New Castle County CHAMBER OF COMMERCE

HEALTH CARE REFORM

Overview

It's an Evolution not a Revolution

Like it or not, the health care reform bill is a done deal. However, its passage marks an evolution and not a revolution in the restructuring of our health care system for individuals and employers. The health care system will not change over night; in fact, most of the major changes will not take effect until 2014. The Patient Protection and Affordable Care Act (PPACA) is the most sweeping piece of legislation to be passed by the Congress in over two decades and it has caused a great deal of uncertainty and political debate. It has complex provisions with very vague descriptions that are difficult to interpret. There is one thing we can be sure of, that the business community must be highly engaged in the implementation of the PPACA over the next few years.

The Chamber is committed to providing its members with relevant information about the health care bill. This special booklet has been prepared to give you an overview of the major elements of the PPACA and highlight the proposed timetable for implementation. Over the last year, the debate about health care reform became rather ugly, very partisan and there was a lot of misinformation put forward by the "talking heads" on cable news. In an effort to provide you with an unbiased and factual overview, we have reformatted a Summary and Timetable prepared by the Kaiser Family Foundation. The Kaiser Foundation is a nationally respected expert on health care and has monitored and analyzed the entire health reform process.

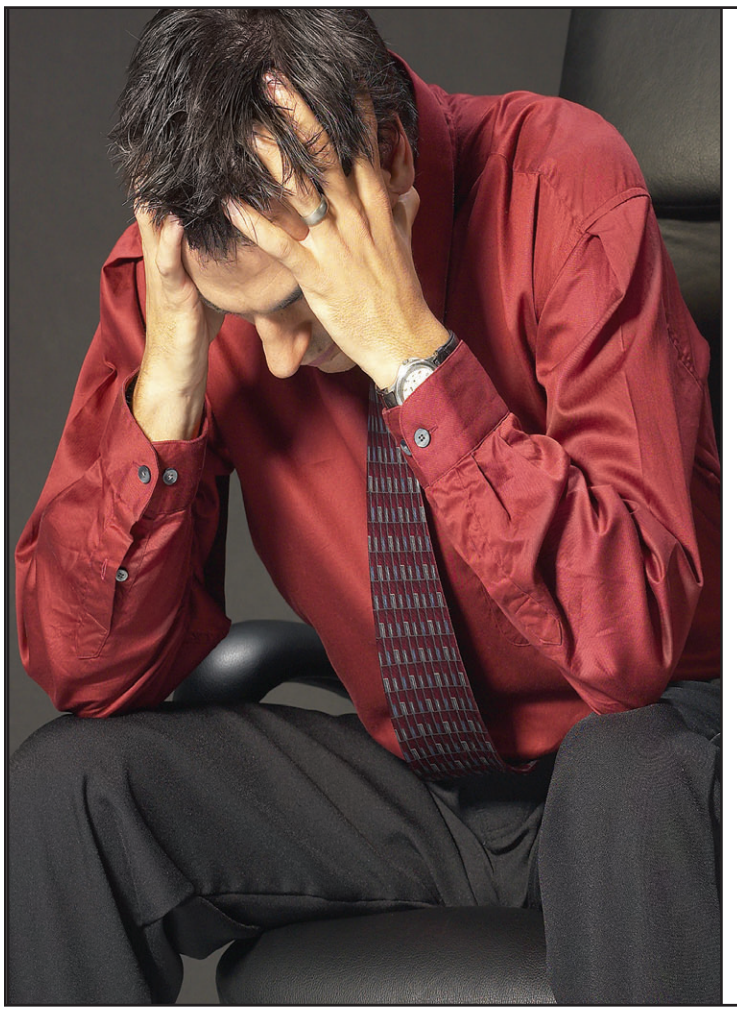
As you will see, the PPACA can be broken down into twelve major categories. As you read through the timeline, you will see when certain elements of these twelve categories are scheduled to be implemented. Several sections have been highlighted to point out areas of major concern that will have direct impact on small businesses. Individual states will become important players in the evolution of the health care system as they move forward with the establishment of health benefits exchanges and there will be many changes and new cost structures for Medicare and Medicaid. The twelve categories contained in the timeline are: Insurance Reforms, Tax Changes, Medicare, Long Term Care, Medicaid, Medical Malpractice, Prescription Drugs, Prevention/Wellness, Quality Improvements, Individual and Employer Requirements, Work Force.

As the implementation process moves forward, do not be surprised if deadlines are extended. It is our hope that this information will help you gain a better understanding of the PPACA so that you can become an engaged participant during the evolution of the health care system. The business community must be prepared to get involved during the development of the various rules and regulations to prevent the creation of a potentially harmful system with a many unintended consequences.

In the following section, we will highlight several of the key aspects of the new legislation. Some establish immediate changes to the tax code; adjust coverage requirements by insurance companies and some set up times to create new delivery methods for the purchase of health benefits.

Small Business Heath Care Tax Credit

This is a provision that will provide direct monetary relief to certain small employers that are currently providing and paying for at least 50% of their health insurance premiums. The legislation has created a new tax credit that is available for the 2010 tax year. Small employers, (including non-profit organizations) with no more than 25 employees that have an average annual wage of less than $50,000, will be eligible for a tax credit worth up the 35% of the premium costs. In 2014, the tax credit will increase to 50%. You should check with your accountant or tax advisor to get more details about this new tax credit.



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Mandates

Insurance Companies: Within six months of the passage of PPACA, all existing health insurance plans are now subject to regulations that prohibit life time limits, rescission of coverage, and excessive waiting periods. In addition, there are requirements to provide coverage for non-dependent children up to the age of 26, no pre-existing condition for children, and in 2014, the no pre-existing condition requirement will be in place for everyone. Insurance companies will be required at the end of 2010 to report their medical loss ratio, which must show 80% of premiums being used for medical expenses; any overages must be rebated to policy holders.

Individuals: Starting in 2014, all US citizens and legal residents must have qualified health coverage or pay penalties. The penalties for not having health insurance will be phased in and will start at $695 per year and increase to $2,085 or 2.5% of income for a family of four.

Employers: There are a series of complex employer mandates that come into effect in 2014 that will require some firms to provide health benefits or pay penalties. At this time, there are no mandates for employers with less than 50 employees, in fact, they have access to the tax credit mentioned above. By 2014, any employer with more than 50 FTEs must provide health benefits or face a penalty of up to $2,000 per employee (the first 30 FTEs are excluded). An employer with more than 200 FTEs is required to have a health benefits program and it must be offered to all employees, who may opt out of it.

Health Benefits Exchanges

Perhaps the most important area in the evolution of health care reform will be the establishment of a state health benefits exchange. **The exchange will be the new marketplace for health benefits.** By 2014, each state must create a Health Benefit Exchange that will be administered by the state or a non-profit organization that will allow individuals and small businesses to purchase qualified coverage (which will be determined by a committee from the Department of Health and Social Services). There is a significant amount of federal grants available to help each state set up an exchange.

The establishment of well designed, and effectively administered state based health benefits exchanges is vital if PPACA is to succeed. Under PPACA, each state has been given a great deal of flexibility to set up and operate a health benefits exchanges for the individual and for the small group market. To improve the potential for success, the states must include the business community in the planning and establishment of the health benefits exchanges. The Chamber will actively work on your behalf to ensure that the voice of business is heard during the planning and implementation process.

2010

Insurance Reforms

- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014)
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.
- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014)
- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Ex-change based on unjustified premium increases.

Medicare

- Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020.
- Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result.
- Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.
- Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity.
- Ban new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limit the growth of certain grandfathered physician-owned hospitals.

Medicaid

- Creates a state option to cover childless adults though a Medicaid State Plan Amendment.
- Creates a state option to provide Medicaid coverage for family planning services to certain low-income individuals through a Medicaid State Plan Amendment up to the highest level of eligibility for pregnant women.
- Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if certain conditions are met.
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
- Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).
- Require the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.

Prescription Drugs

- Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

Quality Improvement

- Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute.
- Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.
- Reauthorize and amend the Indian Health Care Improvement Act.

Workforce

- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.
- Establish Teaching Health Centers to provide Medicare payments for primary care residency programs in federally qualified health centers.

Tax Changes

- Impose additional requirements on non-profit hospitals. Impose a tax of $50,000 per year for failure to meet these requirements.
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers.
- Impose a tax of 10% on the amount paid for indoor tanning services.
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.

2011

Long-term Care

• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice

• Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Prevention/Wellness

• Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare; increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services.

• Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.

• Provide grants for up to five years to small employers that establish wellness programs.

• Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.

• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare

• Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.

• Provide a 10% Medicare bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)

• Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates .

• Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.

• Reduce annual market basket updates for Medicare providers beginning in 2011.

• Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.

• Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.

• Create an Innovation Center within the Centers for Medicare and Medicaid Services.

Medicaid

• Prohibit federal payments to states for Medicaid services related to health care acquired conditions.

• Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion.

• Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services.

• Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

Quality Improvement

• Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.

• Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.

• Establish a new trauma center program to strengthen emergency department and trauma center capacity.

• Improve access to care by increasing funding by $11 billion for community health centers and the National Health Service Corps over five years; establish new programs to support school-based health centers and nurse-managed health clinics.

Tax Changes

• Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account.

• Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount.

• Impose new annual fees on the pharmaceutical manufacturing sector.

• Employers will be required to report the value of employees' health benefits on their W-2s.

2012

Medicare

• Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care.

• Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.

• Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess.

(preventable) hospital readmissions.

• Create the Medicare Independence at Home demonstration program.

• Establish a hospital value-based purchasing program in Medicare and develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.

• Provide bonus payments to high–quality Medicare Advantage plans.

• Reduce rebates for Medicare Advantage plans.

Medicaid

• Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

Tax Changes

• Businesses will have to complete a 1099 form for every business to business transaction of more than $600.

2013

Insurance Reforms

• Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by 7/1/13.

• Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted 7/1/11; effective 1/1/13), electronic funds transfers and health care payment and remittance (rules adopted 7/1/12; effective 1/1/14), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted 7/1/14; effective 1/1/16). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective 4/1/14)

Medicare

• Begin phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25% in 2020, in addition to the 50% manufacturer brand-name discount).

• Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

Medicaid

• Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.

Quality Improvement

• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Tax Changes

• Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.

• Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% assessment on unearned income for higher taxpayers.

• Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment.

• Impose an excise tax of 2.3% on the sale of any taxable medical device.

• Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014

Individual and Employer Requirements

• Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).

• Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

Insurance Reforms

• Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.

• Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.

• Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:

- 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);

- 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);

- 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family).

• Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.

• Limit any waiting periods for coverage to 90 days.

• Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan.

• Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.

• Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.

• Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)

• Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.

• Require qualified health plans to meet new operating standards and reporting requirements.

Medicaid

• Prohibit federal payments to states for Medicaid services related to health care acquired conditions.

• Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion.

• Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services.

• Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

Quality Improvement

• Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.

• Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.

• Establish a new trauma center program to strengthen emergency department and trauma center capacity.

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Tax Changes

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• Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount.

• Impose new annual fees on the pharmaceutical manufacturing sector.

2015 & LATER

Insurance Reforms

• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Compacts may not take effect before 1/1/16.

Medicare

• Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)

Tax Changes

• Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. (Effective January 1, 2018)

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