

What Changes as a Result of Federal Healthcare Reform? H.R. 3590 (signed March 23, 2010) and H.R. 4872 (signed March 30, 2010)

	For Consumers	For Insurance Companies
Effective January 1, 2010	<p>Medicare beneficiaries who reach the drug insurance coverage gap (the “donut hole”) will receive a \$250 rebate in 2010</p> <ul style="list-style-type: none"> • A 75% discount for Medicare donut hole generic drugs will begin to phase in during 2011 • A 50% discount for donut hole brand name drugs will begin to phase in during 2013 • The coinsurance rate in the donut hole will decrease from 100% to 25% by 2020 	
What changes 90 days after the law is signed?	<ul style="list-style-type: none"> • Temporary high-risk pool available to uninsured people with pre-existing conditions, with subsidies to limit cost-sharing to current HSA limits (\$5,950/individual; \$11,900/family in 2010, indexed), and limitations on how much premiums can vary, until Jan. 1, 2014 • Insurance companies cannot cancel your insurance (rescission) if you become sick * • Website to help consumers identify their health coverage options by July 1st, standardized format for presenting coverage within 60 days, and standards for insurers within 12 months, which they must use within 24 months • Early retirees will be subsidized by temporary reinsurance to employers or insurance companies for retirees over age 55 who are not eligible for Medicare; reinsurance will pay 80% of costs between \$15,000–90,000, until January 1, 2014 	
What changes 6 months after the law is signed?	<ul style="list-style-type: none"> • Children can be covered on parents’ individual or group policies up to age 26* • Insurance companies prohibited from excluding pre-existing conditions for children* • Insurance companies may not place lifetime limits on group or individual policies*; annual limits require the Secretary of HHS’s approval until 2014* • Qualified health plans will pay 100% of certain proven preventive care 	<ul style="list-style-type: none"> • Required to justify rate increases to the appropriate state agency (for plan year 2010)

Source: Kaiser Family Foundation (2010). www.kff.org.

* Existing individual and group plans, including employer-sponsored insurance plans, are grandfathered and will change very little. The items that must change in the grandfathered plans are marked with an asterisk (*).

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	For Consumers	For Insurance Companies
What changes January 1, 2011?	<ul style="list-style-type: none"> • Medicare and Medicaid will pay 100% of certain proven preventive care • Medicare patients eligible for comprehensive risk assessment and personalized prevention plan • A voluntary insurance program will begin. It will pay non-medical costs that keep people in their own homes rather than in institutions. There is a five year vesting period. • Medicare Advantage programs will meet quality and financial performance standards and their rates will be set more competitively with fee-for-service Medicare; they may receive bonus payments for outstanding performance • Employer-based wellness programs, including incentives for employees and start-up grants to small businesses, beginning in 2011 	<ul style="list-style-type: none"> • Required to spend a minimum amount of premiums on clinical healthcare (the “medical loss ratio,” as compared to the overhead, which does not have to benefit consumers), equal to at least 80% in small group and individual markets, 85% in large group markets), or to rebate the difference to whomever paid the premiums • Within one year of enactment, there will be proposed regulations requiring chain restaurants and vending machines to provide nutritional content of each item. • Prohibit Medicare Advantage plans from charging patients higher co-pays for Medicare covered benefits than is required under the traditional Medicare fee-for-service program
What changes January 1, 2014? (full healthcare reform)	<ul style="list-style-type: none"> • Insurance companies may not exclude pre-existing conditions for adults* • All new policies will be standardized to conform to one of four benefit categories, except those grandfathered • Insurance companies prohibited from placing annual limits on coverage in policies* • Deductibles limited in the small group market to \$2,000/individual, \$4,000/family unless offset in an equivalent amount • Waiting periods for coverage will be limited to 90 days 	

Source: Kaiser Family Foundation (2010). www.kff.org.

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www.healthfoundation.org/reform

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Elements of health insurance in 2014

- Most citizens and legal residents required to have health insurance, or pay a penalty; some exemptions (financial hardship, religious objections, American Indians, uninsured under three months, undocumented immigrants, incarcerated, those for whom cost is more than 8% of income, those with income under the filing threshold)
- Subsidies for individuals and families from 133%-400% federal poverty level; cost-sharing limits for individuals also subsidized
- State-based health insurance exchanges for people & businesses to find coverage
- Health insurance subsidies, substantial for low-income, declining as income increases, between 133%-400% federal poverty level
- Limits on out-of-pocket spending for those with up to 400% of federal poverty level
- Employers with more than 50 employees pay penalties for employees (after the first 30) who use the subsidies (exceptions for small employers and employers who provide free choice vouchers); employers under 50 employees exempt
- Small employers (under 25 employees with average wage under \$50,000) who purchase health insurance for employees receive a tax credit, phased for size, wages and amount of employer insurance payments; provisions to include non-profits
- Regulations on health insurance plans
- Medicaid expands to 133% of federal poverty level and includes all individuals under age 65 (children, pregnant women, parents, and adults without children) with federal payments to the states (100%, declining to 90% by 2020) to cover the added costs
- Children's Health Insurance maintained through 2019
- Hyde Amendment limits on abortion services with federal funds continue to prohibit funding except for rape, incest, or life of the mother
- An excise tax on insurers for high-cost health plans, with some adjustment for employee age and gender (sic), high risk occupations, excessive medical inflation
- Certain fees and taxes on insurance, pharmaceutical and medical device companies, limits on their executive compensation, and indoor tanning services
- Start-up funds for new consumer operated and oriented plans (co-ops)
- Insurance companies must guarantee issue and renewal of policies, with higher prices permitted only for age (not more than 3 to 1), family composition, and tobacco use
- Insurance companies must meet standards for enrollment outreach, navigators, providing essential services, provider panels, quality measures, and financial reporting
- Permit states to create health plans for individuals between 133%-299% FPL; state may be permitted to merge individual and small group markets
- Defines essential health benefits, and provides for four levels of insurance coverage packages
- Requires financial and administrative simplification and electronic transactions, a single set of eligibility verification and claims processing rules

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Workforce Issues

- Primary care physicians and general surgeons will be paid a 10% bonus if they practice in health professional shortage areas from 2011 through 2015
- Medicaid will pay the same rates as Medicare for primary care services provided by primary care doctors in 2013–2014.
- By July 1, 2010, increase the number of graduate medical education student positions available for primary care and general surgery in states with low MMD-to-population ratios, and in rural and underserved areas, emphasizing community-based care
- Provide grants up to three years to employ and educate family nurse practitioners working in health centers and nurse-managed clinics (five years of funding beginning in 2011)
- Develop interdisciplinary mental & behavioral health programs and oral health programs, 2010 to 2015
- Support health professional educational programs that support medical homes, team management of chronic diseases, and integrated physical and mental health services, for five years, effective 2010
- Fund healthcare workforce professionals through scholarships and loans (dates vary), including registered nurses (begin in 2010)

Provider Issues

- Increase funding for community health centers and the National Health Service Corps, effective 2011
- Establish a federal program office for school-based health centers and provide emergency and expansion funds for SBHCs, effective 2010
- Support nurse-managed clinics, effective 2010
- Require non-profit hospitals to conduct a community needs assessment every three years, adopt a plan to meet those identified needs, publicize financial assistance policies, charge patients getting financial assistance no more than insurance companies are charged, and determine eligibility for financial assistance before extraordinary collection efforts. A tax of \$50,000 for failure to do this, effective for taxable years following enactment.

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Quality of Care and Cost Containment

- Establish an Independent Payment Advisory Board to recommend ways to reduce the per capita rate of growth in Medicare, effective 2013
- Reduce Medicare Disproportionate Share Hospital (DSH) payments by 75% in 2014 and adjust payments as needed after reform is implemented
- Establish Accountable Care Organizations in 2012
- Establish the Innovation Center to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures to reduce program expenditures while maintaining or improving quality of care, effective 2011
- Reduce Medicaid DSH allotments beginning in 2014 and require the Secretary to develop a method of distributing the allotments based on the states' percentage of uninsured
- Support comparative effectiveness research by establishing the Patient-Centered Outcomes Research Institute, effective 2010
- Provide demonstration grants to pilot tort reform efforts, effective 2011
- Create the Independence at Home demonstration program, effective 2012
- Start value-based purchasing programs in hospitals and nursing homes, effective 2012
- Start care coordination for dual eligible Medicare & Medicaid, effective immediately
- Permit Medicaid state plan options for medical homes for Medicaid enrollees with chronic conditions, risks, or serious and persistent mental illnesses, effective 2011
- Fund demonstrations in bundled payments for Medicare and Medicaid patients, including safety net hospitals global capitated payments, cost-savings sharing in pediatric accountable care organizations, emergency stabilization of mental disease adults, effective 2011
- Develop a national health quality improvement strategy beginning in 2011
- Establish the Community-Based Collaborative Care Network Program for low-income, uninsured & underinsured populations, effective 2011
- Require increased disclosure of financial relationships among providers, reporting due 2013
- Require improved reporting on disabilities, disparities, rural and frontier populations, effective 2012
- Establish a National Prevention Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities, beginning in 2010
- Award grants to support the delivery of evidence-based and community-based prevention & wellness, beginning in FY 2010
- Extend Medicaid Money Follow the Person Rebalancing Demonstration program, starting 30 days after enactment through 2016
- Fund Aging & Disability Resource Center initiatives funded between 2010-14
- Establish the Community First Choice Option in Medicaid, effective 2011