

Healthcare Reform Legislation Becomes Law

On March 23, 2010, President Obama signed sweeping healthcare reform legislation into law following more than a year of debate in the House of Representatives and Senate. On Sunday, March 21, 2010, the House passed the Senate health reform bill, H.R. 3590, the "Patient Protection and Affordable Care Act," by a vote of 219 to 212, with all Republicans and 34 Democrats voting against the bill. This legislation was passed by the Senate on December 24, 2009, on a straight party line vote of 60-39.

The House and Senate also passed H.R.4872, the "Health Care and Education Reconciliation Act of 2010," making changes to the Senate health reform bill during the week of March 21, 2010. The reconciliation bill was signed by President Obama on March 30, 2010.

The provisions of the combined health reform bills include several health insurance reforms that reflect NHF's priority issues. For example, the bills:

- Create new temporary national high-risk pools to offer insurance to uninsured individuals with pre-existing conditions, starting 90 days after enactment. These risk pools will exist until 2014, when the insurance exchanges will be operational.
- Eliminate lifetime caps in all – new and existing – health insurance plans 6 months after enactment.
- Eliminate rescissions in all health insurance plans 6 months after enactment.
- Extend coverage for dependents – who could stay on a parent or guardian's insurance plan until age 26 – in all health insurance plans 6 months after enactment.
- Restrict annual caps in new plans and existing group plans before 2014; the bills eliminate annual caps in all new plans and existing group plans in 2014.
- Eliminate pre-existing conditions exclusions for children in new plans 6 months after enactment, and for all people in all plans in 2014.
- Implement modified community rating, and guaranteed issue and renewal starting in 2014

Outlined below are highlights of other key provisions of the healthcare reform bills:

Insurance Exchanges –State-based exchanges and co-ops are created to provide insurance in the individual and small business markets. There is no public option.

Individual Mandate – All individuals are required to have health insurance and will be penalized (fined), if they do not. Individuals below the tax filing income threshold are exempted. Federal subsidies are provided to individuals who do not qualify for Medicaid and have incomes below 400% of the federal poverty level (FPL), equal to \$88,200 for a family of four.

Employer Mandate – Employers with more than 50 full-time employees must provide insurance or pay penalties if any of their employees receive a federal subsidy.

Taxes and Industry Fees – To raise revenues to cover the costs of expanding public insurance and providing subsidies for individuals to purchase private insurance, the bill expands the Medicare payroll tax for individuals earning more than \$200,000 and couples earning more than \$250,000. As of 2018, the bill establishes an excise tax on high-valued insurance plans. In addition, several industries – pharmaceutical manufacturers, medical device manufacturers and health insurance companies – will pay annual fees/taxes.

Medicaid Expansions and Reforms – Requires states to cover individuals with incomes up to 133% of the FPL (\$14,004 for an individual) and provides for 100% federal funding for this expansion. Increases rebates for brand-name drugs and expands rebates to drugs provided by managed care organizations.

Medicare Reforms:

- Medicare Advantage – Reduces payments to Medicare managed care plans, bringing payments more in line with the fee-for-service program.
- Part D: Drug Coverage – Reduces the Part D "donut hole" annually until it is eliminated in 2020 by requiring manufacturers to contribute 50% discounts while beneficiaries are in the gap and by reducing co-insurance. Provides a \$250 rebate for beneficiaries who enter the coverage gap in 2010.
- Payments to Hospitals and Other Facilities – Reduces the annual update in fees for hospitals, skilled nursing facilities, long-term care and rehab facilities, hospices and home health. Reduces disproportionate-share payments to hospitals.
- Delivery Reforms – Creates a new Center for Medicare and Medicaid Innovation. The center will research, develop, test and expand innovative payment and delivery arrangements to improve quality and reduce the costs for patients in the two programs. Successful models can be expanded nationally. The center will fund demonstration projects, create Accountable Care Organizations and other shared savings programs, and provide state grants for community-based delivery systems, such as patient-centered medical homes.
- Physician-owned Hospitals- Prohibits the establishment or expansion of such hospitals as of December 31, 2010.

Independent Payment Advisory Board – Establishes an independent board that will make annual recommendations to Congress and the Administration to constrain the rate of growth in both Medicare and the private sector. Nonbinding Medicare recommendations will be made to Congress in years in which Medicare growth is below the targeted growth rate. Beginning in 2020, the board would make binding recommendations to Congress if health spending exceeds the growth in Medicare spending.

Prevention and Wellness – Provides coverage of annual wellness visits, waives co-insurance and allows the Secretary of the U.S. Department of Health and Human Services to expand coverage of preventive services covered by Medicare and Medicaid. Provides funding to state and local health departments and funds for research and numerous prevention and wellness-oriented programs.

Comparative Effectiveness Research – Creates an independent corporation to set priorities and assess comparative effectiveness research funded by the National Institutes of Health and the Agency for Healthcare Research and Quality. An expert panel including patients and treaters will be created whenever research is being considered on treatments for a rare disease or condition.

Follow-on Biologics – Establishes an FDA approval process for follow-on (generic biologicals) and provides 12 years of market exclusivity.