Patient Protection and Affordable Care Act
Health Care and Education Reconciliation Act

Federal Health Care Reform
Summary of Coverage Provisions
April 6, 2010

The Oklahoma Hospital Association is pleased to provide to its members this general, abbreviated summary of coverage provisions contained within the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

Hospital Impact

Medicare and Medicaid Disproportionate Share Hospital (DSH) Payments

Expanded coverage provided under the new law shrinks the number of uninsured seeking medical care. This, in turn, reduces the need for hospitals to cost-shift such expenses.

Hospitals currently receive an additional payment when they serve high volumes of uninsured patients by Medicaid and Medicare. The Medicare DSH amount will be reduced by $22.1 billion in 2014, but such reductions are subject to a trigger, and will be phased in as coverage of the uninsured increases. A separate methodology will be developed for the Medicaid DSH program, reducing state allotments for this program.

Rural Hospital Provisions

Sustains and improves access to care in rural areas through such improvements as:

1. Extends the outpatient hold-harmless payments for certain hospitals.
2. Improves payments for low-volume hospitals.
3. Ensures that Critical Access Hospitals are paid 101 percent of costs for all outpatient services.
4. Extends and expands the Rural Community Hospital Demonstration Program.
5. Extends the Medicare Dependent Hospital Program for one year.
6. Extends the Medicare Rural Hospital Flexibility Program through 2012.
7. Extends reasonable cost reimbursement for labs in small rural hospitals.

Primary Care Physicians

Requires states to increase Medicaid payment rates to primary care providers to Medicare levels in 2013 and 2014, while providing states with 100 percent federal funding to cover the cost.

Physician Bonus

Provides a 10 percent bonus in Medicare payments to primary care physicians and to general surgeons practicing in health-professional-shortage areas from 2011 through 2015.

Medicare Extenders

Provides additional payments for ground ambulance and outpatient therapy caps, as well as 5 percent more in physician payments for certain psychiatric therapeutic procedures. Includes one-year extensions of certain Medicare provisions, including Section 508 wage-index reclassifications; increasing the work geographic index to 1.0; grandfathers direct billing for anatomic pathology technical component services.

Hospital Market Basket Updates

Reduces hospital Medicare updates by approximately $112.6 billion over 10 years. These reductions will begin on April 1, 2010, at a rate of 0.25 percentage point with an increase up to 0.75 percentage point by 2017-2019. By 2020, hospital payment updates will be reduced by a measure of estimated economy-wide productivity gains.

Hospital-Acquired Conditions (HACs)

Beginning in 2015, adds a 1 percent penalty to hospitals in the top quartile of rates for Hospital Acquired Conditions, resulting in $1.5 billion in payment reductions over 10 years.

Bundling

By 2013, establishes a national voluntary five-year program on bundling payments to providers, involving 10 conditions.

Readmissions

By 2013, imposes financial penalties on hospitals for so-called “excess” readmissions when compared to “expected” levels of readmissions based on measures for heart attack, heart failure and pneumonia, which are currently part of the Medicare pay for reporting program. Critical access hospitals and post-acute care providers are excluded.

Accountable Care Organizations (ACOs)

Beginning in 2013, hospitals may cooperate with physicians to provide leadership in voluntary ACOs, which are responsible for managing care of certain beneficiaries. Any savings from improved care could be shared with providers.

Value-Based Purchasing (VBP)

Beginning in 2013, establishes a VBP program for hospital payments based on hospital performance in 2012 on measures that are part of the hospital quality reporting program.

Geographic Variation

Includes $400 million for payments for FYs 2011 and 2012 to section 1886(d) hospitals located in counties that rank in the lowest quartile for age, sex and race adjusted per enrollee spending for Medicare Parts A and B.

Innovation Center

Creates a Center for Medicare and Medicaid Innovation within CMS by 2011 to test innovative payment and service delivery models to improve quality and reduce program expenditures.

Physician Self-Referral

Eliminates the exception for physician-owned hospitals under the Stark Law but grandfathers hospitals with a Medicare provider number as of Dec. 31, 2010. It requires compliance with disclosure, patient safety, bona fide investment, and growth restriction rules. The bill also provides limited exceptions to the growth restrictions for grandfathered physician-owned hospitals including a new exception for hospitals that treat the highest percentage of Medicaid patients in their county and are not the sole hospital in the county.

Independent Payment Advisory Board (IPAB)

Creates an independent board that would make recommendations on Medicare payment policy and non binding recommendations for changes in private payer payments to providers. The recommendations exclude providers such as hospitals (but not critical access hospitals) through 2019.

340B Program

Extends eligibility for 340B drug discount outpatient program to children's, cancer, critical access and sole community hospitals, and rural referral centers. It does not expand the program for existing 340B hospitals to cover inpatient drugs.

Graduate Medical Education

Contains no reduction in IME payments. Increases the number of GME training positions by redistributing 65 percent of currently unused slots, with priorities given to primary care and general surgery, to states with the lowest resident physician to population ratios. Qualified hospitals would be able to request up to 75 new slots. Allows for teaching health centers, defined as community based, ambulatory patient care centers, including FQHCs and other federally funded health centers that are eligible for Medicare payments for expenses associated with operating primary care residency programs.

Note: Oklahoma is currently ranked 40th in the nation in number of patients per primary care physician.

Long-Term Care Hospitals (LTCH)

Extends for two years selected LTCH provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2008. Further delays the full implementation of the 25% Rule, the short stay outlier cuts, and one-time budget neutrality adjustments planned by CMS. Extends current moratorium on new LTCH beds and facilities, with exceptions.

Workforce Provisions

Increases workforce supply and support training of health professionals through scholarships and loans. Supports primary care training and capacity building. Provides state grants to providers in medically underserved areas. Establishes a public health workforce loan program. Promotes training of a diverse workforce and promotes cultural competence training of health care professionals. Increases mental and behavioral training programs as well as oral health training programs.

Community Needs Assessment

Requires non-profit hospitals to conduct a community needs assessment every three years.

Trauma

Funds emergency medicine research and strengthens emergency department/trauma center capacity.

Medicaid

Medicaid Eligibility

1. Expands Medicaid to all individuals under age 65 (children, pregnant women, parents and adults without dependent children) with incomes up to 133 percent of the federal poverty level based on modified adjusted gross income. Newly eligible adults will be guaranteed a benchmark benefit package. To finance this, newly eligible states will receive 100 percent federal financing for 2014-2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent in 2020 and beyond.

   Primary care physicians will receive 100 percent of Medicare rates for care provided to Medicaid patients, matched at 100 percent federal financing.

   Note: For Oklahoma, this will add 265,000 childless adults with incomes below 133 percent of the federal poverty level to Medicaid beginning in 2014, with 100 percent of the cost paid by the federal government and decreasing to 90 percent by 2020. This means a single person making $14,403 annually, or $6.92 per hour or less would qualify. By 2020, the state's cost for these benefits will be approximately $21 per member per month. This has the potential of reducing Oklahoma's uninsured rate from 16.8 percent to 10.7 percent.

2. Coverage for mental health and substance abuse conditions will provide costs savings to the state of Oklahoma because this care is currently paid for 100 percent by state funds.

Long Term Care Insurance (CLASS Program)

Establishes a national, voluntary insurance program for purchasing community living assistance services and support. After a five year vesting period, the program will provide individuals with functional limitations of $50 per day to purchase non medical services and supports necessary to maintain community residence. This program is financed with voluntary payroll deductions and all working adults will be automatically enrolled in the program unless they choose to opt-out.

Mandates

Individual Mandates

Requires most U.S. citizens and legal residents to have health insurance. Exchanges will be created for individuals and families to purchase coverage with premium and cost-sharing credits based upon income between 133 percent and 400 percent of the federal poverty level. Creates separate exchanges for small business. Further, employers will be required to pay penalties for employees who receive tax credits for insurance through an exchange.

- Tax penalty for individual not obtaining coverage will be phased in of the greater of $695 per year up to a maximum of three times that amount per family or 2.5 percent of household income. Penalty begins in 2014 at $95, $325 in 2015, and $695 for 2016 for the flat fee of 1 percent of taxable income in 2014, 2 percent in 2015, and 2.5 percent in 2016. Exemptions may be granted for certain circumstances.

Premium and Cost Sharing to Individuals

Limits, based upon income level, the availability of premium credits and cost sharing subsidies through the exchanges to U.S. citizens and legal immigrants. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer's plan does not have an actuarial value of at least 60 percent or if the employee's share of the premium exceeds 9.5 percent of income.

Refundable and advanced premium credits are provided to eligible individuals and families with incomes between 133-400 percent federal poverty level to purchase insurance through the exchange. Exchanges will offer tiered plans and premium contributions are tied to income levels, ranging from 2 percent of income (133 percent of federal poverty level) to 9.5 percent of income (300-400 percent federal poverty level).

Employer Mandates

Exempts employers with 50 or fewer employees. Assesses employers with more than 50 employees (that do not offer coverage and have at least one full time employee who receives a premium tax credit) a fee of $2,000 per full time employee, excluding the first 30 employees from the assessment.

Employers with more than 50 employees (that offer coverage but have at least one full time employee receiving a premium tax credit) will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full time employee. (Effective January 2014)

Requires employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400 percent federal poverty level. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan which the employee is enrolled. Employers providing vouchers will not be subject to penalties for employees that receive premium credits in the exchange.

Requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

Premium Subsidies to Employers

Provides a tax credit, phased over two years, to small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees.

Creates a temporary reinsurance program for employers providing health insurance coverage to retirees over the age of 55 who are not eligible for Medicare. This program will reimburse employers for 80 percent of retiree claims between $15,000 and $90,000. Payments will be used for a reinsurance pool to lower cost of other enrollees in the plan.

Tax Changes

Health Insurance

1. Individual mandate outlined above (see section on mandates, page 5). Taxes individuals without qualifying coverage the greater of $695 per year up to a maximum of three times that amount or 2.5 percent of income phased in beginning in 2014.
2. Excludes costs for over the counter drugs not prescribed by a doctor from being reimbursed through health savings accounts (HSAs), flexible spending accounts (FSAs) and from being reimbursed on a tax free basis through an HSA or Archer Medical Savings Account (MSA).
3. Increases tax on distributions that are not used for a qualified medical expense from an HSA or Archer MSA.
4. Limits contributions to flexible spending account to $2,500 per year with annual increases beginning Jan. 1, 2013.
5. Increases threshold for itemized deduction for unreimbursed medical expenses from 7.55 percent adjusted gross income to 10 percent adjusted gross income; waives the increase for individuals greater than 65 for 2013 to 2016.
6. Increases Medicare Part A tax rates on wages by 0.9 percent on earnings for individuals earning $200,000 or married couples earning $250,000 and a 3.8 percent tax on unearned income for higher income taxpayers.
7. Cadillac plans – imposes an excise tax of 40 percent on employer sponsored health plans with aggregate values or premiums that exceed $10,200 for individual coverage and $27,500 for family coverage. Allows for additional threshold amounts for workers in high-risk professions and retired individuals greater than 55 and not eligible for Medicare. These provisions are effective in 2018.
8. Eliminates tax deduction for employers who receive Medicare Part D drug subsidy payments.

Financing Health Reform

1. Imposes new annual fees on pharmaceutical manufacturers; starts at $2.8 billion in 2012-2013, $3 billion in 2014-2016, $4 billion in 2017, $4.1 billion in 2018, and $2.8 billion in 2019 and later.
2. Imposes a new annual fee on the health insurance sector; starts at $8 billion in 2014, $11.3 billion in 2015-2016, $13.9 billion in 2017, and $14.3 billion in 2018, with subsequent years increased by rate of premium growth. Certain exceptions are made for non-profit insurers that receive more than 80 percent of income from government programs for low-income or elderly employees.

3. Imposes an excise tax of 2.3 percent on sales of any taxable medical device.
4. Imposes a tax of 10 percent on amount paid for indoor tanning services.
5. Excludes unprocessed fuel from the definition of cellulosic bio-fuel producer credit.

Insurance

Sale of Insurance Products Across State Lines

Permits states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state exchanges. (Regulations issued by July 1, 2013, with compacts not taking effect before Jan. 1, 2016).

Administrative Simplification

Simplifies health insurance administration by adopting a single set of operating rules for conduct including eligibility verification, claims status, electronic funds transfers, health care payment and remittance, health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health premium payments, and referral certification and authorization.

Medicare Advantage

Restructures payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service rates, with higher payments for areas with low fee-for-service rates and lower payments for areas with high fee-for-service rates. Payment changes will be phased in over time. Bonuses are provided for quality ratings. Requires partial payment back to the government if the medical loss ratio is less than 85 percent.

Insurance Exchanges

SHOP
There is no provision to create a public plan option, but it does create Small Business Health Options (SHOP) Exchanges, administered by a governmental agency or non-profit organization through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permits states to allow businesses larger than 100 employees to participate in this exchange beginning in 2017. Regional exchanges are allowed. There must be at least two multi-state plans in each Exchange and at least one must be a non-profit entity. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and have a separate risk pool

CO-OP (Consumer Operated and Oriented Plan)
Non-profit, member-run health insurance companies in all 50 states will be created that cannot be an existing health insurer or sponsored by a state or local government with governance of the organization subject to a majority vote of its members.

Benefit Tiers
Four benefit categories of plan offerings plus a separate catastrophic plan to be offered through the exchange and in the individual and small group markets:

1. Bronze plan – lowest level of coverage, covers 60 percent of benefit costs plus some health savings account limits.
2. Silver plan – provides essential benefits, covers 70 percent of benefit costs with health savings account out-of-pocket limits.
3. Gold plan – provides essential benefits, covers 80 percent of benefit costs with health savings account out-of-pocket limits.
4. Platinum plan – provides essential benefit, covers 90 percent of benefit costs with health savings account out-of-pocket limits.
5. Catastrophic plans for those up to age 30 or those who are exempt from mandate to purchase coverage, with coverage levels set at health savings account current law levels except for prevention benefits and coverage for three primary care visits without a deductible.

Reduces out-of-pocket limits for those with incomes up to 400 percent federal poverty level (FPL) from a minimum of $1,983 for an individual at 100 percent FPL to a maximum of $3,987 for an individual at 400 percent FPL.

Guarantee Issue and Renewability

1. Age rating limited to a 3 to 1 ratio.
2. Premium rating area, family composition, and tobacco use limited to 1.5 to 1 ratio.
3. Requires risk adjustment in the individual and small group markets and in the exchange.

Qualifications for Health Plans
Requires plans participating in the exchange to have adequate provider networks and be accredited with respect to quality measures, use a uniform enrollment form, report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost sharing requirements, and enrollee rights.

Requirements for the Exchanges
Requires a call center for customer service, establishes procedures for enrolling individuals and determining eligibility for tax credits. Permits exchanges to work with Medicaid agencies to determine eligibility for tax credits. Requires exchanges to submit financial oversight reports.

Basic Health Plan
Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133 percent and 200 percent federal poverty level.

Basic Benefit Design
Creates essential health benefits package that provides a comprehensive set of services, covers at least 60 percent of the actuarial value of the covered benefits, limits annual cost sharing to current health savings account limits.

Temporary High Risk Pool

Establishes a temporary national high risk pool for individuals with pre-existing conditions with premiums established for a standard population and may vary by no more than 4 to 1 due to age. Effective within 90 days of enactment until Jan. 1, 2014.

Medical Loss Ratios

Requires health plans to report when premium spent is less than 85 percent for large group markets and 80 percent for individual markets. Provides for rebates when this occurs.

Requires review of health plan premium increases.

Dependent Coverage

Requires dependent coverage for kids up to age 26 for all individual and group policies.

Insurance Market Rules

1. Prohibits pre-existing condition exclusion for children, effective six months from enactment.
2. Prohibits placing lifetime limits and rescinding coverage except in cases of fraud.
3. Prohibits individual and group health plans from placing annual limits on dollar value of coverage beginning January 2014.
4. Imposes these same insurance market regulations on guarantee issue, premium rating, and pre-existing condition in individual market, the exchange, and in the small group market.
5. Limits deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts.
6. Allows states the option of merging the individual and small group markets.

Consumer Protections

Establishes a Web site to help individuals identify health coverage options. Develops standards for insurers to use in providing information on coverage and benefits.

State Role

Creates a Small Business Health Options Program (SHOP) Exchange for individual and small businesses and provides oversight of health plans with regard to the new insurance market regulations, etc.

Permits states to obtain a five year waiver if state can demonstrate it provides coverage to all residents that is at least as comprehensive as required under the exchange and it doesn't increase the federal budget deficit.

Cost Savings

Administrative Simplification

See Insurance Reforms section, page 7.

Medicare

Freezes threshold for income-related Medicare Part B premiums for 2011-2019 and reduces the prescription drug subsidy for those with incomes about $85,000 for individuals and $170,000 for couples.

Reduces annual market basket updates for health care facilities under Medicare.*

Reduces Medicare DSH payments to hospitals.*

Reduces hospital payment updates.*

Reduces hospital payment for excess readmissions.*

Reduces hospital payments for hospital acquired conditions.*

Accountable Care Organizations and Value Based Purchasing.*

***For more detail, see Hospital Impact section, pages 1-4.*

Medicare Advantage

See Insurance Reforms section, page 7.

Medicaid

Increases Medicaid drug rebate percentages.

Reduces Medicaid Disproportionate Share Hospital allotments.

Prohibits federal payments to states for Medicaid services related to health care acquired conditions. This has already been accomplished as a budget cutting measure this state fiscal year for Medicaid.

Prescription Drugs

Changes FDA approval process for generics.

Waste, Fraud and Abuse

New screening for enhanced oversight by DME suppliers, targeted moratoria in areas identified as high risk, develop database to capture data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health standards.

Improving Quality

Comparative Effectiveness Research

Supports this effort to research clinical effectiveness of medical treatments. Findings may not be construed as mandates, guidelines or recommendation for payment, coverage, or treatment, or used to deny coverage.

Medical Malpractice

Provides five-year demonstration grants for alternatives to current tort litigations. Preference will be given to states that have developed alternatives and are likely to enhance patient safety by reducing medical errors and adverse events and improve access to liability insurance.

Medicare

Develops a national pilot program to evaluate a bundled payment for acute, inpatient hospital, physician, outpatient, and post acute care services for an episode of care. *(See Bundling in Hospital Provisions section above, page 2.)*

Develops an Independence at Home demonstration program to provide high need Medicare beneficiaries with primary care services in their home and allow health professionals to share in savings if hospital preventable admissions are reduced.

Develops a hospital value based purchasing program to pay hospitals based on performance on quality measures. Extends this program to skilled nursing facilities, home health agencies, and ambulatory surgery centers. *(See Value-Based Purchasing in Hospital Provisions section, page 2.)*

Medicaid

Develops medical home model for Medicaid enrollees with at least two chronic conditions.

Develops bundled payment pilot programs for Medicaid and allows pediatric medical providers to develop accountable care organizations.

Provides for Medicaid payments to institutions of mental diseases for adults.

National Quality Strategy

Develops national quality improvement strategy to improve delivery of health care services, patient outcomes, and population health.

Establishes Community-Based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services for uninsured and underinsured populations.

Disparities

Requires enhanced collection of data on race, sex, ethnicity, disability stats, and primary language.

Other Provisions

Medicare

Provides for a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap (donut hole) in 2010.

Phases a decrease in beneficiary coinsurance rate within Medicare Part D coverage gap (donut hole) from 100 percent to 25 percent by 2020.

Wellness/Prevention

Evidence Based Care
Establishes a grant program to support the delivery of evidence-based and community based prevention and wellness services aimed at prevention activities, reducing chronic disease rates and addressing health disparities, especially in the rural and frontier areas. (Funds appropriated for five years beginning in 2010.)

Preventive Health Services
Improves prevention by covering only proven preventing services and eliminates cost sharing for Medicare and Medicaid. Provides incentive modification for Medicare and Medicaid beneficiaries. Requires Medicaid coverage for tobacco cessation services for pregnant women. Requires qualified health plans to provide minimum coverage without cost-sharing for preventive services.

Abortion

Ensures that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or in cases of rape or incest (Hyde amendment). If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted (Hyde amendment), those federal subsidy funds (for premiums or cost sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds.

Nutritional Information

Requires chain restaurants and vending machines to disclose nutritional content of each food item.

Portions of this summary excerpted from Kaiser Family Foundation Web site, www.kff.org, and the American Hospital Association, www.aha.org.