

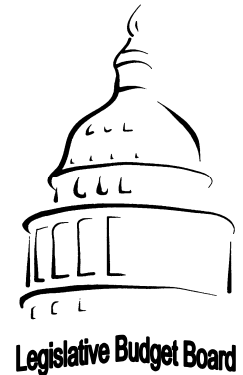
FEDERAL HEALTHCARE REFORM

Presented to the House Special
Committee on Federal Legislation

April 22, 2010



OVERVIEW

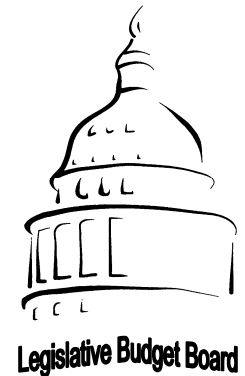


Affects individuals, businesses,
and governments by expanding
health insurance coverage.

- ❖ Reforms Health Insurance
- ❖ Affects Medicaid and other Health and Human Services programs
- ❖ Adds oversight and other responsibilities at the Texas Department of Insurance
- ❖ Implements Health Benefit Exchanges
- ❖ Affects State Employee /Retiree Benefit Systems
- ❖ Provisions take place at different times, some immediately, but many in 2014

INSURANCE REFORMS

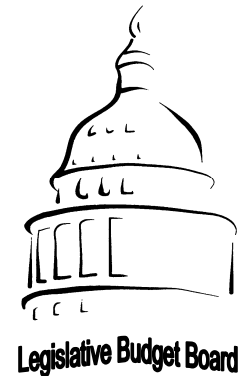
Effective in 2010



- Requires insurance companies to offer coverage of dependent children up to age 26 on parent's policy; tax benefits up to age 27.
- Prohibits discrimination for pre-existing conditions of children (2014 for adults).
- Eliminates cost-sharing for certain preventive services.
- Temporarily establishes a federal High Risk Pool.
- Includes Federal reinsurance assistance:
 - Pays 80% of claims between \$15,000 and \$90,000;
 - For early retirees, ages 55-64;
 - Is limited to \$5 billion nationwide until 2014; and
 - Covers both public and private plans.

INSURANCE REFORMS

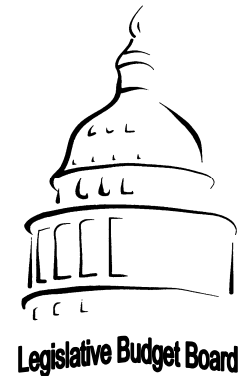
Effective in 2011-2013



- Caps Flexible Savings Accounts to \$2,500 – could increase employer Federal Insurance Contributions Act (FICA) contributions (2011).
- Supports development of a Federal Consumer Operating and Oriented Plan (CO-OP) program to foster member-run health insurance companies (by July 2013).

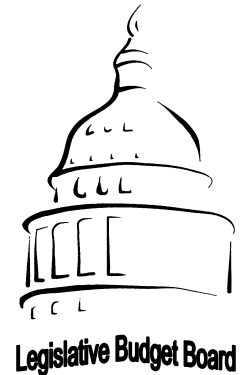
INSURANCE REFORMS

Effective in 2014



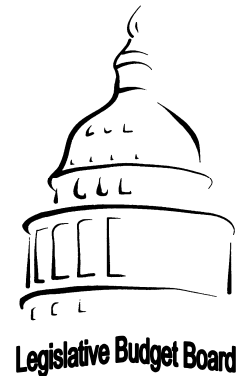
- Mandates individuals get insurance coverage, with phased-in tax penalties for those without it.
- Requires the variation in premiums to be based only on age, geography, tobacco use, and family size.
- Includes provisions intended to simplify and make administration of health insurance more transparent, with a penalty of up to \$1 per covered life for health plans that do not comply.

EMPLOYER IMPACTS



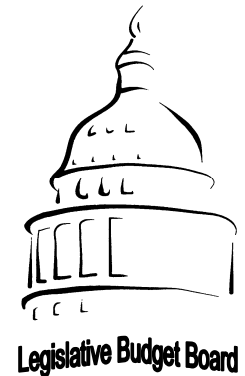
- Large employer mandates for entities with over 50 employees (includes the state):
 - Limits the cap on contributions to flexible spending accounts to \$2,500, possibly increasing FICA contributions (2011).
 - Requires automatic enrollment in insurance plans if over 200 employees, with employee opt out (2014).
 - May be subject to penalties if any employee receives a premium tax credit or cost-sharing reduction through a Health Benefit Exchange (2014).
- Small employers (50 or fewer employees) are not subject to the above requirements:
 - Are not subject to the penalties for large employers.
 - May receive federal tax credits for providing a certain level of insurance (2011).
- Reduces waiting period for new employees to get insurance to no more than 90 days (2014).

HEALTH BENEFIT EXCHANGES



- “Requires” states to develop state-based Exchanges by 2014, but the federal government will do so if states refuse or do not comply with federal requirements by 2013. Health Benefit Exchanges:
 - Facilitate the purchase of qualified health plans by qualified individuals and qualified employers and
 - Assist small employers enroll their employees in a qualified health plan.

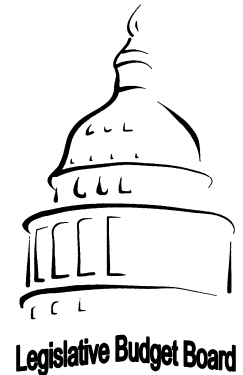
HEALTH BENEFIT EXCHANGES (continued)



- States may contract to offer standard health plans to low income individuals ineligible for Medicaid, instead of offering coverage through an Exchange (2014).
- Enrollment into Medicaid and CHIP must be possible through the Exchange; requires coordination with the Health and Human Services Commission (2014).



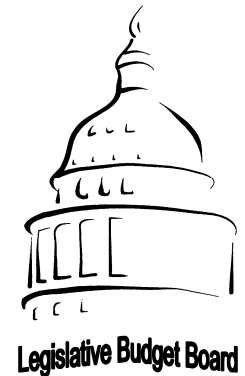
STATE CHANGES



- Health and Human Services Agencies
- Texas Department of Insurance
- Employee/Retiree Benefit Systems
- Institutions of Higher Education

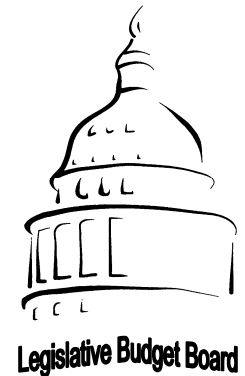


HEALTH & HUMAN SERVICE PROGRAMS



- ❖ Medicaid
- ❖ Children's Health Insurance Program (CHIP)
- ❖ Disproportionate Share Hospital Payments
 - ❖ Community Health Centers
 - ❖ Prevention and Wellness Provisions
 - ❖ Healthcare Workforce

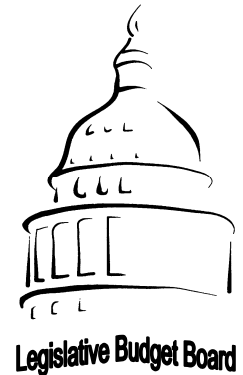
HEALTH & HUMAN SERVICES PROGRAMS



- **Medicaid**
 - Temporary increases the federal share for certain services and populations
 - New required populations
 - Temporary rate increases
 - Changes to eligibility
 - Prescription drug rebates
 - Former Foster Care Children
 - Disproportionate Share Hospital payment reductions

MEDICAID

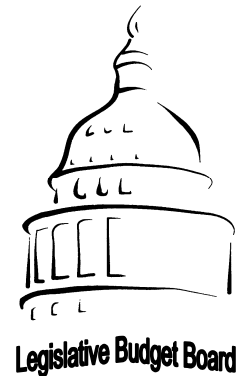
Federal Share and Expanded Populations



- Increases Federal Medical Assistance Percentage (FMAP) for certain preventive services (2011).
- Expands Medicaid to all citizens and legal permanent residents under age 65, up to 133% of poverty (2014):
 - Increases FMAP for newly eligible groups to 100% for three years, reduced gradually to 90% in 2020 forward.
 - Requires minimum benefit levels for the newly eligible.
 - Shifts children under 133% of poverty from Children's Health Insurance Program (CHIP) to Medicaid.

MEDICAID

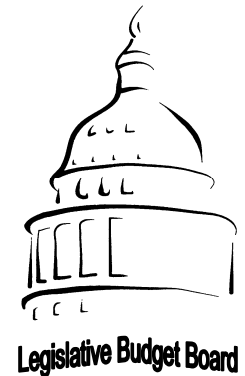
Federal Share and Expanded Populations (continued)



- In order to address current needs and to handle the increased caseload, the Health and Human Services Commission's web-based eligibility system (TIERS) must be fully operational and staffed:
 - Barring delays, HHSC plans to have TIERS rolled out statewide by the end of calendar year 2011.
 - HHSC has requested increases in their capital budget and in Full Time Equivalent staff limits for fiscal year 2011.
 - They will need additional resources to make modifications to comply with the new law.

MEDICAID

Rate Increases



- Increases payments for certain primary care services to Medicare rate:
 - 100% federal funding for two years, 2013-14;
 - State option to return to prior payment level after 2014 at regular FMAP; and
 - Same rate change is not required in CHIP.



MEDICAID

Eligibility Changes

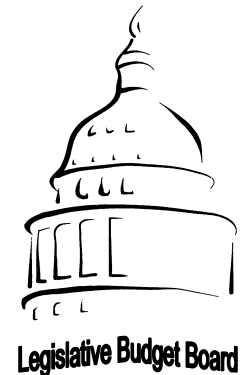


- State must maintain at least the existing eligibility standards until 2014.
- Eliminates assets being considered in determining eligibility (2014).
- Includes new rules for counting income (2014).



MEDICAID

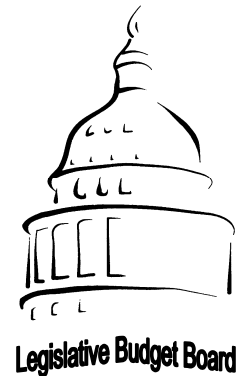
Prescription Drugs



- Increases prescription drug manufacturer rebates to federal government, resulting in:
 - According to the Health and Human Services Commission, loss of revenue for the state initially (2010-13) and
 - Increased rebates due to volume of Medicaid enrollees later.
- Extends prescription drug rebates to managed care organizations (2010).

MEDICAID

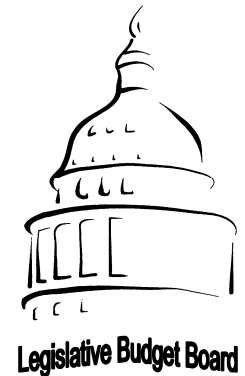
Disproportionate Share Hospital (DSH) Payments



- The Medicaid Disproportionate Share Hospital (DSH) program provides supplemental payments to hospitals that serve large numbers of Medicaid beneficiaries and low-income or uninsured patients.
 - Reduces DSH allotments based on a methodology that will impose the largest reductions to states (2014):
 - With the lowest percentage of uninsured and
 - That do not target DSH funds to hospitals that serve a significant number of Medicaid and uninsured patients.

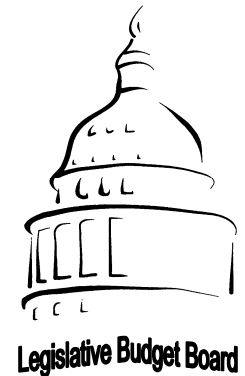
MEDICAID

Other Provisions



- Extends Medicaid coverage through age 26 for individuals who aged out of foster care (2014).
- “Community First Choice” option permits states to offer home and community-based services to disabled people through Medicaid without a waiver (October 1, 2010).
- Provides federal funding for pilots to test payment and service delivery models.
- Eliminates Medicare prescription drug coinsurance for dual-eligible community-based long-term care waiver clients (2012).
- Other changes relating to Medicare could impact Medicaid.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)



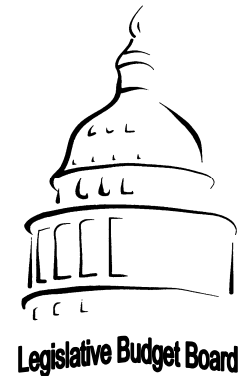
- Extends federal authorization and funding for CHIP through 2015.
- Changes the way to count income for determining eligibility (2014).
- Federal share increases 23 percentage points:
 - From October 2015 to September 2019 and
 - Up to 100 percent.
- State must maintain eligibility standards at least at the level in effect on the date of enactment.

COMMUNITY HEALTH CENTERS



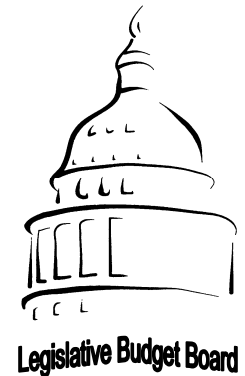
- Expands federal funding for Community Health Centers, including Federally Qualified Health Centers.
 - Community Health Centers:
 - Establishes a Community Health Center Fund to provide enhanced funding for Community Health Center programs.
 - Appropriates a total of \$9.5 billion in enhanced funding over five years: \$1.0 billion in 2011, increasing to \$3.6 billion in 2015.
 - Appropriates \$1.5 billion for construction and renovation of Community Health Centers, available FY 2011 through FY 2015.
 - Federally Qualified Health Centers (FQHCs).
 - Authorizes appropriation of \$3.0 billion in 2010, increasing to \$8.3 billion in 2015.

SELECTED PREVENTION AND WELLNESS PROVISIONS



- Reauthorizes appropriations for preventive health services programs providing vaccines against preventable diseases without charge.
- Requires Medicaid programs to provide tobacco cessation services for pregnant women without cost sharing (October 1, 2010).
- Provides grants to states (2010-19):
 - For pilot programs providing public health interventions, screenings and clinical referrals for individuals between 55 and 64 years of age (2010-14);
 - Childhood obesity demonstration projects (2010-14);

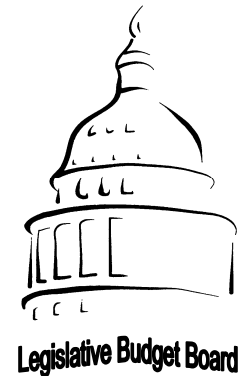
SELECTED PREVENTION AND WELLNESS PROVISIONS (continued)



- Grants to states (continued)
 - To support initiatives providing incentives to Medicaid beneficiaries participating in programs with demonstrated changes in health risks and outcomes;
 - To support cooperative agreements with state for oral health data collection and interpretation, delivery system for oral health and science-based programs to improve oral health (2010-14); and
 - For a demonstration project to improve adult and children immunizations through evidence-based, population-based interventions for high-risk populations (2010-14).

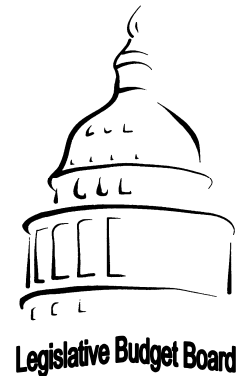


HEALTHCARE WORKFORCE



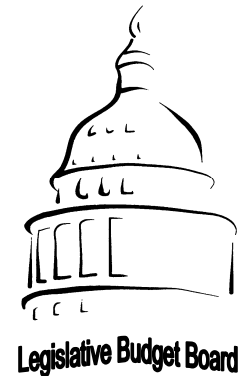
- Additional funding via grants and loans for
 - ❖ Primary Care Physicians
 - ❖ Nursing
 - ❖ School-based Health Centers
 - ❖ Strategic Planning

HEALTHCARE WORKFORCE



- Converts unfilled residency positions under Graduate Medical Education programs to training for primary care physicians (July 2011).
- Amends existing law pertaining to advanced nursing education grants by changing provisions addressing nurse-midwifery programs.

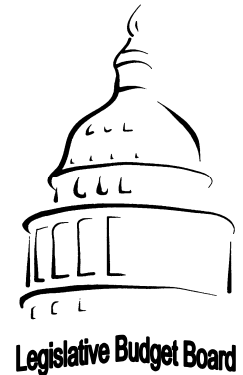
HEALTHCARE WORKFORCE Grant Programs



- Grant funding to:
 - Support new or expanded primary care residency programs at teaching health centers;
 - Initiate and maintain nurse retention programs;
 - Train and enhance primary care providers;
 - Train direct care workers employed in long-term care settings;
 - Train dentists:
 - General, pediatric, and public health dentists
 - \$30 million for FY 2010
 - Amounts as necessary for FY 2011 and 2015;

HEALTHCARE WORKFORCE

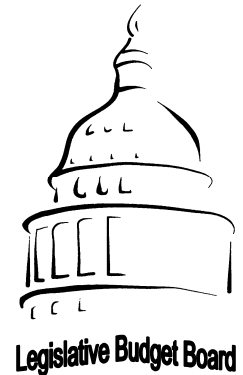
Grant Programs (continued)



- Grant funding (continued) to:
 - Enhance continuing education for health professionals in underserved communities:
 - Priority for primary care
 - Through distance learning, continuing educational activities, and collaborative conferences
 - Includes health professions schools, academic health centers, State or local governments, or other appropriate public or private nonprofit entities;
 - Support community health workers to educate and provide outreach in community settings:
 - Funding is for states, public health departments, clinics, hospitals, federally qualified health centers and nonprofit organizations;

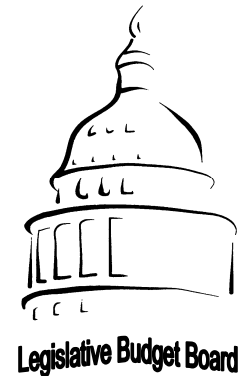
HEALTHCARE WORKFORCE

Grant Programs (continued)



- Grant funding (continued) to:
 - Establish and operate school-based health centers;
 - Establish Area Health Education Centers to support or establish community-based health training and education;
 - Enable states to implement partnerships and comprehensive strategies to develop State health care workforce; and
 - Educate primary care providers about preventative medicine and other quality improvements to improve community health.

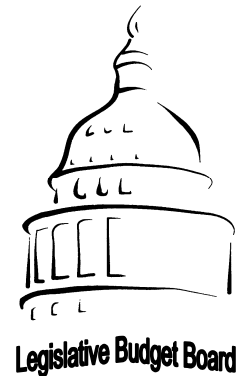
HEALTHCARE WORKFORCE Demonstration Projects and Loan Repayment



- Demonstration Project Grants:
 - Provide low-income individuals with an opportunity to receive education and training for occupations in the health care field.
- Loan repayment programs:
 - Pediatric specialties
 - Nurse faculty
 - Primary care

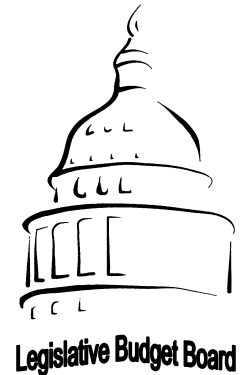


STATE BENEFIT SYSTEMS



- ❖ Employees Retirement System
- ❖ Teacher Retirement System
- ❖ The University of Texas System
- ❖ Texas A&M University System

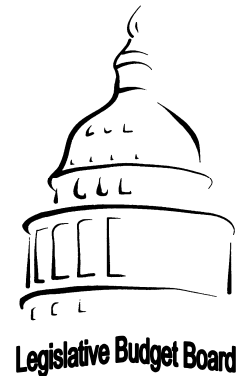
STATE BENEFIT SYSTEMS



- Must include dependent children up to age 26 if health insurance for dependent children is offered (2010).
- Prohibits cost sharing for certain preventive services (2010).
- Limits waiting periods to no longer than 90 days (2014).
- Increased contributions to FICA due to caps on Flexible Savings Accounts (2011).
- Gradually fills in the Medicare “doughnut hole” in coverage for prescription drugs (2011-2020).
- Many provisions, excluding the above, are “grandfathered”, so they will not apply to current plans.

STATE BENEFIT SYSTEMS

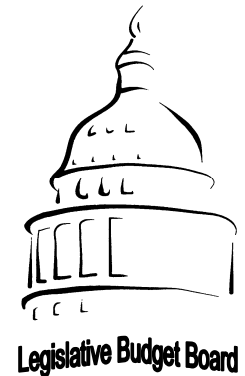
Reinsurance Assistance



- Temporary reinsurance assistance (Effective within 90 days of enactment through December 31, 2013):
 - Is available for early retirees ages 55-64.
 - Federal government pays 80% of claims between \$15,000 and \$90,000.
 - Is limited to \$5 billion nationwide.
 - Applies to both public and private plans.
 - U.S. Secretary of Health and Human Services decides how to distribute the funding.

STATE BENEFIT SYSTEMS

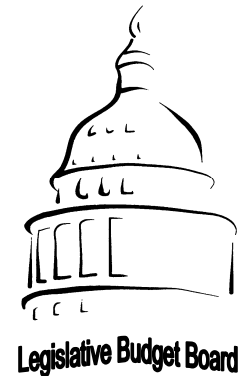
Free Choice Vouchers



- “Free Choice” Vouchers (2014).
 - Vouchers allow employees to seek alternate insurance.
 - Paid by employers for employees who do not participate in the offered health insurance if:
 - Family income is under 400 percent of poverty and
 - Required employee contributions would be 8 to 9.8 percent of annual income.
 - Currently state-paid State Health Insurance Program for children of state employees is paid for families up to 200 percent of poverty.

STATE BENEFIT SYSTEMS

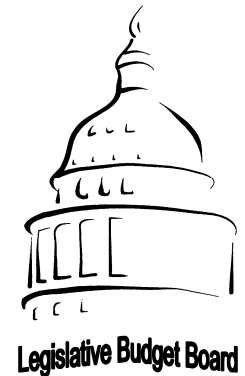
High Cost Plans



- Excise tax on high cost plans (2018):
 - Aggregate value of the plan exceeds \$10,200 for individual and \$27,500 for family coverage.
 - Tax is 40 percent of the value above the threshold.
 - Tax is imposed on the issuer of the policy.
 - Tax is indexed to the increase in health care costs.
 - Texas' plans could become high cost plans in the future due to indexing.

STATE BENEFIT SYSTEMS

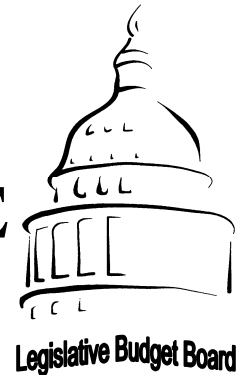
Federal Research Fees



- Fee on plans.
 - Imposed from fiscal year 2013 through 2019.
 - \$1 per covered life for 2013.
 - \$2 per covered life for 2014.
 - Adjusted after 2014 based on the percentage increase in health care costs.
 - Fee is to be used for patient-centered outcomes research.



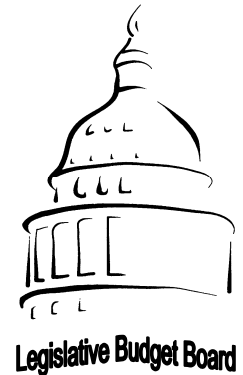
TEXAS DEPARTMENT OF INSURANCE



- ❖ Oversight
- ❖ High Risk Pools.
- ❖ Health Benefit Exchange
- ❖ Consumer Operated and Oriented Plans

TEXAS DEPARTMENT OF INSURANCE

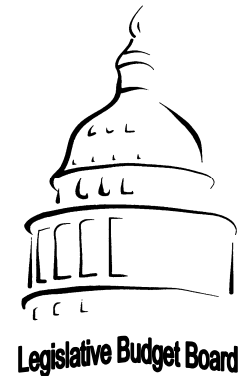
Oversight Responsibilities



- Increased rate and forms reviews, and actuarial analysis for market reforms, for example:
 - Essential benefit plan for employer plans;
 - Pre-existing condition exclusions;
 - Lifetime limits ban;
 - Limits on rating variances to age (3:1) and other factors.
- Increased oversight and enforcement, for example:
 - Medical loss ratio requirements;
 - Guaranteed issuance.
- Increased consumer information, for example:
 - Dual regulation of grandfathered plans;
 - Individual and employer mandates.

TEXAS DEPARTMENT OF INSURANCE

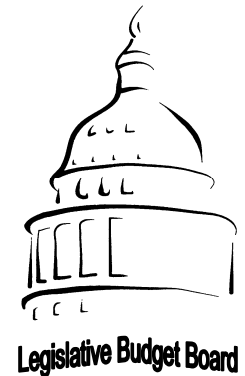
Temporary High Risk Pool



- States can contract with the federal government to operate a temporary federal high-risk pool (Effective within 90 days of enactment (June 21) through 2013).
 - Federal high-risk pool:
 - Individual cannot have been insured within the past six months.
 - Individual must have a pre-existing condition.
 - Texas' high-risk pool:
 - Individual must have been turned down for any other coverage.
 - Individual must have a pre-existing condition.
 - Those currently in Texas' high-risk pool appear to be ineligible for the federal high-risk pool because they currently have insurance coverage.
 - Out-of-pocket costs under the federal high-risk pool program will be lower than out-of-pocket costs in Texas' current high-risk pool program.

TEXAS DEPARTMENT OF INSURANCE

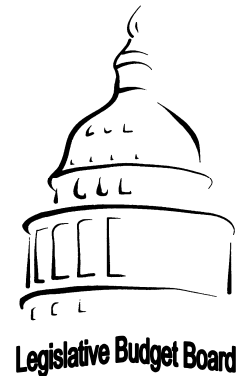
Health Benefit Exchanges



- Texas Department of Insurance is charged with the following for state-based Health Benefit Exchanges (2014).
 - Coordinate with entity that develops and administers the Health Benefit Exchange;
 - Certify qualified health plans;
 - Coordinate with Health and Human Services Commission to identify Medicaid and CHIP eligible;
 - Develop eligibility for subsidy program and affordability credits; and
 - Involvement in development and oversight of a public option if state chooses to participate.

TEXAS DEPARTMENT OF INSURANCE

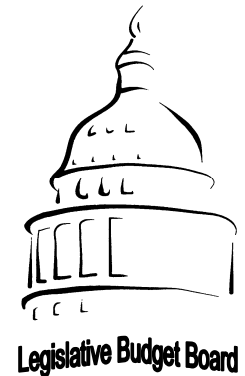
Other



- License Consumer Operated and Oriented Plans (COOPS).
- Coordinate with Health and Human Services Commission on subsidy/tax credit program eligibility.
- Oversee and approve interstate insurance if state chooses to participate.



HIGHER EDUCATION PROVISIONS

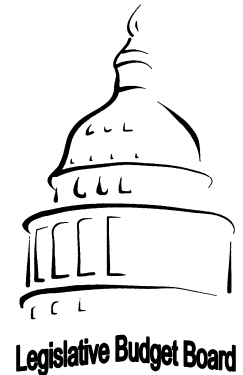


❖ Federal student loan program

❖ Pell Grants

HIGHER EDUCATION PROVISIONS

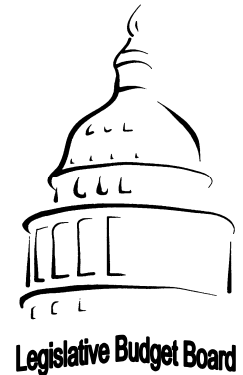
Student Loan Program



- Eliminates the Federal Family Education Loan (FFEL) program that provided student loans originated from private lenders.
- Replaces FFEL with Federal Student Loan program:
 - Administered by the U.S. Department of Education;
 - Funded through the U.S. Treasury;
 - Effective July 1, 2010.

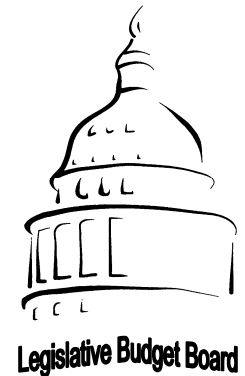
HIGHER EDUCATION PROVISIONS

Pell Grant Program



- Maximum Pell Grant award will increase by the Consumer Price Index from 2013 to 2017:
 - Increases from \$5,550 to \$5,975 per student over the same period.
- Provides additional funding for the Pell Grant program. Increases direct spending nationwide by:
 - \$21 billion in 2010 to 2014 or
 - \$36 billion in 2010 to 2019.

APPENDIX



- The new federal healthcare laws include many other provisions that could impact Texans. The following resources provide more information regarding the new laws:
 - ❖ Attachment A: Kaiser Family Foundation “Health Reform Implementation Timeline”.
 - ❖ Kaiser Family Foundation’s on-line Health Reform Gateway at: <http://healthreform.kff.org/>
 - ❖ National Conference of State Legislatures’ (NCSL) Federal Health Care Reform web site at: <http://www.ncsl.org/IssuesResearch/Health/FederalHealthCareReform/tabid/17639/Default.aspx>



FOCUS *on* Health Reform

THE HENRY J.
KAISER
FAMILY
FOUNDATION

HEALTH REFORM IMPLEMENTATION TIMELINE

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following timeline provides implementation dates for key provisions. It reflects provisions in the new law and incorporates modifications to the law included in the Health Care and Education Reconciliation Act of 2010 passed by the House and the Senate.

2010
<p>Insurance Reforms</p> <ul style="list-style-type: none"> Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014) Provide dependent coverage for adult children up to age 26 for all individual and group policies. Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children. Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. Provide tax credits to small employers with no more than 25 employees and average annual wages of less than \$50,000 that provide health insurance for employees. Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014) Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011) Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases.
<p>Medicare</p> <ul style="list-style-type: none"> Provide a \$250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020. Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result. Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office. Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. Ban new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limit the growth of certain grandfathered physician-owned hospitals.
<p>Medicaid</p> <ul style="list-style-type: none"> Creates a state option to cover childless adults through a Medicaid State Plan Amendment. Creates a state option to provide Medicaid coverage for family planning services to certain low-income individuals through a Medicaid State Plan Amendment up to the highest level of eligibility for pregnant women. Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if certain conditions are met. Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% [except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%]; increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans. Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). Require the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.
<p>Prescription Drugs</p> <ul style="list-style-type: none"> Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.
<p>Quality Improvement</p> <ul style="list-style-type: none"> Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute. Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency. Reauthorize and amend the Indian Health Care Improvement Act.

2010 (continued)**Workforce**

- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.
- Establish Teaching Health Centers to provide Medicare payments for primary care residency programs in federally qualified health centers.

Tax Changes

- Impose additional requirements on non-profit hospitals. Impose a tax of \$50,000 per year for failure to meet these requirements.
- Limit the deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers.
- Impose a tax of 10% on the amount paid for indoor tanning services.
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.

2011**Long-term Care**

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice

- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Prevention/Wellness

- Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare; increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Provide grants for up to five years to small employers that establish wellness programs.
- Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare

- Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
- Provide a 10% Medicare bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)
- Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates.
- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
- Reduce annual market basket updates for Medicare providers beginning in 2011.
- Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.
- Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels, and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple.
- Create an Innovation Center within the Centers for Medicare and Medicaid Services.

Medicaid

- Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion.
- Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based longterm care services.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

Quality Improvement

- Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.
- Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.
- Establish a new trauma center program to strengthen emergency department and trauma center capacity.
- Improve access to care by increasing funding by \$11 billion for community health centers and the National Health Service Corps over five years; establish new programs to support school-based health centers and nurse-managed health clinics.

2011 (continued)**Tax Changes**

- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account.
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount.
- Impose new annual fees on the pharmaceutical manufacturing sector.

2012**Medicare**

- Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care.
- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
- Create the Medicare Independence at Home demonstration program.
- Establish a hospital value-based purchasing program in Medicare and develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Provide bonus payments to high-quality Medicare Advantage plans.
- Reduce rebates for Medicare Advantage plans.

Medicaid

- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

Quality Improvement

- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

2013**Insurance Reforms**

- Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate \$6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)
- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than \$1 per covered life. (Effective April 1, 2014)

Medicare

- Begin phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25% in 2020, in addition to the 50% manufacturer brand-name discount).
- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

Medicaid

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.

Quality Improvement

- Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Tax Changes

- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly and impose a 3.8% assessment on unearned income for higher-income taxpayers.
- Limit the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year increased annually by the cost of living adjustment.
- Impose an excise tax of 2.3% on the sale of any taxable medical device.
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

Individual and Employer Requirements

- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Assess 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. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

Insurance Reforms

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (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.
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchanges.
- Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
 - o 100-200% FPL: one-third of the HSA limits (\$1,983/individual and \$3,967/family);
 - o 200-300% FPL: one-half of the HSA limits (\$2,975/individual and \$5,950/family);
 - o 300-400% FPL: two-thirds of the HSA limits (\$3,987/individual and \$7,973/family).
- Limit 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 above these limits.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan.
- Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.
- Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.
- Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)
- Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
- Require qualified health plans to meet new operating standards and reporting requirements.

Premium Subsidies

- Provide refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges.

Medicare

- Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019);
- Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. (Issue recommendations beginning January 2014)
- Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided.
- Require Medicare Advantage plans to have medical loss ratios no lower than 85%.

Medicaid

- Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) and provides enhanced federal matching for new eligibles.
- Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments.
- Increase spending caps for the territories.

Prevention/Wellness

- Permit employers to offer employees rewards of up to 30%, increasing to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establish 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

Tax Changes

- Impose fees on the health insurance sector.

2015 and later
Insurance Reforms
<ul style="list-style-type: none">• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (Compacts may not take effect before January 1, 2016)
Medicare
<ul style="list-style-type: none">• Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)
Tax Changes
<ul style="list-style-type: none">• Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. (Effective January 1, 2018)

For additional information, see <http://www.kff.org/healthreform/8060.cfm>.

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