



## Federal Health Care Reform Summary of Legislative Provisions

PROPOSAL	COMPOSITE OF H.R. 3950 AND H.R. 4872
<b>Insurance Coverage Expansions &amp; Health Insurance Reform</b>	
Guaranteed issue, renew	Effective 1/1/2014 Cannot exclude coverage to children based on pre-existing condition effective 6/21/2010
Prohibit annual, lifetime benefits	Lifetime limit prohibited effective 9/22/2010 Annual limit prohibited effective 1/1/2014
Insurance Exchanges	State based (state can allow more than one Exchange if each one has separate geographic area; states can form regional Exchanges)  Run by government or nonprofit  Available for individuals and employers with 100 or fewer employees  States can allow larger employers into Exchange in 2017  Federal funding for Exchange start-up costs within one year through 1/1/2015  Effective 1/1/2014
Tiered benefit sets in Exchanges	Individual plans in five benefit sets (bronze, silver, gold, platinum and “young invincible” for under 30 year olds)

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	<p>“Metal” benefit sets include preventive, primary care, ER, hospitalization, outpatient, imaging, pediatric, Rx drugs, mental/chemical health;</p> <p>Young invincible is catastrophic plan + 3 primary care visits per year</p> <p>Out-of-pocket limits set at HSA limits; no cost-sharing for preventive services</p>
Limit out-of-pocket costs for plans within Exchange & necessary to comply with individual mandate	<p>300-400% FPL: \$4,000/individual, \$7,300/family  200-300% FPL: \$3,000/individual, \$5,500/family  &lt; 200% FPL: \$2,000/individual, \$4,000/family</p>
Community rating	Only variation allowed based on age (3:1), geography, family, tobacco (1.5:1) in individual/ small group market and plans sold in Exchange
Allow sale of insurance across state lines	<p>Allow multi-state “health care compacts,” which would allow 2 or more states to agree to allow sale of individual plans at least as comprehensive and affordable as plans sold in Exchanges across state lines</p> <p>Effective 1/1/2016</p>
Multi-state insurance plans within Exchanges	<p>Requires federal employee insurance program to contract with insurers to offer at least 2 multi-state insurance plans in each Exchange, at least one of which must be a nonprofit</p> <p>At least one multi-state plan must not cover abortions</p> <p>Multi-state plans must be licensed by state and meet 3:1 age rating or state’s age rating, whichever is most restrictive</p>
Create Consumer Operated and Oriented Plan (CO-OP)	<p>At least one non-profit, member-run health insurance plan in each state</p> <p>Existing health insurer or state-sponsored entity cannot receive federal money for CO-OP</p> <p>Governance subject to majority vote of members</p> <p>Any profits must be used to lower premiums, improve benefits or improve quality of care</p>

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	\$6 billion in federal grants for start-up costs awarded by 7/1/2013
Individual mandate	Effective 1/1/2014
Essential benefit set	Comprehensive set of services Covers at least 60% of actuarial value of covered benefits Limits cost-sharing to HSA limits (\$5,950/individual, \$11,900/family) Effective 1/1/2014
Individual mandate enforcement	Tax penalty: \$95 (or 1% of taxable income) in 2014 \$325 (or 2% of taxable income) in 2015 \$695 (or 2.5% of taxable income) in 2016 Then increased by cost of living adjustment  Family penalty capped 3x individual  Exemptions: <ul style="list-style-type: none"> <li>• Financial hardship</li> <li>• Religious objection</li> <li>• American Indians</li> <li>• Uninsured for &lt;3 months</li> <li>• Undocumented immigrants</li> <li>• Incarcerated individuals</li> <li>• If lowest cost plan in Exchange is &gt;8% of income</li> </ul>
Premium subsidies	Refundable and advanceable  Available up to 133-400% of FPL if insurance is bought through Exchange  Credit amounts tied to 2 <sup>nd</sup> lowest cost silver plan in area  Sliding scale so individual premium costs limited to 2% of income up to 133% FPL

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	<p>3-4% of income 133-50% FPL  4-6.3% of income 15-200% FPL  6.3-8.05% of income 200-50% FPL  8.05-9.5% of income 250-300% FPL  9.5% of income 300-400% FPL</p> <p>Employees offered coverage by employer are not eligible for premium credits unless employer plan's actuarial value &lt;60% or employee premium share &gt;9.5% of income</p> <p>Increase premium contributions annually to reflect excess of premium growth over rate of income growth from 2014-18, then further adjust premium contributions to reflect excess of premium growth over CPI if aggregate premiums + subsidies &gt;0.54% of GDP</p> <p>Effective 1/1/14</p>
Cost-sharing subsidies	<p>Available if income 100-400% FPL and insurance bought through Exchange</p> <p>100-50% FPL subsidies = 94%  150-200% FPL subsidies = 85%  200-50% FPL subsidies = 73%  250-400% FPL subsidies = 70%</p>
Employer mandate	<p>50+ employees, do not offer coverage and one or more employees receive premium tax credit:</p> <ul style="list-style-type: none"> <li>• \$2,000/FTE but exclude first 30 FTEs</li> </ul> <p>50+ employees, offer coverage and one or more employees receive premium tax credit:</p> <ul style="list-style-type: none"> <li>• \$3,000/employee receiving tax credit or \$2,000/FTE, whichever is less</li> </ul> <p>200+ employees must autoenroll employees into coverage offered by employer (employee can opt out)</p> <p>No penalties for waiting periods  Limits waiting periods to not more than 90-days</p>

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	<p>Exempt employers &lt;50 FTEs from penalties</p> <p>Employers that offer coverage must provide “free choice voucher” in amount = employer’s share of premium to employees &lt;400% FPL whose premium share &gt;8% and &lt;9.8% of income and who plan to obtain insurance through Exchange (employers offering voucher are not subject to penalties above)</p> <p>Effective 1/1/2014</p>
Limit enrollment waiting period	<p>Limits waiting periods to not more than 90-days</p> <p>Effective 1/1/2014</p>
Medicaid expansion (for lowest income with or without children)	<p>Yes; up to 133% FPL</p> <p>FMAP rate for newly eligible = 100% in 2014-16  = 95% in 2017  = 94% in 2018  = 93% in 2019  = 90% in 2020 and beyond</p> <p>States that cover up to 100% FPL will receive phased-in increases for childless adults up to 90% by 2020</p> <p>Nebraska treated the same as other states</p> <p>Effective 1/1/14</p> <p>Beginning April 1, 2010, states can cover adults at/below 133% FPL in Medicaid</p>
Require CHIP enrollees to get coverage through Exchange	<p>Yes; CHIP funding ends in FY15, then eligible children covered through Medicaid or Exchange (with DHHS approval)</p> <p>States continue to receive 23% enhanced FMAP up to 100% cap for FY16-19</p> <p>Children of qualifying state/local employees can enroll in CHIP</p>
Minimum loss ratios (mandatory payout	Medical loss ratio reporting

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percentage) for health plans	<p>Must rebate excess of 85% medical loss ratio in large group or 80% of small group market</p> <p>Effective plan year 2010 for reporting; 1/1/2011 for rebates</p> <p>Require rebate to HHS if Medicare Advantage plan's loss ratio &lt;85% (effective 2014)</p> <p>3-year suspension from Medicare Advantage if plan's medical loss ratio &lt;85% two years in a row; disqualify plan from Medicare Advantage if medical loss ratio &lt;85% five years in a row (effective 2011)</p>
Basic Health Program	<p>Available for states to offer to individuals between 133-200% of FPL who would otherwise receive premium subsidy. Plan must meet essential benefit set and premiums cannot exceed those of Exchange premiums. State receives 95% of premium subsidy amount</p> <p>Operates outside of the Exchange.</p>
High risk pool	<p>Individuals previously denied coverage due to pre-existing condition and uninsured for 6 months could enroll in high risk pool with premium subsidies</p> <p>Cost sharing limited to HSA limits</p> <p>Effective 6/21/2010 to 1/1/2014</p>
Dependent coverage extension	<p>Up to age 26 for individual and group policies</p> <p>Effective 9/22/2010</p>
<b>Payment Cuts &amp; Reforms</b>	
Value Based Purchasing Program	<p>Applies to PPS hospitals, budget neutral</p> <p>Based on quality measures for heart failure, heart attack, pneumonia, surgical care activities, and patient satisfaction</p> <p>Efficiency measures (at least 2) included in 2014</p> <p>Funded through phased-in 1-2% withholds across all DRGs on low-performing hospitals</p>

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	<p>Includes incentives for attainment or improvement</p> <p>Effective 10/1/2012</p> <p>CAHs: 3-year demo projects</p> <p>Pilot programs for VBP for psych, IRFs, LTCHs, cancer hospitals and hospice in 2016; could be expanded in 2018.</p> <p>Physicians: 2% incentive for reporting; 1% penalty for not reporting</p>
Hospital-acquired conditions	<p>1% Medicare cut to bottom quartile of hospitals based on hospital-acquired conditions</p> <p>Effective 10/1/2014</p>
Extend Medicare nonpayment policy for health care acquired conditions to Medicaid	<p>Effective 7/1/2011</p>
Readmissions policy for PPS hospitals	<p>Begin with heart attack, heart failure and pneumonia measures from Hospital Compare; expanded to other yet-to-be-named conditions in 2015</p> <p>Not limited to preventable/avoidable readmissions</p> <p>Poor performing hospitals will have all Medicare payments reduced by an amount equal to value of payments for excess readmission</p> <p>Effective 10/1/2012</p>
Bundles – Medicare pilot program	<p>Establish pilot program to test 8-10 conditions for bundled payment by 2013; HHS may expand program by 1/1/2016</p> <p>Hospitals, physician groups, SNF and home health agency may apply</p> <p>Requires separate pilot program for continuing care hospital (CCH) model, which provides traditional inpatient rehab facility services, LTCH and SNF under common management. Would include CCH stay + 30 days post discharge</p>
Bundles – Medicaid demo program	<p>Medicaid bundling demo in 8 states from 2012-16</p>

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Accountable Care Organizations	<p>Authorizes DHHS to use other payment methodologies, including ACOs, effective 1/1/2012</p> <p>Includes Part A and Part B services</p> <p>Allows DHHS to give preference to providers participating in ACO model with private payers</p> <p>Allows hospitals to participate in leadership role of ACO</p> <p>Allows state Medicaid programs to run pediatric ACO demos from 2012-17</p>
Independence at Home Medicare demo project	<p>Project to provide high-need beneficiaries with primary care services in home and allow providers to share in savings from reduced preventable hospitalizations, readmissions, improved outcomes, reduced costs and patient satisfaction</p> <p>Effective 1/1/2012</p>
Global payment demonstration project (Medicaid)	<p>Safety net hospitals</p> <p>Effective 10/1/2009 through 12/31/2012</p>
Promoting value in Medicare payments and/or reduce geographic disparities	<p>Beginning in 2012, CMS provides reports to physicians comparing their resource use with that of other physicians</p> <p>Beginning in 2015 for certain physicians and 2017 for all physicians, budget neutral value-based purchasing program for physicians based on quality of care compared to cost and applying a payment modifier (value index) under the physician fee schedule</p> <p>\$400 million over 2011 and 2012 to hospitals in counties with lowest quartile Medicare spending</p> <p>\$400 million in 2010-11 to physicians in counties with lowest quartile Medicare spending</p> <p><i>(side agreement with Obama administration to complete two studies of geographic disparities and rewarding value over volume in payment methodologies with implementation beginning in 2013 and to hold national summit on payment disparities in 2010)</i></p>

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Medicare DSH cuts	<p>\$22.1 billion over 10 years</p> <p>75% cut in FY2014 and beyond to eliminate DSH payments above "empirically justified" amounts; amount of cut would be reduced if uninsured rate decreases don't materialize</p> <p>Portion of 75% cut returned to hospitals depending on amount of uncompensated care they provide</p>
Medicaid DSH cuts	<p>\$17.5 billion over 10 years</p> <p>\$500 million in 2014  \$600 million in 2015  \$1.8 billion in 2017  \$5 billion in 2018  \$5.6 billion in 2019  \$4 billion in 2020</p> <p>Instructions to distribute cuts so larger reductions in states with lowest uninsured rate</p> <p>Effective 10/1/2011</p>
Market basket update cuts	<p>\$112.6 billion over 10 years; phased-in with larger cuts in out years; cuts are not dependent on drops in rate of uninsured or uncompensated care</p> <p>Cuts apply to PPS inpatient; hospital outpatient; inpatient psych. hospitals; inpatient rehab and LTCHs:</p> <p>4/1/2010-11: market basket - 0.25%  2012-13: market basket – (0.1% + productivity adjustment)  2014: market basket – (0.3% + productivity adjustment)  2015-16: market basket – (0.2% + productivity adjustment)  2017-19: market basket – (0.75% + productivity adjustment)  2020 and beyond: market basket – productivity adjustment</p>
Wage index reform	Requires CMS report and recommendations for comprehensive reform by 2012
Extend section 508 reclassifications	One-year extension

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Independent Payment Advisory Board	<p>15 members appointed by President with advice and consent of Senate</p> <p>Submit legislative proposals to reduce per Medicare beneficiary growth rate if spending exceeds targets beginning 1/15/2014</p> <p>IPAB prohibited from rationing care, increasing revenues or changing benefits</p> <p>Excludes PPS hospitals through 2019, clinical labs for one year</p>
Physician rate increases	<p>10% bonus to primary care physicians and general surgeons in health professional shortage areas</p> <p>Effective 2011-15</p> <p>1% FMAP increase for preventive services and immunizations provided to Medicaid patients without cost sharing Effective 1/1/2011</p> <p>Increase Medicare payments to 100% of charges or fee schedule for certain preventive care services Effective 1/1/2011</p> <p>Fee for service and managed care Medicaid payment rates for primary care provided by primary care doctors (family, general internal or pediatric) = 100% of Medicare rates for 2013-14 with 100% federal financing for increases</p>
Medicaid health care home incentive	<p>State plan option to permit Medicaid enrollees with two or more chronic conditions or one chronic condition and risk factors for developing a second chronic condition to select a provider as their health care home; provide states with 90% FMAP match for two years</p> <p>Effective 1/1/2011</p>
Community First Choice Option (Medicaid)	<p>Provide community based attendant supports to individuals with disabilities and provide state with enhanced FMAP of 6% for reimburseable expenses</p> <p>Effective 10/1/2011 through 9/30/2016</p>

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Expand 340B drug program	Extends eligibility for the 340B drug discount outpatient program to children's, cancer and critical access hospitals, certain sole community hospitals and rural referral centers. Does not expand the program for 340B hospitals to inpatient drugs. Exempts orphan drugs from required discounts for new 340B entities.
Medicare Advantage	<p>Revise payments by setting payments to different percentages of fee for service rates with higher payments in areas with low FFS rates (phase-in effective 2011)</p> <p>Cap total payments, including bonuses, at current payment levels</p> <p>Require rebate to HHS if loss ratio &lt;85% (effective 2014)</p> <p>3-year suspension from Medicare Advantage if medical loss ratio &lt;85% two years in a row; disqualify plan if medical loss ratio &lt;85% five years in a row (effective 2011)</p>
<b>Transparency</b>	
Hospital-Acquired Infections	Requires public reporting of HAI based on Medicare claims data used to prevent moving from lower- to higher-paying DRG
Quality transparency	<p>Value-based purchasing and other quality measures would be publicly available</p> <p>IRFs, LTCHs and Hospice: pay-for-reporting with 2% reduction for non-reporting</p> <p>Inpatient psych hospitals and units required to report quality measures in 2014 with 2% reduction for non-reporting</p> <p>Insurers in Exchanges must report on pediatric quality measures</p> <p>Medicaid-specific quality measures created and publicly reported</p>
Cost transparency	Public reporting of all charges for DRGs
Health plan transparency	Requires all qualified plans to publicly report payment claims, payment policies, rating practices, clinical services expenses, quality improvement costs, non-claims costs and premium revenues

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Comparative effectiveness research	Creates an institute for clinical comparative effectiveness research including at least 1 hospital representative on 21-member board; results cannot be used to mandate coverage or reimbursement decisions; financed partially by fee on health plans through 2019
Center for Medicare and Medicaid Innovation (CMI)	Allows for testing payment and delivery reform within Medicare, Medicaid, CHIP; focus on projects expected to reduce costs and improve quality Effective 1/1/2011
<b>Provisions Relating to Specific Types Hospitals or Providers</b>	
New requirements for 501(c)(3) hospitals	Complete and publicly report community needs assessment at least every 3 years; adopt and publicize a financial assistance policy; prohibit charging uninsured individuals more than insured rates; additional Form 990 reporting and IRS review similar to SEC oversight of publicly traded companies
Rural hospitals	<p>Extends the outpatient hold-harmless payments for certain hospitals in rural areas</p> <p>Ensures that CAHs are paid 101% of costs for all outpatient services regardless of the billing methods elected</p> <p>Extends and expands the Rural Community Hospital Demonstration Program for 5 years</p> <p>Extends the Medicare Dependent Hospital program for one year</p> <p>Extends the Medicare Rural Hospital Flexibility Program through 2012</p> <p>Extends reasonable cost reimbursement for laboratory services in small rural hospitals</p>
Low-volume hospitals	<p>\$300 million over 10 years</p> <p>Expands and improves Medicare inpatient PPS adjustment for low-volume hospitals</p> <p>Increases size of low-volume hospital from 1,500 to 1,600 discharges per year</p>
Long-Term Care Hospitals	2-year extension of LTCH protections and moratorium in Medicare, Medicaid and SCHIP Extension Act of 2008

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<b>Employer provisions</b>	
Small business tax credits for employee health insurance	<p>From 2010-13:</p> <p>25 or fewer employees and avg wages &lt;\$50,000 that purchase coverage for employees eligible for tax credit worth 35% of employer's premium contribution if employer pays at least 50% of cost</p> <p>10 or fewer employees and avg wages &lt;\$25,000 that purchase coverage for employees eligible for tax credit worth 100% of employer's premium contribution</p> <p>Tax exempt business with 25 or fewer employees and avg wages &lt;\$50,000 eligible for tax credit worth 25% of premium cost</p> <p>After 2013 and purchasing insurance through Exchange, 2 years of tax credits for small businesses:</p> <p>25 or fewer employees and avg wages &lt;\$50,000 that purchase coverage for employees through Exchange eligible for tax credit worth 50% of employer's premium contribution if employer pays at least 50% of cost</p> <p>10 or fewer employees and avg wages &lt;\$25,000 that purchase coverage for employees through Exchange eligible for tax credit worth 100% of employer's premium contribution</p> <p>Tax exempt business with 25 or fewer employees and avg wages &lt;\$50,000 eligible for tax credit worth 35% of premium cost</p>
Reinsurance for early retirees	<p>Pay employer or insurer 80% of claims between \$15,000 and \$90,000 for retirees over 55 but not yet Medicare eligible</p> <p>Effective 6/21/10 through 1/1/14</p>
Wellness program incentives	<p>\$200 million in grants over 5 years for businesses with less than 100 employees and don't have wellness program as of enactment</p> <p>Effective 10/1/2011 through 9/30/2016</p> <p>Employer-sponsored plans could offer premium discounts or other incentives for employee</p>

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	participation in wellness programs Effective 1/1/2014  DHHS demo program for individual market incentives in 2014
<b>Workforce Provisions</b>	
Redistribute unused GME slots	Redistribute 65% of unused residency training positions with focus on primary care and general surgery and states with lowest resident physician-to-population ratio; qualified hospitals could request up to 75 new slots Effective 7/1/2011
Increase scholarship and loan repayments	Grants, scholarships and loans for primary care, rural providers, public health workers, preventive medicine training for medical residents, cultural competence
<b>Other Provisions</b>	
Administrative simplification	Adopt single set of operating rules for <ul style="list-style-type: none"> <li>• eligibility verification and claims status (rules by 7/1/2011, effective 1/1/2013)</li> <li>• EFT, payment and remittance (rules by 7/1/2012, effective 1/1/2014)</li> <li>• Claims, enrollment, premium payments, referral/authorization (rules by 7/1/2014, effective 1/1/2016)</li> </ul> Health plan noncompliance penalty = \$1/covered life (effective 4/1/2014)
Physician self referral/physician-owned hospitals	Eliminates Stark exception for physician-owned hospitals other than those with Medicare provider number as of 12/31/2010; growth restrictions on grandfathered hospitals
Tort reform	Authorizes DHHS to award 5-year demo grants to states for development, implementation and evaluation of tort litigation alternatives Effective 10/1/2010
Abortion	Ensure that federal premium or cost-sharing subsidies are not used for coverage for abortion other than for saving life of woman, or rape/incest  Individual receiving federal assistance that purchases coverage of abortion, federal funds cannot

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	be used for abortion coverage and must be segregated from private premium costs or state funds Allow states to prohibit plans offering abortion coverage in Exchange
<b>Revenue provisions</b>	
Increase Medicare Part A tax rate	Increase 0.9% on >\$200,000 for individuals, >\$250,000 married and impose 3.8% tax on unearned income for these taxpayers Effective 1/1/2013
Cap deductibility of employee compensation for health insurers	\$500,000/employee Effective 1/1/2009
Pharmaceutical industry	\$2.8 billion in 2012-13 \$3 billion in 2014-16 \$4 billion in 2017 \$4.1 billion in 2018 \$2.8 billion in 2019 and annually thereafter
Medical device manufacturer fee	2.3% excise tax on any taxable medical device sold after 12/31/2012
Health insurance fee	\$8 billion in 2014 \$11.3 billion in 2015-16 \$13.9 billion in 2017 \$14.3 billion in 2018 Previous fee x rate of premium growth thereafter  Nonprofit insurers have only 50% of net premiums taken into account when calculating share of annual fee  Exemptions for nonprofit insurers with >80% of premium revenue from government programs targeted to low-income, elderly or disabled populations and VEBA not established by employer
High-premium plans (Cadillac plan) tax	40% excise tax on value of employer-sponsored premium that exceeds \$10,200/individual, \$27,500/family Effective 1/1/2018

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Tanning services	10% tax Effective 1/1/2010
Eliminate tax deduction for employers that receive Medicare Pt D retiree drug subsidy payments	Effective 1/1/2013
Limit HSA, medical flex account, pre-tax expenditures to prescription medications (not over-the-counter drugs)	Effective 1/1/2011
Increase tax on non-qualified distributions from HSA	Increase from 10% to 20% Effective 1/1/2011
Limit medical flex account contribution to \$2,500 then tied to cost of living adjustment	Effective 1/1/2013
Increase threshold for medical expense itemized deduction	Increase from 7.5% to 10% AGI except for people over age 65 for 2013-16 Effective 1/1/2013