion to pay claims and cover administrative costs of the high-risk pool that exceed the premiums that are collected. If the funding in a given fiscal year is insufficient, HHS can make necessary adjustments.

INDIVIDUALS AND EMPLOYER REQUIREMENTS

■ **Individual mandate.** Starting in 2014, all citizens and legal residents are required to have "minimum essential coverage," defined as employer-sponsored coverage; government programs including Medicare, Medicaid or CHIP; or coverage obtained through the new health insurance exchanges. Those exempted from the requirements include illegal immigrants or individuals who are incarcerated; individuals who cannot afford coverage, defined as those whose contributions to the cost of insurance are greater than 8 percent of their household incomes; individuals who have a household income that is less than 100 percent of the federal poverty level (currently, $10,830 per year for an individual or $22,050 for a family of four), although people at this income level would be entitled to coverage under Medicaid; members of American Indian tribes; individuals who are uninsured for a period of less than three continuous months; individuals for whom obtaining health insurance would create a "hardship," as determined by HHS; and those who belong to certain religious groups with tenets that include conscientious objection to private or public insurance.

■ **Individual penalties.** A flat penalty tax will be phased in over 2014 to 2016 on individuals who do not obtain health insurance coverage. By 2016, the penalty will be $695 per year for each individual who does not have health insurance for more than three months in a given year. The penalty per household cannot exceed 2.5 percent of the household income.

■ **Employer penalties.** Starting in 2014, employers with more than 50 employees that offer health benefits will face a penalty of either $3,000 for each full-time or part-time employee who receives a tax credit to purchase coverage through the exchange, or $750 per full-time employee, whichever is less. In calculating the fine, the first 30 employees will be subtracted from the total number of workers. For instance, a company with 51 full-time employees in which any employee received the tax credits would pay a fine of $750 for 21, rather than 51, full-time employees.

Employers who do not offer health insurance will face a fine of $2,000 for every employee who receives a federal premium tax credit to purchase insurance through an exchange.

■ **Employer vouchers.** Starting in 2014, employers who offer health benefits must offer vouchers to purchase insurance in the exchanges for low- and moderate-income employees who would have difficulty paying for the workplace health plan. Specifically, employers must offer vouchers to employees with incomes of up to 400 percent of the federal poverty level whose contribution to employer-sponsored insurance would constitute from 8 percent to 9.8 percent of their incomes.

■ **Automatic enrollment in employer health plans.** Employers with more than 200 employees are required to enroll automatically new, full-time employees in a health insurance plan (if one is offered), and to maintain the coverage each year unless an employee opts out. It requires employers to provide adequate notice so that employees can choose to opt out. This provision would not supersede any state law regarding automatic enrollment that is at least as stringent as this provision.

MEDICAID EXPANSION

■ **Medicaid eligibility.** The law expands eligibility under state Medicaid programs to all individuals with household incomes of up to 133 percent of the federal poverty level, effective in 2014 (currently, $14,404 for an individual or $29,327 for a family of four). State Medicaid programs are required to cover individuals who would not categorically qualify for Medicaid, including those under age 65, those who are not disabled and adults without dependent children. The law prohibits states from changing their Medicaid programs in a way that imposes more restrictive standards, methodologies or procedures than those that were in effect on the date of enactment — a so-called maintenance of effort requirement — through Dec. 31, 2013.

■ **Federal matching funds for Medicaid.** In all states, the federal government will cover 100 percent of the cost of coverage to newly eligible people — including parents and childless adults — from 2014 through 2016. The percentage will drop to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. Under the formula to determine federal matching funds, states that have previously provided such coverage to individuals at 100 percent of the federal poverty level or greater who continue to be enrolled in Medicaid will receive the same federal funding as a state that did not previously provide such coverage.

■ **Increased matching funds for Louisiana.** Starting in 2011, the law provides an increase in federal Medicaid matching funds for Louisiana for continuing recovery efforts from major disasters, including Hurricane Katrina.

■ **Medicaid income eligibility rules.** Starting in 2014, the law requires all states to use a uniform method to determine eligibility for Medicaid, based on a household's modified gross income. States will no longer be permitted to disregard income or deduct certain types of income when determining eligibility, as many states currently do. However, states could continue to disregard or deduct income for applicants who are elderly, blind or disabled. The law also prohibits states from imposing an asset test when determining eligibility for Medicaid, as many states currently do when calculating eligibility for parents.

■ **Federal matching funds for U.S. territories.** Provides an estimated increase of $7.3 billion for federal matching payments for Medicaid programs in the five U.S. territories over the period of fiscal 2014 through fiscal 2019 and increases the caps on federal funding in the territories. It earmarks $925 million of those funds for Puerto Rico.

■ **Medicaid reimbursements for primary care.** In 2013 and 2014, increases Medicaid reimbursements for primary care services to 100 percent of the Medicare payment rates for such services.

CHILDREN'S HEALTH INSURANCE PROGRAM

■ **Federal matching funds for CHIP.** Starting in fiscal 2014, states will receive an increase of 23 percentage points in their federal matching funds for CHIP, to a cap of 100 percent of the cost of a state's program. This provision effectively increases the minimum federal match for CHIP programs to 88 percent, from the current 65 percent, meaning that states will have to fund, at most, 12 percent of the cost of their CHIP programs.

■ **Eligibility rules.** States are not permitted to change their CHIP programs in a way that imposes more restrictive standards, methodologies or procedures than were in effect June 16, 2009, through Sept. 30, 2019.

■ **Exchanges.** Children who meet income-eligibility guidelines for CHIP,

but are unable to enroll because a state has frozen enrollment due to budget constraints, will be eligible for premium tax credits to obtain health insurance through the new exchanges starting in 2014. Children who receive subsidized coverage through the exchanges will be ineligible for coverage under CHIP. Children in an exchange cannot switch to CHIP if the state re-opens enrollment. Starting in fiscal 2016, the measure permits states to transition children who are eligible for CHIP to receive coverage through one of the new health insurance exchanges instead, as long as HHS approves this transition.

NEW HEALTH INSURANCE REGULATIONS

■ **Pre-existing conditions.** Starting in 2014, health insurers who offer group or individual coverage are prohibited from denying coverage because a potential enrollee has a pre-existing condition. The law immediately prohibits insurers from denying coverage to children with pre-existing conditions. Specifically, when determining eligibility for coverage, health insurers cannot take into account health status, claims history, physical or mental medical conditions, genetic information, disability, and other factors determined by HHS.

■ **Protection against coverage rescissions.** Starting in September 2010 (six months after enactment), health insurers are prohibited from rescinding group or individual coverage, unless there is clear and convincing evidence of fraud or intentional misrepresentation by an enrollee. If insurers do rescind coverage, they must provide adequate prior notice to the affected enrollees.

■ **Coverage of young adults.** Starting in September 2010, health insurers who offer dependent coverage are required to continue coverage of children on their parents' plans, at the parents' discretion, until their 26th birthday. Group health plans that were operating before enactment have to cover these adult children only if they do not have an offer of employer-sponsored insurance.

■ **Lifetime spending limits.** Starting in September 2010, health insurers are prohibited from setting lifetime limits on the dollar value of health care provided to an enrollee. Starting in 2014, insurers are barred from setting annual spending limits. Before 2014, insurers can set "reasonable" annual spending limits only if approved by the federal government.

■ **Limit on deductibles.** The law limits deductibles in employer-sponsored health plans in the small-group markets to $2,000 per year for individual coverage and $4,000 per year for family coverage, starting in 2014. These deductibles can be increased only if such an increase is offset through an amount "reasonably available" to an employee through a flexible spending arrangement.

■ **Coverage of preventive care.** The law requires health insurers to cover certain preventive care services without requiring any cost-sharing — meaning co-payments, co-insurance or deductibles — by enrollees in group or individual plans. The services that must be covered include vaccinations and screening recommended by federal agencies. The law specifically states that the recommendations issued by November 2009 by the federal Preventive Service Task Force on breast cancer screening and mammography do not apply, and, therefore, insurers must provide mammograms more frequently than called for in the guidelines. The task force stated that women younger than 50 with no family history of breast cancer do not need to undergo mammograms, and that women 50 and older need mammograms only once every two years. Previous guidelines called for annual mammograms for women 40 and older.

■ **Premium reporting.** Health insurers who offer coverage in the small- and large-group markets must publicly report the percentage of premiums that are spent for specific services, such as reimbursement for

clinical services, efforts to promote quality of care and administrative costs. The law also requires insurers to provide rebates to enrollees if the medical loss ratio for a given year is below 85 percent for large-group plans, or 80 percent for small-group and individual market plans. The medical loss ratio measures the portion of the premium that is spent on medical services as opposed to administrative expenses. The provision is intended to limit insurers' administrative costs to 15 percent for large groups, and to 20 percent for small-group and individual coverage. The rebates begin in 2011 and will be in effect only until the health insurance exchanges are fully established.

■ **Review of premium increases.** The law creates a process for reviewing premium increases by health insurers. The annual review process, created by HHS in conjunction with the states, will start in 2010. Health insurers will have to submit a justification for any premium increase before its implementation and place the information prominently on its Web site. HHS will have to ensure public disclosure of the information. Starting in 2014, states are required to monitor premium increases inside and outside their insurance exchanges. States that meet certain requirements can receive grants to assist them in reviewing and approving premium increases, where allowed by state law.

CHANGES IN PUBLIC PROGRAMS

MEDICARE

■ **Payment advisory commission.** The law creates an Independent Payment Advisory Board to draft legislative proposals to slow the growth rate in Medicare spending if spending exceeds a certain target rate. The Centers for Medicare and Medicaid Services (CMS) must project, on April 15, 2013, whether Medicare spending will exceed the projected growth in the Consumer Price Index that year. If so, the new 15-member board must meet and submit recommendations to Congress and the president on how to slow Medicare's growth. The recommendations would be due by Jan. 15, 2014. Beginning in January 2018, recommendations will be required if the growth in Medicare spending is projected to exceed gross domestic product growth by more than 1 percent.

Board recommendations could include a reduction in reimbursements to Medicare Advantage plans or to prescription drug plans, or proposals to restructure Medicare payment mechanisms generally. Under the Medicare Advantage option, individuals who are eligible for Medicare get their insurance from private firms rather than the federal government. The board's targeted savings rate will be 0.5 percent of projected total Medicare spending in 2015, 1 percent in 2016, 1.25 percent in 2017, and 1.5 percent in 2018 and beyond. The target rate can be less than the specified levels if so recommended by the chief actuary of CMS. The board recommendations cannot ration care nor can they change benefits, eligibility rules or require cost-sharing, such as premiums and co-payments.

Once the commission submits recommendations, Congress is required to consider the legislative proposals. If Congress does not act on a proposal by August 15 in the year it is submitted, CMS must implement the commission's proposal.

■ **Medicare drug benefit.** The law provides a one-time $250 rebate for beneficiaries who fall into the coverage gap known as the "doughnut hole" in 2010. Under existing law, after beneficiaries meet their deductible for the year, 75 percent of their drug costs are covered by the government up until a set dollar amount. After that dollar amount has been reached, the beneficiary enters the doughnut hole and is responsible for 100 percent of the costs up to a second dollar amount, known as the catastrophic threshold. The federal government is responsible for 95 percent of any remaining costs above the catastrophic limit for the rest of the year.

The new law phases out the doughnut hole over 10 years. Starting in 2011, beneficiaries who fall into the doughnut hole will get a discount of 50 percent on brand-name drugs. The discount will increase to 75 percent by 2020, with the government paying the rest of the cost of the drugs.

■ **Medicare Advantage payments.** Starting in 2011, the law freezes federal payments to Medicare Advantage and then reformulates payments according to local costs. Under the new formula, which will be phased in, payments will be allocated based on geographic variability of Medicare spending. Payments will start at 95 percent of traditional fee-for-service Medicare payments in areas that are in the top quartile of Medicare spending, and increase to 115 percent in areas that are in the lowest quartile. Starting in 2014, the amount that Medicare Advantage plans can spend on administrative costs will be capped at 15 percent of the amount collected from premiums. If a plan spends more than that, it must pay HHS a fine equal to the amount of funds spent on administrative costs that exceed the cap.

■ **'Market basket updates.'** The law reduces the "market basket updates" used to determine the reimbursement for certain services by Medicare providers. Generally, market baskets are used to adjust payments annually based on projected changes in indexes that are used to measure how much more or less it will cost to buy the same goods and services that year. The law incorporates "productivity adjustments" — adjustments based on gains in productivity — into several market baskets used under Part A that do not currently incorporate such provisions. The adjustments will be phased in during different years for different types of providers and will affect inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospitals. The formula is expected to generate an estimated $156.6 billion in reduced mandatory spending over 10 years.

■ **Disproportionate-share payments.** The law reduces Medicare disproportionate-share hospital payments, which are federal payments to hospitals that treat a disproportionate share of low-income patients. Starting in fiscal 2014, the payments will be reduced by 75 percent, and then increased based on both the percentage of the population that is uninsured in the area served by the hospital and the percentage of the hospital's care that goes to uninsured patients.

■ **Additional Medicare hospital payments.** A total of $400 million will be set aside to cover fiscal years 2011 and 2012 from the Federal Hospital Trust Fund for additional Medicare payments to hospitals that are located in counties that are in the lowest quartile of per-capita Medicare spending for Part A and Part B (hospital services and physician services, respectively).

■ **Center for Medicare and Medicaid Innovation.** The law creates a new Center for Medicare and Medicaid Innovation as part of CMS and provides $15 million over 10 years for the center. The new center will evaluate "innovative payment and service delivery models" that would reduce costs without negatively affecting the quality of care or the scope of benefits provided to enrollees. Models to be explored include: payment structured around patient-centered medical homes, contracting directly with groups of providers for care coordination, using comprehensive care plans for geriatric care, creating community-based health teams to support medical homes and promoting greater access to outpatient services when possible.

■ **Physician-owned hospitals.** New physician-owned hospitals generally are prohibited from receiving Medicare reimbursements for patients

who are referred by physicians with investment interests in the hospitals, effective in 2011. The law prohibits physician-owned hospitals from expanding, although hospitals can apply to the federal government to be exempted from this expansion limit. The law permits physician self-referrals to hospitals only if the hospital meets certain criteria, including public disclosure of the financial interests of referring physicians and agreements with physicians governing investment in such hospitals.

■ **Medicare Part B premiums.** Freezes the income levels used to calculate premiums for Medicare Part B (physician services) in 2011 through 2019 at levels set for 2010. Medicare Part B premiums are calculated based on income levels, and beneficiaries pay premiums based on their annual incomes two years before the coverage year. According to CMS, in 2010 most Medicare beneficiaries will pay $96.40 per month for Part B coverage, although some new beneficiaries will pay $110.50.

■ **Reimbursement for hospital-acquired infections.** Starting in fiscal 2015, reimbursements will be reduced by 1 percent for certain hospital-acquired conditions, to be determined by HHS.

■ **Reimbursement for preventable re-admission.** Hospitals will get reduced reimbursement rates for what are considered to be preventable re-admissions of Medicare beneficiaries. The provision is intended to give hospitals and health care providers incentives to allow for adequate medical follow-up to prevent multiple hospital re-admissions for patients with chronic conditions. Starting in fiscal 2012, CMS will reduce payments by specified percentages, depending on the billing code, for preventable hospital re-admissions. CMS will determine the number of hospital re-admissions for a given condition that will be considered excessive and thus subject to reduced reimbursements. Within two years of enactment, a new CMS program will assist hospitals in reducing excessive re-admissions.

■ **Accountable Care Organizations.** Starting in 2012, qualified health care providers can form groups, or Accountable Care Organizations, that are eligible for federal payments if they meet certain quality standards. Eligibility criteria include having a leadership and administrative structure in place, and demonstrating a willingness to take responsibility for the overall quality and cost of care of Medicare beneficiaries who are assigned to the group and agreeing to contract with CMS for at least three years. The organizations must submit data that will allow CMS to evaluate the quality of care being provided.

MEDICAID COST SAVINGS

■ **Medicaid Disproportionate Share payments.** Federal matching Medicaid Disproportionate Share payments, which are additional reimbursements for hospitals that serve a disproportionate share of low-income individuals, will be reduced by $14.1 billion over the period of fiscal 2014 through 2019.

■ **Medicaid prescription drug rebates.** The rebate that Medicaid programs receive for brand-name drugs is increased by 23.1 percent starting in 2010. The discount includes Medicaid managed-care plans that are run by private insurers. The law increases the Medicaid drug rebate for generic drugs to 13 percent of the average manufacturer price.

■ **Health care acquired conditions.** Starting July 1, 2011, the law prohibits federal funding to state Medicaid programs for certain acquired health care conditions, with the specific list to be determined by HHS.

■ **Premium assistance.** Starting in 2014, states are required to provide premium assistance to anyone eligible for Medicaid who has employer-sponsored coverage available, if it is cost-effective for the state. The employer would have to contribute at least 40 percent of the cost of

the health insurance premium. Previously, it was optional for states to provide premium assistance for employer-sponsored coverage for children and parents who were eligible for Medicaid, if it was cost-effective for the state.

OTHER HEALTH CARE PROVISIONS

■ **Long-term care program.** The law establishes a new national voluntary insurance program called Community Living Assistance Services and Support (CLASS) to assist adults with functional limitations in purchasing community living assistance services, while also establishing an infrastructure to address national needs, alleviate burdens on family caregivers and address institutional bias.

HHS is required to develop at least three actuarially sound benefit plans as alternatives for designation as the CLASS Independence Benefit Plan to provide benefits. The premiums established in the first and subsequent years would have to be based on actuarial analysis of the 75-year costs to ensure solvency for that 75-year period. Such plans would have to provide for payment of a cash benefit with an average of at least $50 per day, and permit the payment to vary based on functional ability, be paid either daily or weekly, and not be subject to lifetime or aggregate limits.

Once set, a monthly premium generally will remain the same as long as an individual is enrolled. The measure provides exceptions to guarantee the program's solvency, but premium increases under that case would not apply to those 65 or older or to those who have paid premiums for at least 20 years.

Those 18 or older who receive qualifying taxable wages and are actively employed will be eligible for the program, as long as they are not patients in a hospital, nursing home, care facility or institution for mental diseases and receiving Medicaid.

■ **Comparative effectiveness research.** The law creates a nonprofit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research to compare the effectiveness of medical treatments and technologies. The Federal Coordinating Council that was created under the economic stimulus law (PL 111-5) is repealed and replaced by this new institute. The purpose of this institute will be "to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis." The law appropriates $210 million for the institute in fiscal years 2010 through 2012, and $150 million in each of fiscal years 2013 through 2019.

■ **Biologic drug patents.** The law creates a process through which the Food and Drug Administration (FDA) will receive and approve applications for offering biological products that are either similar to, or interchangeable with, a biological product that has already been approved, known as a reference product. Biologic drugs are a new technology in which drug manufacturers use living cells to produce drug technology; previously, the FDA lacked statutory authority to approve generic versions of biologic drugs, which are known as biosimilars.

The law provides exclusivity for the first interchangeable product for certain periods and stipulates that a biosimilar product application cannot be approved until 12 years after the date that a reference product is first approved. It provides for an additional six months for reference products with demonstrated benefits from pediatric studies. The FDA would have to require labeling and packaging that uniquely identifies the biosimilar product.

■ **Community health centers.** Funding is increased for community health centers, which provide primary care services in areas where economic, geographic or cultural barriers limit access to primary care. The law appropriates $1 billion in fiscal 2011, $1.2 billion in fiscal 2012, $1.5 billion in fiscal 2013, $2.2 billion in fiscal 2014 and $3.6 billion in fiscal 2015.

■ **Medical malpractice.** A new five-year demonstration program will allow states to evaluate alternatives to the current medical liability tort system. HHS can award grants to states that develop pilot programs that allow for the resolution of medical malpractice disputes and would promote a reduction of medical errors by encouraging the collection and analysis of relevant data. For instance, a state could propose a "no fault" dispute-resolution process, in which all victims of certain errors would be compensated equally and health care providers would not be held at fault. States would have to identify funding sources for any victim compensation. In addition, states would have to identify a "scope of jurisdiction" for the alternative system they were testing and notify patients who fell within that scope. Jurisdiction could be a geographic area, a health care system, a specific group of health care providers or a specific specialization within medical practice.

■ **Restaurant menu labeling.** Chain restaurants and food vending machines with more than 20 outlets will be required to list nutritional information for each available item. Menus must disclose the caloric content of each standard item, as well as contain a "succinct statement" regarding the daily recommended intake of calories, in a way that is easily understood by the general public. Calorie labeling must be placed near menu boards and drive-through window menus, and near food in self-service areas such as buffets or salad bars. Vending machine operators have to post caloric content in proximity to the food item being sold or next to the selection button. The Agriculture Department is required to issue regulations regarding this provision within one year of enactment.

■ **American Indian health.** The law permanently reauthorizes the Indian Health Care Improvement Act, which governs the provision of health care through the HHS Indian Health Service to American Indians and Alaskan natives. The law authorizes programs aimed at increasing the recruitment and retention of health care professionals; expands mental and behavioral health programs to address issues such as fetal alcohol spectrum disorders as well as child sexual abuse and domestic violence; and authorizes long-term care services. It also requires that the Indian Health Service budget account for medical inflation rates and population growth to address underfunding of the Indian Health Service.

■ **Abstinence education.** The law provides grants of at least $250,000 per year for each state to conduct "Personal Responsibility Education Programs" to educate teenagers about "both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS," as well as other life topics such as financial literacy and career skills.

■ **Health insurance reform implementation fund.** The law appropriates $1 billion for HHS for the administrative costs of implementing the new health care overhaul law.

REVENUE PROVISIONS

MAJOR REVENUE-RAISERS

■ **Excise tax on health plans.** The law creates a 40 percent excise tax on high-cost insurance plans offered by employers. The tax, which will begin in 2018, applies to the cost of premiums for medical coverage above designated thresholds: $10,200 for individuals and $27,500 for families. If medical costs rise faster than expected between 2010 and

2018, as measured by a formula set out in the law, the 2018 thresholds will be adjusted accordingly. The starting thresholds will increase from 2018 to 2019 by the consumer price index plus 1 percent, and by the consumer price index after that.

Several specified groups of taxpayers will get adjusted thresholds in an attempt to ensure that the tax targets the highest-cost benefits. The thresholds will be increased to the extent that the age and gender characteristics of the company's workforce require higher premiums than a more typical pool of employees. The thresholds are also increased by an additional $1,650 for individuals and $3,450 for families for retirees who are not eligible for Medicare and for workers in high-risk professions, such as law enforcement, mining, construction, agriculture and fishing.

Generally, the tax will be paid by the insurance company or by the plan administrator for self-insured companies. The threshold amount is the sum of premiums and contributions to flexible spending arrangements, health savings accounts and other similar mechanisms. Dental and vision benefits do not count toward the total.

The tax is expected to raise $32 billion in 2010 through 2019, the window set under the budget resolution, but because the tax does not begin until 2018, it is expected to bring in much more money after that.

■ **Additional hospital insurance tax.** Beginning in 2013, the law creates a second tax bracket in the payroll levy that has long been used to finance Medicare. In addition to paying the 1.45 percent employee share of the previous Medicare tax, workers will pay an extra 0.9 percent on wages and self-employment income above $200,000 for individuals, and above $250,000 for married couples. Both come on top of the 1.45 percent employer share, which remains unchanged.

Also starting in 2013, individuals with adjusted gross income over $200,000 and married couples with adjusted gross income over $250,000 will pay a new 3.8 percent Medicare tax on unearned income. That includes capital gains, interest, dividends, annuities, royalties and rents, along with passive business investments. Active business income from sole proprietorships, S corporations and partnerships will not be subject to the tax. The tax applies to all of an individual's unearned income, but only to the extent that the total adjusted gross income exceeds the threshold. For example, an individual with $150,000 in unearned income out of a total of $250,000 in adjusted gross income will pay taxes on $50,000 of the unearned income — the amount by which adjusted gross income exceeds the $200,000 threshold.

Together, the two provisions raise $210.2 billion over 10 years.

■ **Pharmaceutical industry fee.** The prescription drug industry as a whole is responsible for paying an annual fee, beginning with a total of $2.5 billion in 2011. The amount will rise to $2.8 billion for 2012 and 2013; $3 billion for 2014, 2015 and 2016; $4 billion for 2017; $4.1 billion for 2018; and $2.8 billion beyond that. The government will divide the fees among pharmaceutical companies based on the value of the drugs they sell to certain government health care programs. The fees are expected to raise $27 billion over 10 years.

■ **Medical device tax.** A new 2.3 percent excise tax on medical devices will begin in 2013 and will apply to a wide range of devices, particularly those used in hospitals and doctors' offices. The tax will not apply to eyeglasses, contact lenses and hearing aids; other items manufactured and sold at retail stores for individual use can also be exempted. The tax is expected to generate $20 billion over 10 years.

■ **Health insurance industry fee.** Health insurance providers will pay an annual industrywide fee starting in 2014. The total annual fee will

start at $8 billion, then rise to $11.3 billion for 2015 and 2016, $13.9 billion for 2017 and $14.3 billion for 2018. After that, the total will increase by the same percentage as health care premiums. The annual total will be divided among health insurers according to market share, based on each company's premiums as a percentage of those of the overall health insurance industry. The law provides a break for certain not-for-profit insurers and does not include any government entities or self-insuring employers. Its fees are projected to raise $60.1 billion over 10 years.

SMALLER HEALTH CARE REVENUE-RAISERS

■ **Health spending account limits.** The law limits the ability of people with health flexible spending arrangements, health savings accounts, health reimbursement accounts and Archer medical savings accounts to use pretax money to pay for over-the-counter medication. Starting in 2011, the accounts can be used for over-the-counter medication only if prescribed by a doctor. The provision is expected to raise $5 billion over 10 years.

■ **Penalties on non-medical expenses.** The law raises, from 10 percent to 20 percent, the tax penalty paid by people who use tax-advantaged health savings accounts and Archer medical savings accounts for non-health purposes. The higher penalties would raise $1.4 billion over 10 years.

■ **Flexible spending caps.** For the first time, there will be a cap on the amount of pretax dollars that a worker can set aside in a health flexible spending arrangement. The cap of $2,500 takes effect in 2013, and it will be adjusted each year according to the consumer price index. The change will generate $13 billion.

■ **Charitable hospitals.** Nonprofit hospitals must meet a new set of requirements to keep their tax exemptions. They must conduct regular community health needs assessments and tell the IRS how they meet the need. They also must establish written, publicized criteria for providing financial assistance to patients, and the law places limits on their collections processes and fees.

■ **Part D deduction elimination.** A deduction that businesses receive for providing prescription drug plans for their retirees is repealed. Under the previous law, companies could get federal subsidies for offering the plans without counting the subsidies as income, then deducting the full cost of the plans, including the value of the subsidies. The $4.5 billion change allows companies to continue excluding subsidies from income but prohibits them from also deducting the subsidies.

■ **Itemized deduction.** The law raises the so-called floor above which taxpayers can deduct medical expenses from 7.5 percent of adjusted gross income to 10 percent. The provision takes effect in 2013, but for the first four years it does not apply to taxpayers who are 65 and older or have a spouse in that age group. It is expected to raise $15.2 billion over 10 years.

■ **Executive-compensation deductions.** Health insurance companies face new limits on their ability to deduct the compensation of their executives. The cap is $1 million for most companies, but it will be $500,000 for health insurers. The provision takes effect for payments made starting in 2013 for services provided any time after 2009. Unlike most companies, health insurers must count any performance-based compensation and commissions toward the cap, and the limitation applies to all employees, directors and consultants, not just a small group of executives. It is projected to raise $600 million.

■ **Blue Cross and Blue Shield.** Blue Cross and Blue Shield health insurance plans face new restrictions starting in 2010. To keep a special 25 percent deduction for certain claims and an exception from the 20 percent reduction in deductions for certain premiums that for-profit companies face, the Blue Cross and Blue Shield plans must have a medical loss ratio of at least 85 percent. The provision would raise $400 million over 10 years.

■ **Tanning tax.** A new 10 percent tax on indoor tanning services will take effect July 1, raising $2.7 billion over 10 years.

NON-HEALTH CARE REVENUE PROVISIONS

■ **'Black liquor.'** The law prevents paper companies from claiming the $1.01-per-gallon cellulosic biofuel tax credit for a manufacturing byproduct known as "black liquor." The substance is often used as fuel in the manufacturing process, and the elimination of the credit will raise $23.6 billion over 10 years.

■ **'Economic substance.'** The doctrine of "economic substance" that governs certain tax cases is now codified. Under the legislation, business transactions must have a substantial economic or business purpose and not be executed just for tax purposes. Companies engaging in such transactions face penalties of 20 percent to 40 percent if the maneuvers are disallowed; the changes will raise $4.5 billion over 10 years.

■ **Information reporting.** A new tax-compliance measure requires that businesses report to the IRS any payments to corporations that total $600 or more in a calendar year. This expands the previous requirement that similar payments to individuals be reported, and it includes penalties for failure to file. The provision takes effect in 2012 and will generate $17.1 billion over 10 years.

■ **Corporate estimated taxes.** Corporations will face a timing shift in their quarterly estimated taxes in 2014.

OTHER REVENUE-RELATED PROVISIONS

■ **Adoption credit.** The law increases the maximum tax credit for people who adopt children by $1,000, to $13,170. The credit becomes refundable, and the scheduled date for the expiration of the credit is delayed from the end of 2010 to the end of 2011. The exclusion for employer-provided adoption assistance gets a similar change. The provision is expected to cost $1.2 billion over 10 years.

■ **W-2 reporting.** Starting in 2011, employers must report the cost of their employees' health coverage on their annual W-2 form.

■ **Therapeutic discovery projects.** Small companies will be able to get a 50 percent tax credit for certain investments for medical research. Projects must be certified by the administration and its medical needs that are not currently being met, reduce long-term health care costs or make a major advance in cancer treatment. The provision, which expires at the end of 2010, took effect for expenses made starting in 2009 and is expected to cost $900 million over 10 years.

■ **Veterans' health study.** By the end of 2012, the Secretary of Veterans Affairs must produce a study on whether the fees and taxes on insurers, prescription drug manufacturers and medical device makers are having an effect on the cost of veterans' medical care and on their access to drugs and devices.

■ **Indian tribal governments exclusion.** People who receive health care provided by the Indian Health Service or an American Indian tribe will be able to exclude the value of those benefits from income.

■ **Simple cafeteria plans for small businesses.** Beginning in 2011, the law makes it easier for small businesses to set up cafeteria plans for employee benefits. ■