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## Health Care Changes Near Enactment – Key Provisions

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With the imminent Christmas Eve vote and almost certain passage of the Senate's amendment to HR 3590, the Patient Protection and Affordable Care Act of 2009, we thought it would be appropriate to provide you with a list of the major provisions of this historic revised piece of legislation. Unless you have already read the entire amended bill, a number of these provisions will be new to you and more than a couple may startle or alarm you, however, it is what it is! These new proposals are rolling down hill like a huge snowball. There are some good parts and some bad, so sit down, brace yourself and read on!

Needless to say, this is not the last word on the subject but as it stands now, the Senate amendment includes the following provisions:

- Prohibits any annual limits or lifetime limits in group or individual plans after 2014. Between now and then, the only limits allowed are for nonessential benefits.
- Starting on January 1, 2011, creates a minimum loss ratio requirement that applies to all fully insured plans including grandfathered plans. The MLR is 85% for large group plans and 80% for individual and small group plans (100 and below). Allows the Secretary of DHHS to make adjustments to the percentage if it proves to be destabilizing to the individual or small group markets.
- The amendment creates a premium rebate to individuals for plans that fail to meet the minimum MLR. The calculation is independent of federal or state taxes and any payments as a result of the risk adjustment or reinsurance provisions.
- Requires the National Association of Insurance Commissioners (NAIC) to establish uniform definitions regarding the MLR and how the rebate is calculated by December 31, 2010.
- Requires hospitals to annually publish a list of standard charges.
- Group and individual plans will have to have internal appeals processes.

- Group and individual plans will have to have an external appeals process that meets or exceeds state law on the subject, meets or exceeds the NAIC external review model act requirements or complies with a regulation the Secretary of DHHS will promulgate on the topic. Grants the Secretary of DHHS authority over the external review process and certification of plans.
- Requires group and individual plans to cover emergency care services even if the provider is not a participating provider at in-network rates, using a reasonable layperson definition of emergency services.
- Requires plans that make beneficiaries establish a primary care provider to allow the beneficiary to set any available participating provider their primary care physician. Requires that pediatricians be allowed to be set as primary care providers.
- Prohibits the requirement of authorizations or referrals for OB/GYN services.
- Creates Medical Reimbursement Data Centers to be established in academic and non-profit institutions to collect medical reimbursement data from insurers and make it available to policymakers, researchers, providers and the public, including fee schedules and geographic differences in rates.
- Requires coverage of clinical trial participation.
- Requires the Secretary of Labor, within a year of the enactment of this bill, to begin annual studies on self-funded plans.
- Changes the group size definitions relative to the rating provisions, so that there are no distinctions between small and large employer groups that do not self-fund their health plans. This means all fully insured groups are required to abide by the modified community rating provisions, regardless of their size, and that experience rating for larger fully insured groups will be prohibited.
- Requires the Secretary of DHHS, within a year of enactment of this bill, to conduct a study on the impact the market reforms in the bill will have on the large group market, if they increase adverse selection and if they will increase the incentive to self-fund.
- Requires more transparency in the exchanges.
- Eliminates the requirement that the Secretary of Health and Human Services sets agent/broker commission rates in the exchanges.
- Requires the co-op plans to repay their start-up loan/grant funding within 5-15 years.
- Increases funding for community health centers by \$10 billion (to \$95 billion).
- Creates multistate plans to be offered through the exchanges, provided by private insurers and administered by the federal Office of Personnel Management (OPM).
- At least two multistate plans must be offered through each state exchange and offer individual and small group coverage, and one must be offered by a non-profit entity. Multistate plans must operate under specified standards.]

- States can require that multistate plans offer additional benefits that are more expensive than what is required federally, but then the states are responsible for the increased cost of exchange subsidies for the provision of those benefits. In addition, if a state imposes stricter age bands than what are imposed nationally (3:1) then the multistate plan has to comply with the state rules.
- Insurers who contract to be multistate plans must offer qualified coverage in 60% of states the first year of participation, working up to 100% of states by year four of participation.
- Although OPM also operates Federal Employees Health Benefits Plan (FEHBP), the two programs must have completely separate risk pools. Also OPM cannot divert funds or resources away from FEHBP to operate the multistate plan program.
- Applies the reinsurance provisions to all markets, not just the individual and small group markets.
- Slightly expands the small business tax credit provisions and makes the credit available beginning in 2010, not 2011.
- The individual mandate penalty for not having insurance would be the greater of a flat dollar amount per person or a percentage of the individual's income. This is a change from \$750 per person (to a max of \$2,250) beginning in 2017 to the lesser of: (1) the average bronze-level insurance premium (60% actuarial) for your family; or (2) the greater of either (a) 2% of taxable (gross) household income beginning in 2016, or (b) \$495 for each family member not covered, to a maximum of \$1,980.
- Establishes the penalty for large employers that impose a waiting period for benefits applies to waiting periods beyond 60 days, not 30, and is \$600 per applicable employee.
- Carves out the construction industry from the rest of the employer-responsibility requirement. Instead of applying to employers of more than 50, for the construction industry only, the responsibility requirement to provide affordable coverage applies to employers of more than 5 people with annual payrolls of more than \$250,000.
- Requires a GAO study on coverage denials by insurers.
- Includes the Wyden/Collins Employee Free Choice Amendment provisions which beginning in 2014 would require employers to give a voucher to use in the individual market or exchange to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the exchange instead of participating in the employer-provided plan. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount.
- Funds CHIP through 2015 instead of 2014.
- Eliminates the one-year Medicare provider payment fix that was included in the original bill and replaces in with the two-month delay in scheduled cuts included in the defense appropriations bill.

- Provides for the creation of federal standards to simplify insurer forms and administrative processes.
- Requires that the federal government pay for the entire share of the Medicaid expansion for all states until 2017, then phases out the increased federal match over time. Provides that the federal government will always pay for entire the Medicaid expansion population in perpetuity for the state of Nebraska.
- Expands Medicaid funding for the states of Vermont and Massachusetts.
- Appropriates \$100 million for an unnamed hospital somewhere in the United States.
- Includes the Harkin workplace wellness program grant provisions to provide grants to small businesses that start qualified wellness programs and provides \$200 million in funding from 2011-2015.
- Increases the Medicare payroll tax from 2.9 percent to 3.8 percent for wages and self-employment income above \$200,000 (\$250,000 married). Current 2.9 percent rate retained for wages and self-employment income below this amount
- Provides protections against Medicare Advantage benefit cuts to residents of New York, Pennsylvania and Florida.
- Establishes HRSA grant 10-state demonstration project to create state-based non-profit/private partnerships to provide coverage to the uninsured at reduced fees.
- Increases health care fraud protections
- Provides \$50 million over five years in grant funding for state-based demonstration projects relative to medical liability alternatives.
- Adjusts the \$2500 FSA limitation for inflation.
- Fully implements the excise tax on insurance companies with \$50 million in profits and assess the tax on a pro-rated basis to insurance companies based on profits. Carves out certain non-profit insurers from the insurer assessment
- Delays and reduces the annual fee for medical device providers.
- Includes longshoremen on the list of industries protected from the federal excise tax penalty on high-cost health plans.
- Replaces the 5 percent excise tax on plastic surgery with a 10 percent excise on indoor tanning.

Some of these provisions may not survive the remaining legislative processes. The version of this bill which was previously passed by the House is dramatically different from the one the Senate is expected to pass, but it is reasonable to believe that most of them will. We will keep you apprised of major new developments as they occur.