

Overview of Health Reform Legislation

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Enacted Legislation

Patient Protection and Affordable Care Act (“PPACA”)

- ❑ Became law March 23, 2010, Pub. L. No. 111-148
- ❑ Contains “bulk” of health reform law

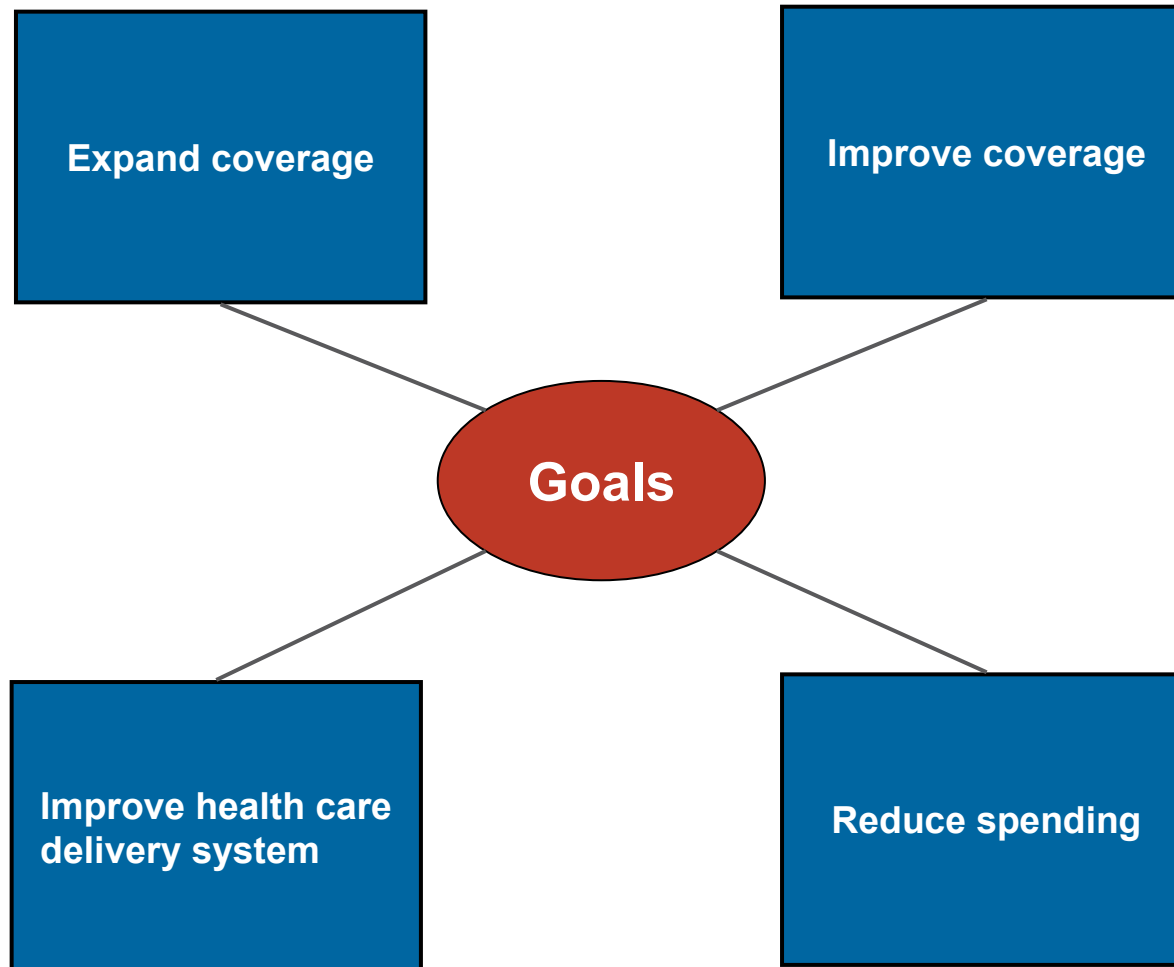
Health Care and Education Affordability Reconciliation Act

- ❑ Became law March 30, 2010, Pub. L. No. 111-152
- ❑ Modifies/adds to PPACA

Health Reform



Goals of Legislation



Impact of Coverage Expansion (excluding Medicare-eligible population)

Current coverage

Employer-Sponsored Coverage	Medicaid/CHIP	Exchanges	Uninsured
150 million covered through their employer	40 million covered by Medicaid & CHIP		Currently 50 million are uninsured

By 2020

Employer-Sponsored Coverage	Medicaid/CHIP	Exchanges	Uninsured
159 million will have coverage through their employer	51 million will be enrolled in Medicaid & CHIP	24 million will purchase coverage through Exchanges	22 million nonelderly residents will remain uninsured (about 1/3 of whom are unauthorized immigrants)

See CONG. BUDGET OFFICE, Letter to the Honorable Nancy Pelosi providing an estimate of the direct spending and revenue effects of H.R. 4872, the Reconciliation Act of 2010 (Mar. 20, 2010) at 9-10.



Costs of Coverage Over 10 Years

Most coverage expansion begins



COSTS OF EXPANDED COVERAGE (Billions of dollars, by fiscal year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Medicaid & CHIP Outlays	0	-1	-2	-4	29	56	81	87	91	97	434
Exchange Subsidies & Related Spending	0	2	2	2	20	45	77	97	106	113	464
Small Employer Tax Credits	2	4	5	6	5	4	3	3	4	4	40
Gross Cost of Coverage Provisions	2	5	5	5	54	104	161	187	201	214	938

See CBO, Estimate of the direct spending and revenue effects of H.R. 4872 (Mar. 20, 2010), tbl. 4.



Financing Reform through Program Cuts, Higher Taxes/Fees

Over 10 years, despite \$938 billion in additional spending, Health Reform actually reduces the deficit by cutting other programs and increasing revenues

Cuts to Medicare/Medicaid

- ❑ Market basket adjustments (including productivity adjustments) for certain hospitals and other providers - \$196 billion
- ❑ Restructuring of payments to Medicare Advantage (MA) plans - \$136 billion
- ❑ Reducing Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to hospitals - \$36 billion
- ❑ Other cuts (e.g., home health payment rates) - \$87 billion

Total = \$455 billion

See CBO, Estimate of the direct spending and revenue effects of H.R. 4872 (Mar. 20, 2010), tbl. 2

Revenue provisions

- ❑ Industry fees (pharmaceutical industry fee, medical device fee, insurance industry fee) - \$107 billion
- ❑ Higher Medicare tax on high-income taxpayers - \$210 billion
- ❑ “Cadillac tax” - \$32 billion
- ❑ Penalty payments by employers and uninsured individuals - \$65 billion
- ❑ Other revenue (e.g., indoor tanning tax) - \$111 billion

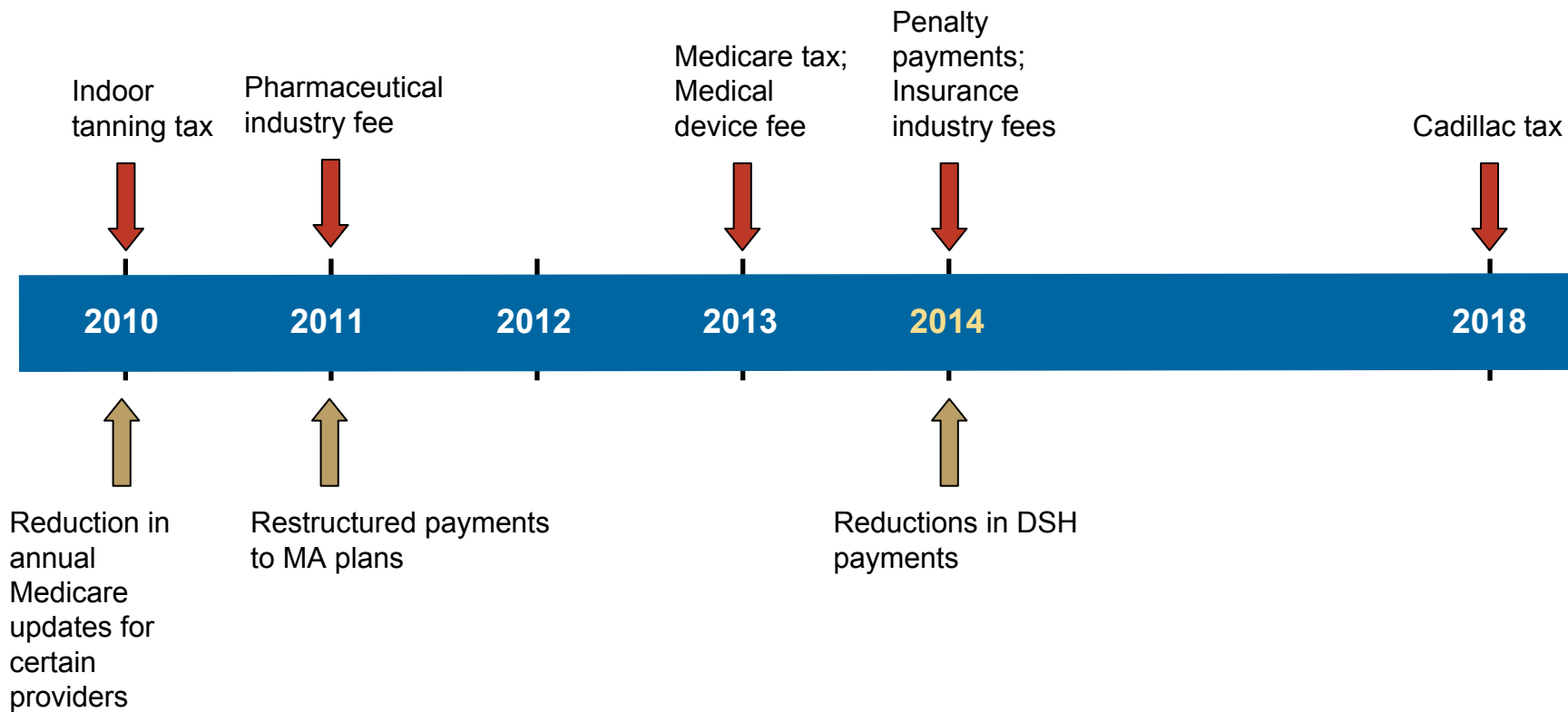
Total = \$525 billion

JOINT COMM. ON TAXATION, Estimated revenue effects of H.R. 4872, the “Reconciliation Act of 2010” JCX-17-10 (Mar. 20, 2010)

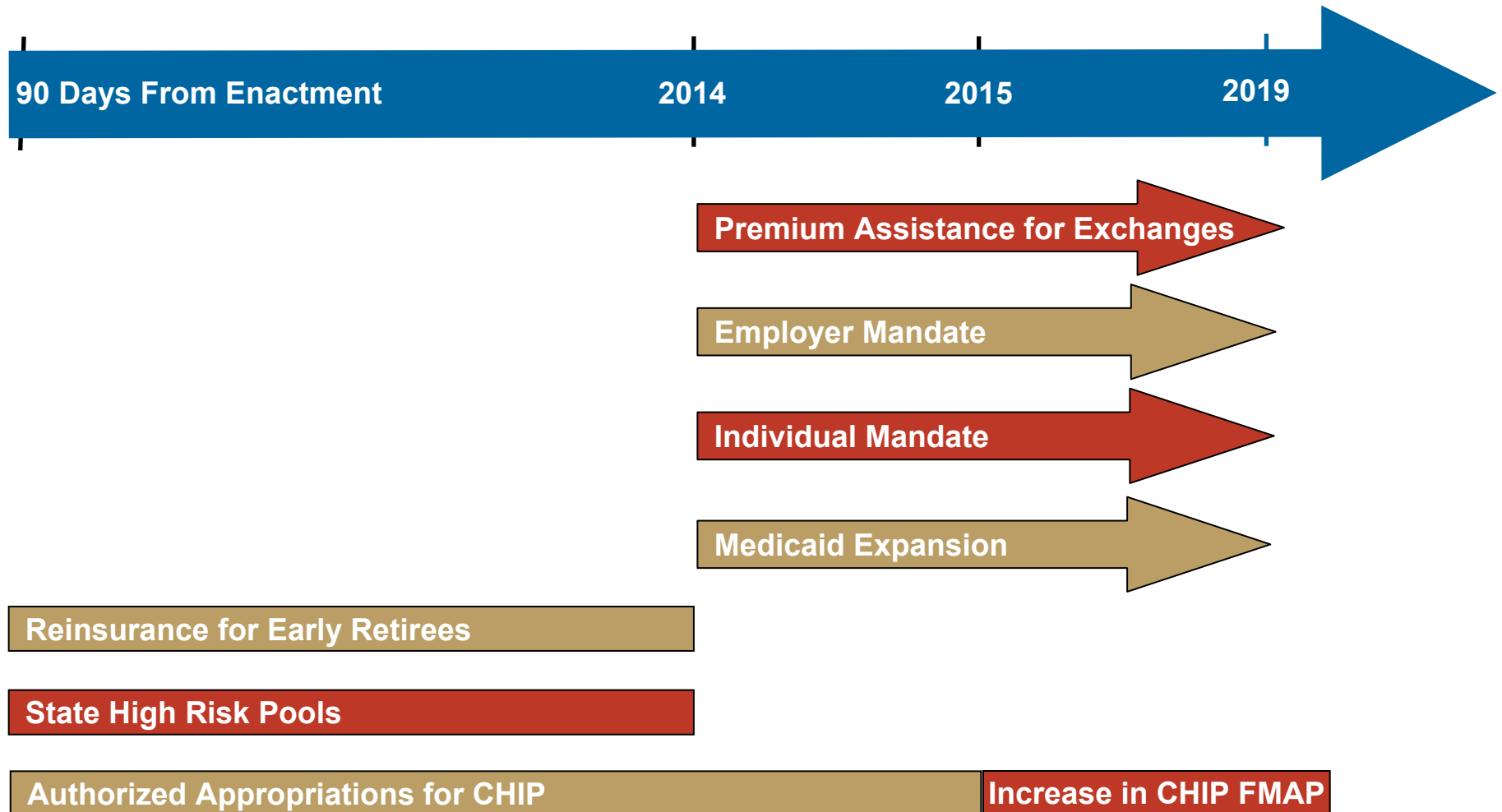


Effective Dates of Taxes and Cuts

Certain program cuts, taxes and fees go into effect before coverage expansion starts in 2014



Expanding Coverage



High-Risk Pools – A Bridge to 2014 Coverage Expansion

- Temporary high-risk pools for uninsured with pre-existing conditions who have been uninsured for at least six months
- To be established within 90 days of enactment and terminates in 2014 when Exchanges must be established
- Subsidized premiums available, as well as limits on cost-sharing
- Limited amount of \$5 billion available to fund pools
- As of May 5, 2010, 29 states have agreed to implement pools; 19 have opted out and the Secretary of Health and Human Services (HHS) will operate pools in those states



Individual Mandate

- Beginning in 2014, most individuals must either
 - Obtain coverage → All individuals required to maintain coverage, with some exceptions
- OR**
- Pay a penalty → Those who do not have coverage will pay an annual penalty of the *greater* of \$695 per person (maximum \$2,085/family) or 2.5% of household income, to be included in income tax return
- Certain individuals are exempted from penalties, including
 - Individuals who cannot afford coverage (if required contribution > 8% of household income)
 - Taxpayers with income under 100% of Federal Poverty Level (FPL)
 - Members of Indian Tribes
 - Individuals without coverage for less than three months
- If individual cannot afford insurance, then premium credits as well as cost-sharing subsidies are available on a sliding scale to low-income individuals and families to purchase insurance through the Exchanges



Employer Mandate

- Beginning in 2014, large employers
 - With > 50 employees that *do not offer coverage* and have at least one full-time employee receiving a premium credit or cost-sharing reduction through an Exchange will pay up to \$2,000 annually per full-time employee (to be assessed monthly)
 - With > 50 employees that *offer coverage* but have at least one full-time employee receiving a premium credit or cost-sharing reduction through an Exchange will pay up to \$3000 annually for each employee receiving such subsidies (to be assessed monthly)
 - With > 200 employees that offer coverage must automatically enroll employees into a plan (employees may opt out)
- Beginning in 2014, all employers that offer coverage must provide a “free choice voucher” to certain low-income employees who choose to obtain coverage through an Exchange instead of through the employer
- Beginning in 2010, small employers with 25 or fewer employees with average annual wages of less than \$50,000 per employee that contribute at least 50% of total premium costs for their employees will be eligible for premium subsidies
- Beginning in 2010 and ending in 2014, all employers will be reimbursed for a portion of the cost of providing coverage to Medicare-ineligible retirees over 55



Health Insurance Exchanges

- By January 1, 2014, States must create American Health Benefit Exchanges for individuals and Small Business Health Options Programs (“SHOP Exchanges”) for small businesses (≤ 100 employees)
 - Individual and small business exchanges may be merged into one Exchange
 - If States fail to establish Exchanges, HHS will establish and operate Exchanges
- New plans in Exchanges must offer one of four levels of coverage (Bronze, Silver, Gold or Platinum) that vary based on premiums, out-of-pocket costs, and benefits beyond “essential health benefits”
- Exchanges must also offer a catastrophic plan available to individuals under 30 or exempt from the individual mandate
- Insurers may offer coverage outside of Exchanges
- No public option, but
 - Office of Personnel Management must contract with private insurers to offer at least two multi-state plans through each Exchange in each state
 - Funding for Consumer Operated and Oriented Plan (CO-OP) program to establish non-profit, member-run health plans in each state



Expansion of Public Programs

■ Medicaid

- Beginning in 2014, Medicaid will cover all individuals under 65 with incomes up to 133% of Federal Poverty Level (FPL)
- Federal government will provide 100% funding for newly eligible adults from 2014 to 2016, and a lesser percentage each year thereafter
- States that have already expanded eligibility to at least 100% of FPL for parents and non-pregnant childless adults will receive a phased-in increase in FMAP from 2014 to 2019
- Federal government will fund increase in payments (to 100% of Medicare payment) to primary care doctors for primary care services in 2013 and 2014

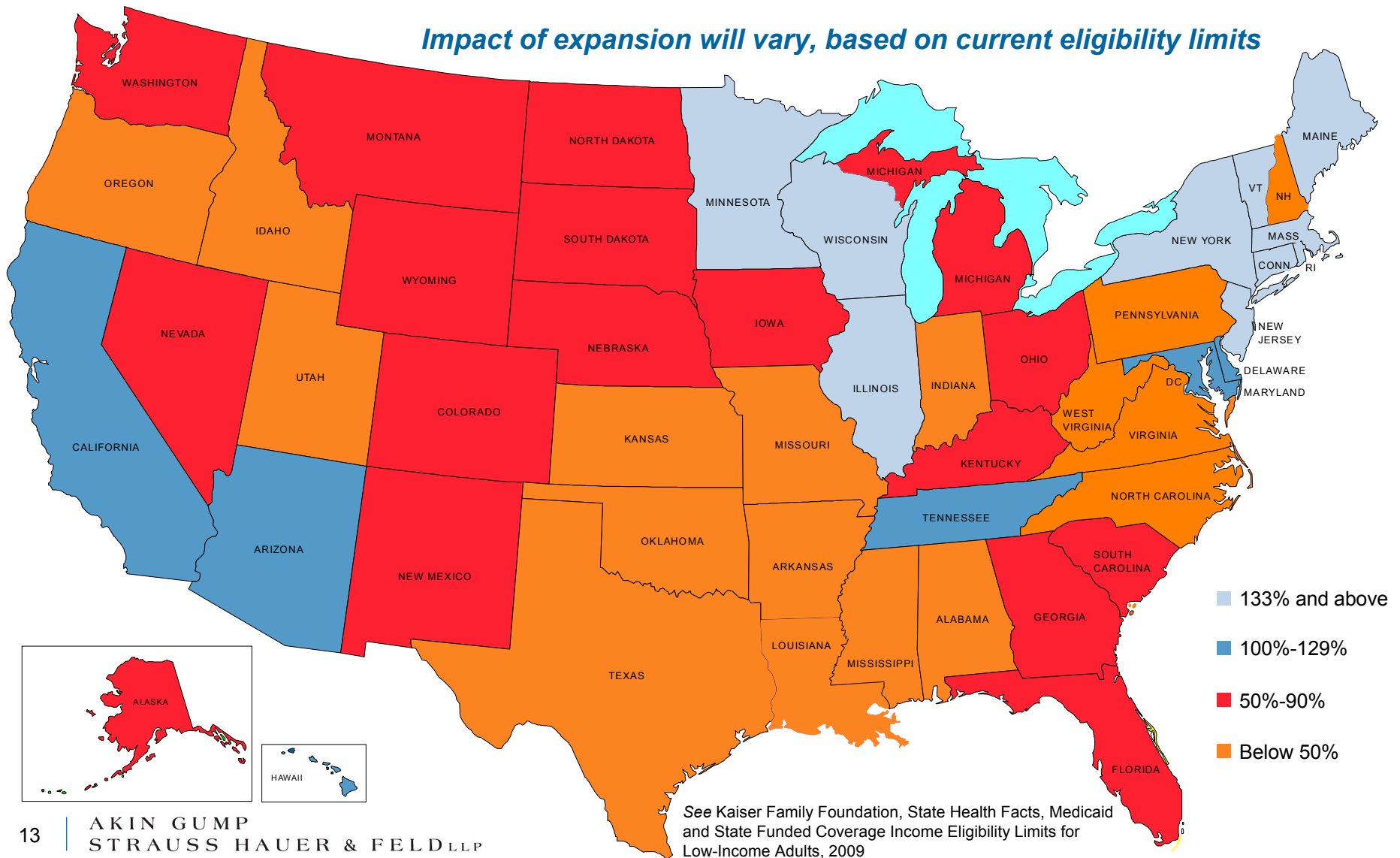
■ CHIP

- Funding for CHIP extended through FY 2015
- FMAP for states increased beginning in FY 2016
- Eligibility will continue at current levels through FY 2019



2009 Medicaid Income Eligibility Limits (% of FPL)

Impact of expansion will vary, based on current eligibility limits



Private Insurance Reforms

- Many key reforms must be implemented within 6 months of enactment, including
 - Prohibition on pre-existing condition exclusions for children
 - Prohibition on rescissions of coverage for reasons unrelated to fraud
 - Prohibition on lifetime coverage limits and restrictions on annual limits
 - Elimination of cost-sharing for certain preventive services
 - Expansion of coverage to dependents up to age 26
 - Prohibition on discrimination in favor of highly compensated individuals
- Other reforms will take effect in 2014, including
 - Prohibition on annual coverage limits
 - Prohibition on excessive waiting periods
 - Prohibition on discrimination based on health status
 - Prohibition on pre-existing condition exclusions for adults
- By 2011, all insurers must maintain a medical loss ratio (ratio of dollars spent for health care services to premiums collected) of at least 85% in large group market or at least 80% in small group/individual market; insurers failing to maintain such ratios must pay a rebate to beneficiaries
- “Grandfathered plans” are exempt some reforms but are subject to most of the significant reforms described above



Improving Health Care Delivery System

- Modifications to existing Medicare and Medicaid payment systems, including
 - Value-based payment modifier for physicians and value-based purchasing program for hospitals
 - Pilot programs to develop and evaluate bundled payment
 - Center for Medicare and Medicaid Innovation (CMI) to test, evaluate and expand different payment systems
- Other measures to improve health care delivery, including
 - Establishment of Accountable Care Organizations (ACOs) under Medicare and Medicaid
 - Extension of Medicare gainsharing demonstration project
 - Fixes to addresses geographic disparities in Medicare reimbursement
 - Rebates and drug discounts for Part D beneficiaries entering “donut hole,” and gradual closing of donut hole
 - Encouraging development of medical homes for Medicare and Medicaid beneficiaries
 - Medicare and Medicaid coverage of proven preventive services
 - Increased funding for comparative effectiveness research through a new nongovernmental institute
 - Increased funding for community health centers and National Health Service Corps



Controlling Costs

- Medicare and Medicaid payment reforms
 - Restructured payments to MA plans
 - Downward annual market basket adjustments (including productivity adjustments) for certain providers
 - Establishment of Independent Payment Advisory Board (IPAB) to propose measures to reduce Medicare spending if spending exceeds target growth rate
 - Reduced Medicare and Medicaid DSH payments
 - Reduced Medicare payments for preventable hospital readmissions
 - Reduced Medicare payments for hospital-acquired conditions (HACs)
 - Prohibition on federal Medicaid payments for health care-acquired conditions
 - Higher Medicaid drug rebate percentage
 - Expansion of 340B drug discount program
- Pathway for biosimilars
- Measures to reduce waste, fraud and abuse

