

Summary of Certain Key Provisions of the new U.S. Healthcare Laws



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The legislation signed by President Obama on March 23, 2010, titled the Patient Protection and Affordable Care Act (“Act”) (P.L. 111-148) alters the landscape of federal and state law applicable to health insurers, healthcare providers and consumers of such services, as well as employers, federal agencies and state governments. Rather than provide a laundry list of the many and varied provisions of the Act, this summary focuses on key provisions of significant importance to certain entities:

- Physicians, nurses and hospitals
- Employers
- Specific Industry Sectors

What the Act Means for Physicians, Nurses, and Hospitals

The expanded access to coverage for the uninsured and the increased protections for the insured are projected to decrease the number of uninsured patients seeking medical services that may have a positive impact on revenue for healthcare providers. Beyond the specific requirements of the Act applicable to insurers and the benefits provided to those seeking insurance or concerned about their existing coverage, there are specific provisions that impact providers of medical services.

Physicians:

- Increases Medicaid payments in fee-for-service and managed care for primary physicians to 100% of Medicare rates for 2013 and 2014. States receive 100% federal financing for the increase. [Provision effective 01/01/2014]
- Increases the number of insured patients by:
 - providing dependent coverage for children up to age 26 for both group and individual policies. [Effective in 6 months]
 - Removing lifetime limits on the dollar value of coverage and prohibits rescission absent cases of fraud. [Effective in 6 months]
 - Prohibiting annual limits beginning 2014. Prior to that, annual limits only as determined by the Secretary HHS.
 - Limits waiting periods to 90 days [Effective 01/01/2014]
- Grandfathers existing plans regarding new benefit standards, except that the extension of dependent coverage and prohibition on rescission of coverage applies. Eliminates coverage waiting periods in excess of 90 days for existing plans and eliminates lifetime limits in grandfathered plans and annual limits after 2014. Requires such grandfathered plans to eliminate pre-existing condition exclusions for children within 6 months of enactment and for adults by 2014.

- Limits establishing new physician-owned hospitals as well as placing certain limitations on expansion of existing facilities by eliminating Medicare reimbursement for services in such new or expanded facilities [Effective 12/31/2010]
- Establishes a non-profit “Patient-Centered Outcomes Research Institute” to conduct comparative effectiveness research. Findings cannot be used as mandates for payment, coverage, or treatment or to deny coverage. [Effective upon enactment]
- Creates program to allow Pediatrics providers organized as accountable care organizations to share in cost-savings under Medicaid from 01/01/2012 – 12/31/2016.
- Creates funding for mental health facilities treating adult Medicaid beneficiaries needing stabilization of an emergency condition [Effective 10/101/2011 – 12/31/2015]
- Restricts coverage for preventive services to “proven” prevention methods and eliminates cost-sharing for preventive services in Medicare and Medicaid. {Effective 01/01/2011} But, increases Medicare payments for some preventive services to 100% of actual charges or fee schedule. [01/01/2011]
- Provides comprehensive health risk assessments to Medicare beneficiaries and establishment of an individual, personalized prevention plan.
- Increases the number of graduate medical training education positions by redistributing unused slots. Primary care training and general surgery receive priority attention. [Effective 07/01/2010]
- Creates Teaching Health Centers focused on community-based medicine and ambulatory care centers with funding for residency programs for such entities. [Monies available in FY 22010]

Hospitals:

- Reduces annual market basket updates for inpatient, home health, skilled nursing facilities (SNFs), hospice and other Medicare providers and provides adjustments for productivity.
- Reduces Medicare Disproportionate Share Hospital (DSH) payments by 75% and then increases payments thereafter based on the % of population uninsured and amount of uncompensated care provided. [Effective FY 2014]
- Provides cost sharing for Accountable Care Organizations (ACO) and establishes minimum criteria for qualifying as an ACO. [Established 01/01/2012]
- Provides for a new trauma program by funding research on emergency medicine and demonstration programs for innovation in emergency care systems. [Appropriation beginning FY 2011]
- Non-profit hospitals required to conduct community needs assessment on a three-year basis and publish charity-care policies and how to apply for assistance. Charges for patients qualifying for financial assistance limited to amount generally billed to insured patients and eligibility for financial aid must be determined before initiating collection actions. Tax of \$50k per year for failure to comply.
- Creates Innovation Center to develop payment reform models to reduce federal health program expenditures and to improve quality of care. [Effective 01/01/2011]
- Reduces Medicare reimbursements to hospitals for “excess preventable hospital readmissions.” [Effective 10/01/2012]

- One percent reduction in Medicare reimbursements to hospitals for “hospital acquired conditions.” [Effective FY 2015]
- Prohibits Medicaid payments to states for “hospital acquired conditions.” [07/01/2011]
- Creates a pilot program to evaluate paying a bundled payment for medical services provided 3 days before a hospitalization and continuing 30 days after discharge involving inpatient acute hospital, physician, outpatient hospital, and post-acute care.[5-year funding beginning in 2011]
- Creates in Medicare a hospital purchasing program to pay hospitals based on certain performance and quality measures [October 1, 2012 Effective Date] and extends the Physician Quality Reporting Initiative (PQRI) beyond 2010. Requires plans for extending such programs to SNFs, home health, and ambulatory surgery centers (“ASCs”) {Report to Congress 01/01/2011}
- Requires the development of a national quality improvement program to establish quality measures for reporting and reimbursement under Medicare, Medicaid, and other federal health programs. [Strategy due to Congress 01/01/2011]

Nurses:

- Increase education opportunities and nursing training programs, provide loan repayment support, retention grants, and creates a career ladder to nursing. [FY 2010 appropriation]
- Three-year grants for employing and training family nurse practitioners providing primary care in federal health centers and nurse-managed clinics. [5-Year appropriation beginning FY 2011]

What the Act Means For Employers

- Employees offered employer coverage not eligible for “premium credits” unless employer plan does not have actuarial value of at least 60% or employee share exceeds 9.5% of income.
- Small employers with no more than 25 employees and avg. annual wages under \$50k receive tax credit for health insurance purchased for employees. Phased in over time:
 - Phase 1:** Up to a 35% credit for tax years 2010-2013 if employer contributes at least 50% of premium cost or benchmark premium. Employers with 10 or fewer employees and average wages under \$25k receive full credit. Tax exempt small businesses eligible for credits up to 25%
 - Phase 2:** For tax years 2014 and beyond, eligible small business employers purchasing coverage via state Exchanges receive up to a 50% tax credit if such employers contribute at least 50% of total premium cost. Full credit is available to employers with 10 or fewer employees and average annual wages under \$25k. Tax-exempt small businesses receive up to a 35% tax credit.
- Employers providing health insurance to retirees over 55 can utilize a temporary reinsurance program that reimburses employers/insurers for 80% of retiree claims between \$15k and \$90k. Payments from the reinsurance plan will be used to reduce enrollee costs. [Effective in 90 days through 2014]
- Eliminates the tax deduction for employers receiving Medicare Part D retiree drug subsidies [Effective 01/01/2013]

- Creates a Small Business Health Options Program (SHOP) administered by a governmental agency or non-profit through which individuals and employers with up to 100 employees can purchase coverage. States can allow employers with greater than 100 employees to purchase coverage under SHOP beginning in 2017.
- Allows employers to provide employees with premium discounts of up to 30% of the cost of coverage for participating in wellness programs and meeting certain health related standards. Also provides for increasing the premium discount to 50% in appropriate cases. [Effective 01/01/2014]

What the Act Means for Specific Industry Sectors

Certain industries may be impacted more than others by the new law. While not exhaustive, below are some key industries and specific statutory provisions that may be of interest to companies in those respective industry sectors.

Drugs, Devices Biologics:

- Imposes annual fees on name brand pharmaceutical manufactures of:

2012–2012	\$2.8 billion
2014–2016	\$3.0 billion
2017	\$4.0 billion
2018	\$4.1 billion
2019 on	\$2.8 billion
- 2.3% excise tax on sale of any taxable medical device [Effective for sales after 12/31/2012]
- FDA authorized to approve generics and grant biologics manufacturers 12 years of exclusive use before generics can be approved [Effective as of enactment]
- Increased scrutiny of the DME industry, including development of a database across federal and state programs, greater penalties for false claims, and increased funding for fraud enforcement.

Skilled Nursing Facilities:

- Medicare and Medicaid nursing facilities must disclose ownership information, accountability requirements, and expenditures. Medicare must create a website polishing standardized information on nursing facilities so beneficiaries can compare facilities.

CO-OP Programs:

- \$6 billion appropriated for CO-Ops. Eligible entities must not be an exiting health insurer or sponsored by a state or local government. Its activities must be devoted to the issuance of qualified health benefit plans in the states in which it is licensed, governance must be by majority vote of members, it must have a strong consumer focus, and profits must be used to lower premium, improve benefits, or enhance healthcare quality for its members.

Restaurants, Food Companies, Vending Companies:

- Such entities must disclose nutritional content of food sold in restaurants and via vending machines. Regulations to be proposed in one year from enactment.

Real Estate:

- Experts predict that medical office buildings construction, expansion, and leasing will increase as various aspects of the new law become effective. See, for example, *Medical Developers, Hospitals Early Winners as Health Care Overhaul Becomes Law*, by Randall Drummer CoStar Realty Information, Inc.

The above is but a snapshot of a broad, sweeping statute that not only makes entirely new law but amends many existing laws. As agencies propose implementing regulations and publish interpretations and guidelines, the contours of the Patient Protection and Affordable Care Act will become better defined.

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