

## HEALTH CARE REFORM - MOVING FORWARD

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The Health Care Group at Murtha Cullina is pleased to provide clients and friends with information about topics of interest in the Health Care area.

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The long and often contentious journey of health care reform legislation has come to an end -- at least for the time being. President Obama has signed both the "Patient Protection and Affordable Care Act" (H.B. 3590, Public Law 111-148) (the "PPACA") and the Health Care and Education Reconciliation Act (H.R. 4872) (the "Reconciliation Act").

The health care reform legislation as finally enacted is detailed and comprehensive. As sent to President Obama for his signature, the PPACA alone totaled 906 pages. The Reconciliation Act contained 153 pages. In this Bulletin we will provide an overview of the principal provisions of the laws.

### Title I. Quality, Affordable Health Care for all Americans

The PPACA has 10 titles. Title I addresses health insurance reform. Many provisions will not take effect until 2014, but some are effective in 2010. Effective in 2010 are provisions which will:

- Prohibit insurers from establishing lifetime limits and unreasonable annual limits; i.e.; capping the dollar value on essential health benefits for a plan that is required to provide essential health benefits.
- Prohibit all plans from rescinding coverage except in instances of fraud and misrepresentation.
- Establish a national high risk pool to provide coverage for persons with pre-existing conditions who have been uninsured for at

least six months (effective 90 days after enactment until 2014).

- Prohibit pre-existing condition exclusions for children.
- Require coverage of preventive services and immunizations.
- Require all plans offering dependent coverage to allow unmarried children to remain on their parents health insurance until age 26.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than \$50,000 that provide health insurance for employees.
- Require the development of uniform coverage documents so that consumers can make apples-to-apples comparisons when shopping for health insurance.
- Cap insurance company non-medical, administrative expenditures, in excess of certain levels through December 31, 2013.
- Create a temporary re-insurance program to support coverage for early retirees (effective 90 days after enactment until 2014).

- Ensure consumers have access to an effective appeals process, establish an internet portal to assist in identifying coverage options and facilitate administrative simplification to lower costs.

**Reforms Beginning in 2014.** Additional significant insurance reforms will be implemented beginning in 2014. New rules will end pre-existing condition exclusions across individual and small group health insurance markets. Insurers will be prohibited from denying coverage, or setting rates, based on gender, health status, medical condition, claims experience, genetic information, evidence of domestic violence or other health related factors. Premiums will vary only by family structure, geography, actuarial value, tobacco use, participation in a healthcare promotion program and age (by not more than three to one).

**American Health Benefit Exchanges.** By 2014, each state will establish an Exchange to help individuals and small employers obtain coverage. Exchanges must be a governmental agency or a nonprofit entity established by a state.

To be qualified to receive tax credits for Exchange coverage, individuals must be ineligible for affordable employer-sponsored insurance and public coverage. Plans participating in the Exchanges will be accredited for quality, present benefit options in a standardized manner and use one, simple enrollment form. A qualified health plan offered through the Exchange must provide essential health benefits as defined by the Secretary of Health and Human Services (the “Secretary of HHS”) and enumerated in the statute and include cost sharing limits. No out-of-pocket requirements can exceed those in Health Savings Accounts, and deductibles in the small group market cannot exceed \$2,000 for an individual and \$4,000 for a family. Coverage will be offered at the following four levels with actuarial values defining how much the insurer pays: Platinum – 90%; Gold – 80%; Silver – 70%; and Bronze – 60%. There will also be a less expensive catastrophic-only plan for individuals under age 30 and others exempt from the individual responsibility requirement.

Undocumented immigrants are ineligible for premium tax credits. No federal dollars will be used to pay coverage for abortion services if coverage extends for services beyond cases of rape or incest or saving the life of the mother.

**Shared Responsibility. Individuals.** Beginning in 2014, most individuals will be responsible for maintaining minimum essential coverage or paying a penalty, either a flat amount or a percentage of household income, whichever is greater. The flat amount will be \$95.00 in 2014, \$325.00 in 2015, and \$695.00 in 2016 and will include dependants (with special rules) up to a family maximum of \$2,085 (indexed in subsequent years). The penalty amount based on a percentage of household income will be 1% of income in 2014, 2% of income in 2015, and 2.5% for 2016 and subsequent years. Exceptions to this requirement will include religious objectors, those who cannot afford coverage, taxpayers with incomes less than the tax filing threshold, Indian tribe members, those who receive a hardship waiver, individuals not lawfully present, incarcerated individuals and those without coverage for less than three months.

Advanceable and refundable tax credits calculated on a sliding scale will be available for Americans with incomes between 100% and 400% of the Federal Poverty Level (FPL) (about \$88,000 for a family of four).

**Employers.** Employers with more than 200 full-time employees must automatically enroll new full-time employees in coverage. Employees may opt out of coverage.

Certain requirements are imposed on “large” employers; i.e.; employers with more than 50 full-time employees. If a large employer does not offer qualifying coverage, and has at least 1 full-time employee receiving a premium tax credit or cost sharing deduction, the employer must make a penalty payment which would total \$2,000 per full-time employee on an annual basis. However, the first 30 full-time employees are excluded, so that an employer with 51 full-time employees who does not offer coverage will pay for 21 employees. An employer that offers coverage that is deemed unaffordable, or does not meet the standard for minimal essential coverage, which has at least 1 full-time employee receiving the premium tax credit for certain reasons, must pay up to \$3,000 (annualized) for each employee receiving a credit, up to an aggregate cap of \$2,000 per full-time employee (again, the first 30 employees are excluded).

The term “full-time employee” means an employee working an average of at least 30 hours per week. Solely for the purpose of determining whether an employer is a large employer, an employer must include, in addition to full-time employees for any month, a number of full-

time equivalents determined by dividing the aggregate number of hours of service of part-time employees by 120.

Employers that offer coverage to their employees must provide a free choice voucher to employees with incomes less than 400% of the FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in an Exchange. The voucher amount equals what the employer would have paid to provide coverage to the employee under the employer's plan, and is to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers are not subject to penalties for the employees who receive premium credits in the Exchange.

The PPACA also provides tax credits beginning this year for employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees. For tax years 2010 through 2013, the law provides a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to an employer with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases out as firm size and average wage increases. Different rules apply for tax years 2014 and later.

## Title II. The Role of Public Programs

The PPACA expands Medicaid eligibility and assumes federal financial responsibility for much of the expansion. It also enhances federal support for the Children's Health Insurance Program (CHIP) and takes other actions.

**Medicaid Expansion.** Beginning on January 1, 2014, all children, parents and childless adults who are not entitled to Medicare who have family incomes up to 133 percent of the FPL will become eligible for Medicaid. States will receive enhanced federal funding for newly eligible Medicaid recipients which will begin in some cases at 100 percent and will level off at 90% in 2020 and subsequent years. States may expand Medicaid eligibility as early as April 1, 2010, but will not receive enhanced funding until 2014.

**Children's Health Insurance Program.** States are required to maintain income eligibility levels through September 30, 2019. The PPACA also extends the current reauthorization period of CHIP to September 30, 2015.

Beginning in 2015, states are eligible for an increase in the CHIP federal match rate.

**Disproportionate Share Hospital Allotments.** States' disproportionate share hospital (DSH) allotments are subject to being reduced. DSH allotments are reduced once a state's uninsured rate decreases by 45%. Reductions will vary depending on various factors.

The PPACA also includes provisions for simplifying enrollment in Medicaid and CHIP and includes a new optional Medicaid benefit through which states may offer community-based supports to Medicaid beneficiaries with disabilities who would otherwise require institutional care.

## Title III. Improving the Quality and Efficiency of Health Care

There are a number of provisions intended to improve the quality and efficiency of medical care services, especially for those in Medicare and Medicaid programs. Some of the provisions include:

- A value-based program for hospitals (in FY2013) which links Medicare payments to quality performance on common, high cost conditions.
- A new Center for Medicare & Medicaid Innovation will develop innovative payment and delivery arrangements. Accountable Care Organizations (ACOs) that take responsibility for cost and quality of care will receive a share of savings they achieve from Medicare. Beginning in 2012, hospital payments will be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions.
- Medicare Advantage (Part C). The Reconciliation Act freezes Medicare Advantage payments in 2011 and reduces Medicare Advantage benchmarks relative to current levels beginning in 2012.
- Medicare Prescription Drug Plan Improvements (Part D). In order to have their drugs covered under Medicare Part D, drug manufacturers will provide a 50% discount for brand-named drugs and biologics purchased during the coverage gap beginning July 1, 2011. This amount will increase to 75% for generic and brand name drugs by 2020. Medicare Part D enrollees who exceed the initial coverage limit (i.e., enter the "donut hole") in 2010 will receive a \$250 rebate.

The PPACA also creates a 15-member Independent Payment Advisory Board to present Congress with proposals to reduce costs and improve quality. Under this provision, when Medicare costs are projected to exceed certain targets, the Board's proposals will take effect unless Congress passes an alternative measure to achieve the same savings level. The Board will not make proposals that ration care, raise taxes or beneficiaries' premiums or change Medicaid benefits eligibility or cost-sharing standards.

#### Title IV. Prevention of Chronic Disease and Improving Public Health

A new interagency prevention council will be created and supported by a new Prevention and Public Health Investment Fund to address Health Promotion and Disease Prevention (the interagency council). The interagency council will promote healthy policies and establish a national prevention and health promotion strategy.

The PPACA also authorizes a number of new programs and benefits related to preventive care and services, including programs:

- For the operation and development of School-Based Health Clinics.
- For an oral health care prevention education campaign.
- To provide Medicare coverage without co-payments or deductibles for an annual wellness visit and development of a personalized prevention plan.
- To waive co-insurance requirements and deductibles for most preventive services, and requiring 100% coverage by Medicare.
- To require Medicaid coverage for counseling and pharmacotherapy to pregnant women to cease tobacco use.
- To award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy life styles.

**Break Time for Nursing Mothers.** The Fair Labor Standards Act is amended to require employers to provide reasonable break time for an employee to express breast milk for her nursing child for one year after the child's birth in a location which affords privacy. An employer is not required to compensate an employee who receives reasonable break

time for any work time spent for this purpose. An employer that employs less than 50 employees is not subject to this requirement if the requirement would impose an undue hardship. State laws that provide greater protection are not preempted.

There are a number of other initiatives. One interesting provision provides that restaurants which are part of a chain with twenty or more locations doing business under the same name must disclose calories on the menu board and in written form.

#### Title V. Health Care Workforce

The PPACA establishes a National Health Workforce commission to review current and projected workforce needs and provide information to Congress and the Administration on how to align federal policies with national needs. It will also establish competitive grants to enable state partnerships to complete comprehensive workforce planning and to create development strategies.

**Increasing the Supply of Health Care Workers.** A number of initiatives are included to increase the supply of health care workers. These include, but are not limited to: student loan programs, including the nursing student loan program, and a loan repayment program established for pediatric subspecialties and providers of mental and behavioral health services to children and adolescents who work in underserved areas. Loan repayment will be offered to workers in exchange for working at least three years at a federal, state, local, or tribal public health agency. Loan repayment will be offered also to allied health professionals employed at public health agencies or in underserved areas. A Ready Reserve Corps is established for service in times of national emergency.

**Enhancing Workforce Education and Training.** New support for workforce training programs is established in a number of areas including, but not limited to:

- Family medicine, general internal medicine, general pediatrics, and physician assistantship.
- Rural physicians.
- Direct care workers providing long-term care services and supports.
- General, pediatric, and public health dentistry, and alternative dental health providers.

- Geriatric education and training for faculty in health profession schools and family caregivers.
- Grants to schools for the development, expansion or enhancement of training programs in social work, graduate psychology, and training to professionals and paraprofessionals in child and adolescent mental health.
- Various types of support for nursing, including grants for accredited nurse midwifery programs, grants to nursing schools to strengthen nurse education and training programs and improve retention, nurse practitioner training programs in community health centers and nurse-managed health centers, and a faculty loan program for nurses who pursue careers in nurse education.
- A U.S. Public Health Sciences Track to train health care professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response.
- The authorization of the Centers of Excellence Program for minority applicants for health professions, expansion of scholarships for disadvantaged students who commit to work in medically underserved areas and a program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health.

Beginning in 2011, the Secretary of HHS may redistribute unfilled residency positions, redirecting those slots for training of primary care physicians. A demonstration grant program is established to develop core training competencies and certificate programs for personal and home care aides, and a grant program is established to provide funding to teaching health centers focused on training primary care providers in the community.

The PPACA authorizes new and expanded funding for federally qualified health centers.

#### **Title VI. Transparency and Program Integrity**

This title creates new requirements to provide information to the public and promotes new requirements to combat fraud and abuse in public and private programs. Some of these requirements are addressed below.

#### **Physician Ownership and Other Transparency.**

Manufacturers of drugs, devices and biological and medical supplies must report gifts and other transfers of value made to physicians and hospitals. Physicians referring for imaging services must inform patients in writing that the individual may obtain such services from a person other than the referring physician or physicians of the same group practice or individuals supervised by the physician or another physician in the group. Prescription drug-makers and distributors must report to HHS information pertaining to drug samples currently being collected internally. Pharmacy benefit managers (PBM) or health benefit plans that provide pharmacy benefit management services that contract with plans under Medicare or the Exchange must report information regarding the generic dispensing rate, rebates, discounts or price concessions negotiated by the PBM.

#### **Nursing Home Transparency and Improvement.**

Nursing homes must make ownership information available and implement compliance and ethics programs. The Secretary of HHS will publish additional information on the Nursing Home Compare Medicare website, including standardized staffing data, a model complaint form, a summary of complaints, and the number of criminal violations by a facility or its employees.

**Medicare, Medicaid and CHIP Program Integrity Provisions.** New program integrity provisions include, but are not limited to:

- Establishment by the Secretary of HHS of procedures to screen suppliers and providers participating in Medicare, Medicaid and CHIP. Providers and suppliers in these programs will be subject to new requirements, including a fee and disclosure of any affiliation with a provider or supplier that has an uncollected debt or has had payments suspended, or billing privileges revoked, or been excluded from participating in a federal health care program. The Secretary of HHS may deny enrollment in these programs if an undue risk is posed.
- New penalties for individuals who make false statements on applications or contracts to participate in a federal health care program or know of, or do not return, an overpayment. Violations are subject to a fine of up to \$50,000. The Secretary may suspend payments to a provider or supplier pending a fraud investigation.

- A data collection program for reporting adverse actions taken against health care providers, suppliers, and practitioners, and submission of information to the National Practitioner Data Bank (NPDB).
- Authority of the Secretary of HHS to disenroll a Medicare physician or provider who fails to maintain access to written orders or requests for payment for durable medical equipment (DME), certification for home health services or referrals for other items and services.
- Exclusion of individuals or entities from Medicaid for a specified period if the entity or individual owns, controls, or manages an entity that: has failed to repay overpayments, is suspended, excluded from participation in any Medicaid program, or is affiliated with such an individual or entity.

In addition to the above, the Secretary of HHS will establish a nationwide program for national and state background checks of direct patient access employees of certain providers. The Secretary may reduce certain monetary penalties for facilities that self-report and correct deficiencies. Various programs and integrity provisions are established concerning multiple employer welfare arrangements (MEWAs). There are also provisions to prevent and eliminate elder abuse, neglect and exploitation.

The PPACA also expresses the “sense of the Senate” that health reform presents an opportunity to address issues relating to medical malpractice and medical liability insurance. States should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider a state demonstration project to evaluate all alternatives.

#### Title VII. Improving Access to Innovative Medical Therapies

A process is established for licensing biological products that are shown to be biosimilar or interchangeable with a licensed biological product.

Drug discounts through the 340B program are extended to inpatient drugs and also to certain children’s hospitals, cancer hospitals, critical access and sole community hospitals in rural referral centers.

#### Title VIII. Community Living Assistance Services and Supports

A national voluntary insurance program for purchasing community living assistance services and supports (CLASS) program is established beginning in 2011. This

is a voluntary, self-funded long-term care insurance program for such purchases by individuals with functional limitations. The Secretary of HHS will develop an actuarially sound benefit plan that: insures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitations; and provides a cash benefit that is not less than an average of \$50 per day. No taxpayer funds will be used to pay benefits under this provision.

#### Title IX. Revenue Provisions

**Excise Tax on High Cost Employer-Sponsored Health Coverage.** Effective January 1, 2018, there is levied a new excise tax of 40% on insurance companies or plan administrators for any health coverage plan with an annual premium that is above the threshold of \$10,200 for single coverage and \$27,500 for family coverage (indexed beginning in 2020). The tax applies to self-insured plans and plans sold in the group market, not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax applies to the amount of the premium in excess of the threshold. Additional threshold amounts of \$1,350 for singles and \$3,450 for families are available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. The threshold can be increased for firms with higher costs due to the age or gender of its workers.

**Health Savings Accounts.** The PPACA increases the tax on HSA and Archer MSA withdrawals that are used for purposes other than qualified medical expenses to 20% for HSAs and Archer MSAs and excludes the cost for over-the-counter drugs not prescribed by a physician from being reimbursed through these accounts on a tax-free basis. Over-the-counter drugs not prescribed by a physician also are excluded from being reimbursed by an HRA or health FSA. Contributions to a flexible spending account for medical expenses are limited to \$2,500 effective January 1, 2013, increased annually by the cost of living.

**Assessment of Hospitals.** The PPACA establishes new requirements applicable to nonprofit hospitals, including a periodic community needs assessment.

**Increase in the Medicare Payroll Tax.** Effective January 1, 2013, the Medicare Part A payroll tax is increased from 1.45% to 2.35% on earnings over \$200,000 for individuals,

\$250,000 for couples, and a 3.8% tax is imposed on unearned income for higher-income taxpayers.

**Fees and Taxes for Certain Industries.** Annual fees are imposed on pharmaceutical manufacturers and health insurance providers. For example, the annual fee on pharmaceutical manufacturers, beginning in 2012, is \$2.8 billion allocated across the industry according to market share. With respect to health insurance providers, the annual fee begins at \$8 billion in 2014 and rises through the years. There are certain exemptions for smaller companies. An excise tax of 2.3% is imposed on the sale of any taxable medical device after December 31, 2012.

**Limitation on Deduction of Medical Expenses.** The adjusted gross income threshold for claiming the itemized deduction for medical expenses increases from 7.5% to 10%, although individuals age 65 and older are able to claim the deduction at 7.5% through 2016.

**Elimination of Employer Subsidy.** The deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees is eliminated.

**Limitation on Deductibility of Executive Compensation.** The deduction for executive and employee compensation is limited to \$500,000 per applicable individual for health insurance providers effective January 1, 2009.

**Indoor Tanning Services.** These services are subjected to a 10% tax.

## Title X. Strengthening Quality, Affordable Care

Title X made many improvements to the preceding nine titles which are included within the above discussion and a number of additional changes. Some of those changes, of particular interest, include:

- Financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into homes and community based services (HCBS).
- Various provisions for improvement of Indian health care.
- Enhancement of the fraud sentencing guidelines, a change in the intent requirement for fraud under the anti-kickback statute, and an increase in subpoena authority relating to health care fraud.

- Grants to states to test alternatives to civil tort litigation that emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes.
- Extension of protections from liability contained in the Federal Tort Claims Act to free clinics.
- Modification of requirements applicable to the labeling of generic drugs.
- Delays in certain skilled nursing facility "RUGs IV" payment changes, authorization of the Secretary of HHS to test the value-based purchasing programs for certain providers.
- Improvements to Medicare beneficiary services, including coverage for individuals exposed to environment health hazards, and prescription drug review through medication therapy management programs.
- A national report card developed by the Secretary of HHS on diabetes to be updated every two years, grants for small businesses to provide comprehensive workplace wellness programs, and other public health program improvements.

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