

## The Patient Protection and Affordable Care Act

## Introduction

On March 23, 2010, the president signed into law H.R. 3590, the Senate's healthcare reform legislation passed by it on December 24, 2009. One week later, the president signed into law H.R. 4872, a set of House proposed amendments to the Senate bill consisting primarily of budgetary changes, such as to taxes and spending. These two statutes, the Patient Protection and Affordable Care Act of 2009, Pub.L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub.L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010), (collectively, the "Affordable Care Act" or the "Act") comprise the federal healthcare reform law of 2010.

The Act represents only the beginning of the federal law-making process for healthcare reform.<sup>1</sup> Interpreting and applying the Act's provisions requires considerable administrative agency action. For instance, there are 1,051 "the Secretary shall" directives involving studies, implementation, legislative actions and the creation of new programs and oversight bodies within the Affordable Care Act alone where Congress has delegated establishing specific policies to federal agencies, primarily through "informal" or "notice and comment" rulemaking.<sup>2</sup> Accordingly, the Department of Health and Human Services and the agencies under its control, along with the Departments of Labor and Treasury, have created, or promulgated, numerous regulations providing implementing details and other rules as required by the Act.<sup>3</sup>

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<sup>1</sup> See Theda Skocpol, "The Political Challenges That May Undermine Health Reform," Health Affairs, July 2010, 1288-1292.

"As with all major social legislation, years of decisions and disputes over implementation lie ahead for the [Affordable Care Act]. Opponents at the state and national levels may seek the law's judicial overturn or repeal. However, a far more serious effort to undermine the law will come about through challenges to various administrative arrangements, taxes, and subsidies to fund expansions of coverage. The redistributive aspects of health reform will be especially at risk, as business interests and groups of more-privileged citizens press for lower taxes, looser regulations, and reduced subsidies for low-income people."

See also *Commonwealth of Virginia Ex Rel. Cuccinelli v. Sebelius*, 702 F. Supp. 2d 598 (E.D. Va. 2010); *Baldwin v. Sebelius*, No. 10-cv-1033, 2010 U.S. Dist. LEXIS 89192, 2010 WL 3418436 (S.D. Cal. Aug. 27, 2010); *Thomas More Law Ctr. v. Obama*, F. Supp. 2d, No. 10-cv-11156, 2010 U.S. Dist. LEXIS 107416, 2010 WL 3952805 (E.D. Mich. Oct. 7, 2010); *Florida ex rel. McCollum v. U.S. Dep't Health & Human Servs.*, 716 F. Supp. 2d 1120 (N.D. Fla. 2010).

<sup>2</sup> Estimates for the number of new offices, agencies, and boards vary significantly - the Center for Health Transformation estimates 159 new offices, agencies and programs created by the Act while the Joint Economic Committee estimates only 47.

<sup>3</sup> These agencies include the Internal Revenue Service within the Department of Treasury, the Employee Benefits Security Administration within the Department of Labor, and the Office of Consumer Information and Oversight within the Department of Health and Human Services. See notes 4 and 5, *infra*.

The Affordable Care Act will impact almost every American and American employer by imposing new requirements on individuals, employers, and health plans; providing financial assistance to certain individuals and, in some cases, small employers to meet those requirements; setting minimum standards for health coverage; and restructuring the private health insurance market.

In its legislative findings set out in the Act, Congress explained that the national market in health insurance and healthcare services amounted to \$2.5 trillion in 2009 and consumed 17.6 percent of the annual gross domestic product. It found that administrative costs for private health insurance amounted to \$90 billion in 2006 and constituted 26 to 30 percent of premiums in the individual and small group insurance markets. Moreover, the costs of providing uncompensated care for the uninsured amounted to \$43 billion in 2008 and were passed on to consumers in the form of substantially higher premiums.

In order to reduce these costs and make coverage more affordable, Congress prescribed certain benefit provisions, including the requirement that insurers guarantee coverage for all individuals, even those with preexisting medical conditions. It also required most individuals to obtain health insurance, which it determined would add millions of people to the insurance market and increase the number of covered individuals. Congress found the individual coverage requirement to be “essential to creating effective health insurance markets” because without it, people would be more likely to postpone purchasing health insurance until they need medical treatment, at which point the Act would obligate insurers to cover them at the same cost as everyone else. This would increase the cost of health insurance and decrease the number of insured individuals - the very problems that Congress sought to address through the Affordable Care Act.

### Brief Summary

The Affordable Care Act reforms the national health insurance market to increase the availability and affordability of health insurance. It prohibits insurers from denying coverage or increasing the price of coverage for individuals with preexisting medical conditions, from rescinding coverage or declining to renew coverage based on health status, and from capping the amount of coverage available to a policyholder. It supplies federal funds and expands Medicaid to assist the poor with obtaining coverage by providing premium tax credits and reduced cost-sharing options for individuals and families with income between 100 and 400 percent of the poverty line, and expanding Medicaid eligibility to individuals with income below 133 percent of the federal poverty level. It encourages small businesses to purchase health insurance for their employees through tax incentives. It creates health benefit exchanges where states will educate consumers on coverage choices and serve as the marketplace for individuals and small businesses to enroll in health insurance plans after comparing their features. The Act also requires certain large employers to offer health insurance to their employees and requires all individuals who do not meet a statutory exemption to purchase and maintain health insurance.

Beginning in 2014, citizens and legal residents, other than those falling within specified exceptions, are required to have “qualifying health coverage,” meaning every “applicable individual” must obtain “minimum essential coverage” for each month or make a “shared responsibility payment” as part of the taxpayer’s annual tax return. An “applicable individual” is any individual except one who qualifies for a religious exemption, who is not a United States citizen, national, or an alien lawfully present in the United States, or who is incarcerated. Exemptions will also be granted for those with incomes below the tax filing threshold and for whom the lowest cost plan option exceeds 8 percent of an individual’s income.

Also starting in 2014, certain large employers that fail to offer “minimum essential coverage” to their employees will be liable for an assessment, or financial penalty. The Act’s “shared responsibility for employers” section regulates the level and quality of healthcare coverage or insurance that large employers make available to their employees, providing that if an “applicable large employer ... fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan ... for any month” and at least one full-time employee receives a “premium tax credit or cost-sharing reduction” through a Health Benefit Exchange, then a fine or assessment is imposed on the employer. An “applicable large employer” is one who employs fifty or more full-time employees on average over a calendar year.

These “shared responsibility” requirements and penalties are often referred to as “individual and employer mandates.”

While employers are not required to provide health insurance coverage, automatic enrollment in health insurance plans sponsored by large employers is mandated. Employers that offer coverage will be required to provide a free choice voucher to employees with incomes less than 400 percent of the federal poverty level if their share of the premiums exceeds certain levels. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the new state-based Exchange. Refundable and advanceable premium credits will be available to eligible individuals and families below certain income levels, and certain small employers are provided with a tax credit.

Effective in 2014, state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges are established through which individuals and small businesses with up to 100 employees can purchase qualified coverage. States are permitted to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area.

Also effective in 2014, an essential health benefits package is established, based on the current benefits provided by the typical employer plan that provides a comprehensive set of services while limiting annual cost-sharing to the current law HSA limits. Abortion coverage is prohibited from being required as part of the essential health benefits package.

The Affordable Care Act reorganizes, amends, and adds to the provisions of the Public Health Service Act (PHSA) relating to group health plans and health insurance issuers in the group and individual markets. It provides that:

- Generally, no group health plan or health insurance issuer may impose a preexisting condition exclusion to limit or deny coverage for plan years beginning on or after January 1, 2014;
- Lifetime or annual benefit limits cannot be imposed by group health plans or health insurance issuers offering group or individual health insurance. A phase-in rule applies for “essential health benefits”;
- Health insurance issuers in the group and individual markets may not rescind an enrollee’s coverage, except where an individual has engaged in fraud or made an intentional misrepresentation of material fact as prohibited under the terms of the plan or coverage. Coverage may not be cancelled without prior notice to the enrollee, and only in certain cases; and
- Health insurance plans must allow enrollees to select any participating primary care provider available, including a pediatrician for children, and to cover emergency services provided at a hospital emergency department. Female enrollees must be able to obtain obstetrical/gynecological specialist services without a referral from another primary care provider.

The Departments of Health and Human Services, Labor, and Treasury jointly issued interim final regulations implementing the "Patient's Bill of Rights" requirements of the Affordable Care Act, concerning preexisting condition exclusions, lifetime and annual limits on benefits, rescissions, and patient protections related to the selection of healthcare providers and access to emergency care.<sup>4</sup> The regulations are generally applicable for plan years beginning on or after September 23, 2010, with certain exceptions.

Other private health insurance provisions that take effect prior to 2014 (including some this year) include the following: requiring coverage of preventive services and immunizations, extending dependant coverage up to age 26, capping insurance companies’ nonmedical administrative expenditures, guaranteeing coverage for preexisting health conditions for enrollees under age 19, and providing assistance for those who are uninsured because of a preexisting condition. Effective in 2014, waiting periods for coverage are limited to 90 days, and states have the option of merging the individual and small group markets.<sup>5</sup>

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<sup>4</sup> Fact Sheet: The Affordable Care Act’s New Patient’s Bill of Rights, available at [healthreform.gov/newsroom/new\\_patients\\_bill\\_of\\_rights.html](http://healthreform.gov/newsroom/new_patients_bill_of_rights.html).

<sup>5</sup> The Department of Health and Human Services (HHS or “the Department”) is issuing regulations in several phases in order to implement revisions to the PHS Act made by the Affordable Care Act. All of the previous regulations were issued jointly with the Departments of Labor and the Treasury. A request for information relating to the medical loss ratio (MLR) provisions of PHS Act section 2718 was pub-

The Affordable Care Act adds several provisions related to the link between quality outcomes and payments under Medicare. Provisions to increase the program integrity of both Medicare and Medicaid are also included. The Act establishes a value-based purchasing program for hospitals starting in 2013. A portion of a hospital's Medicare payment will be linked to the hospital's performance on quality measures related to common and high-cost conditions, such as cardiac, surgical, and pneumonia care. The Physician Quality Reporting Initiative, providing financial incentives to physicians who report quality data to CMS, will be extended through 2014. The Act bases Medicare Advantage (MA) payments on the average of the bids from MA plans in each market, rather than on a statutorily set benchmark rate. The Act requires drug manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap, or "donut hole" beginning July 1, 2011. The initial coverage limit in the standard Part D benefit will be increased by \$500 for 2010. Drug manufacturers are required to provide a 75 percent discount on brand-name and generic drugs by 2020. And all Part D enrollees who enter the donut hole in 2010 will receive a \$250 rebate.

Physician-owned hospitals that did not have a provider agreement prior to December 31, 2010 are prohibited from participating in Medicare. After December 31, 2010, physician ownership of hospitals to which they self-refer is prohibited.

Starting in 2014, states are given the option to expand Medicaid eligibility to non-elderly, non-pregnant individuals with incomes up to 133 percent of the federal poverty level. From 2014 through 2016, the federal government will pay 100 percent of the cost of covering newly eligible individuals. States are required to maintain income eligibility levels for the Children's Health Insurance Program through the end of fiscal year 2019.

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lished in the Federal Register on April 14, 2010 (75 FR 19297) (notice, or request for information). Additionally, a series of interim final regulations were published earlier this year implementing PHS Act provisions added by the Affordable Care Act. Specifically, interim final rules were published implementing (1) section 2714 (requiring dependent coverage of children to age 26) (75 FR 27122 (May 13, 2010)); (2) section 1251 of the Affordable Care Act (relating to status as a grandfathered health plan) (75 FR 34538 (June 17, 2010)); (3) sections 2704 (prohibiting preexisting condition exclusions), 2711 (regarding lifetime and annual dollar limits on benefits), 2712 (regarding restrictions on rescissions), and 2719A (regarding patient protections) (75 FR 37188 (June 28, 2010)); (4) section 2713 (regarding preventive health services) (75 FR 41726 (July 19, 2010)); and (5) section 2719 (regarding internal claims and appeals and external review processes) (75 FR 43330 (July 23, 2010)). Most recently, HHS, Department of Labor, and Department of the Treasury published an amendment to the interim final regulations relating to status as a grandfathered health plan (regarding change in health insurance issuers) in the Federal Register on November 17, 2010 (75 FR 70114). The Departments have also published sub-regulatory guidance regarding various issues related to the implementation of the Affordable Care Act, available at <http://www.dol.gov/ebsa> and <http://www.hhs.gov/ociio>.

The Congressional Budget Office (CBO) estimates that the coverage components of the Affordable Care Act will cost some \$1,053 billion over ten years, to be paid for in part through savings from Medicare and Medicaid, the financial penalties on individuals and employers for failing to meet their “shared responsibilities” for health insurance, and a number of new taxes and fees, including a tax on the sale of any medical device by the manufacturer, producer, or importer, on additional hospital insurance for high-income taxpayers, and on indoor tanning service. Starting in 2018, a 40 percent excise tax is imposed on the providers of employer-sponsored health insurance coverage to the extent that the aggregate value of the coverage for an employee exceeds a threshold amount, \$10,200 for individual coverage and \$27,500 for family coverage, the so-called “Cadillac” tax.

The increased revenues and program cost-savings adopted by Congress should result (according to CBO) in the resources necessary to provide healthcare coverage for those lacking employer-sponsored insurance or otherwise. Even so, healthcare expenditures are predicted to increase 6.2 percent annually over the next decade, with little done to directly address these anticipated costs. Much of the Affordable Care Act was modeled on Massachusetts’ healthcare reform legislation, enacted in 2006. But healthcare costs in Massachusetts remain untenable, exceeding those in other states by 33 percent and continuing to rise at unsustainable rates.<sup>6</sup>

Historically, employers have not been required to provide health insurance to their employees under federal law. However, most large and many small employers provide such coverage. Around 60 percent of the United States’ population under the age of 65 has employer-sponsored group health insurance coverage. The opportunity provided to an employee to enroll in an employer-sponsored healthcare plan is a valuable benefit offered in exchange for the employee’s labor, much like a wage or salary, with the employer’s cost generally deductible as an ordinary and necessary business expense for compensation. Subjecting employers to financial penalties for failing to offer “affordable” employer-sponsored health insurance plans (affordable as defined by the Act for employees) will punish many employers who can no longer meet the expense of providing such health insurance.

The fact that the “shared responsibility” requirements do not take effect until 2014, however, does not mean that they lack impact for the immediate or very near future. Many employers will soon have to rearrange their financial affairs to provide the requisite coverage, or budget for the penalties that they would incur for being out of compliance. There are additional mandates in the Act that will likely affect the design and cost of sponsoring group health insurance plans and care must be taken to comply with those provisions as well. For example, employers must disclose on an employee’s annual Form W-2 the value of the employee’s health insurance coverage

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<sup>6</sup> See Boston ERISA & Insurance Litigation Blog, “What Goes Up Just Keeps Going Up – Health Costs and Employer Mandates,” September 16, 2009 by Stephen D. Rosenberg, citing The New York Times, “Questions for Dr. Marcia Angell,” August 12, 2009, “[a]s a result, they’re chipping away at benefits, dropping beneficiaries and increasing premiums and co-payments.”

sponsored by the employer for taxable years beginning after December 31, 2010. Payroll systems must therefore be updated for this change by January 2011.<sup>7</sup> Likewise, individuals who are presently insured will have to confirm that their current plans comply with the Act's various conditions and obligations concerning coverage and, if not, take appropriate steps to comply. The uninsured will need to research available insurance plans, find one that meets their needs, and begin budgeting accordingly. State governments will need to establish Health Benefit Exchanges and review their own healthcare programs to ensure full compliance with the new law.

Prudent employers, individuals, and state governments should soon begin planning, if they have not already started to plan, for compliance with the Affordable Care Act's various obligations before many of the more well-known mandates "kick-in" or legally take effect in 2014.<sup>8</sup>

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<sup>7</sup> In October of 2010 the Internal Revenue Service (IRS) released Notice 2010-69, providing a one-year delay in the Act's requirement to report the cost of coverage under an employer-sponsored group health plan on Form W-2. The notice acknowledged the delay was necessary to allow employers adequate time to change payroll systems and processes in compliance with the new Affordable Care Act requirement.

The IRS also issued a draft Form W-2 for 2011, which would allow employers to voluntarily provide information about the employee health benefits cost, but this reporting requirement is not mandatory for Forms W-2 issued for 2011, and the IRS will neither treat the omission of the reporting as failing to meet the requirement, nor apply any penalties for failure to report the cost of employer-sponsored health coverage. The IRS stated it plans to publish additional guidance on this requirement before the end of 2010.

On a separate requirement, beginning in 2012, the Act requires all businesses to report all payments and purchases involving any taxable entity totaling \$600 or more in a calendar year, regardless of the payee's corporate status or whether the payments were made for merchandise or other property.

<sup>8</sup> A July 2010 poll conducted by the Society for Human Resource Management (SHRM), "Organizations' Response to Health Care Reform," demonstrated that that 75 percent or more of responding organizations were: (1) Working with a legal or benefits counsel to better understand the law's implications; (2) Sending staff to classes - including seminars and webcasts - to learn details of the law and its impact; and (3) Partnering with current health benefits providers to design 2011 plans to include areas affected by the law. More than 50 percent of poll respondents stated that their organizations were developing a cost analysis for their executives and analyzing the short-term financial impact of the law and the feasibility of offering health insurance.

## The Affordable Care Act

### I. Individual and Employer Coverage Responsibilities

#### A. Individual Penalty for Failing to Carry Health Insurance (the “Shared Responsibility Payment”)

Beginning January, 2014, non-exempt U.S. citizens and legal residents are required to maintain minimum essential coverage. Minimum essential coverage includes government sponsored programs, eligible employer-sponsored plans, plans in the individual market, grandfathered group health plans and other coverage as recognized by the Secretary of Health and Human Services (the Secretary, or HHS) in coordination with the Secretary of the Treasury. Government sponsored programs include Medicare, Medicaid, Children's Health Insurance Program, coverage for members of the U.S. military, veterans health care, and health care for Peace Corps volunteers. Eligible employer-sponsored plans include: governmental plans, church plans, grandfathered plans and other group health plans offered in the small or large group market within a State.

Individuals are exempt from the requirement for months they are incarcerated, not legally present in the United States or maintain religious exemptions. Those who are exempt from the requirement due to religious reasons must be members of a recognized religious sect exempting them from self employment taxes and adhere to tenets of the sect. Individuals residing outside of the United States are deemed to maintain minimum essential coverage. If an individual is a dependent of another taxpayer, the other taxpayer is liable for any penalty payment with respect to the individual.

Individuals who fail to maintain minimum essential coverage in 2016 are subject to a penalty equal to the greater of:

- 2.5 percent of household income in excess of the taxpayer's household income for the taxable year over the threshold amount of income required for income tax return filing for that taxpayer under the Internal Revenue Code;<sup>9</sup> or
- \$695 per uninsured adult in the household.

The fee for an uninsured individual under age 18 is one-half of the adult fee for an adult. The total household penalty may not exceed 300 percent of the per adult penalty, or \$2,085. The total annual household payment may not exceed the national average annual premium for a bronze level health plan offered through the Exchange that year for the household size.

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<sup>9</sup> Generally, in 2010 the filing threshold is \$9,350 for a single person or a married person filing separately and is \$18,700 for married filing jointly, See IR-2009-93, Oct. 15, 2009.

This per adult annual penalty is phased in as follows: \$95 for 2014; \$325 for 2015; and \$695 in 2016. For years after 2016, the \$695 amount is indexed to CPI-U, rounded to the next lowest \$50. The percentage of income is phased in as follows: one percent for 2014; two percent in 2015; and 2.5 percent beginning after 2015. The penalty applies to any period the individual does not maintain minimum essential coverage and is determined monthly. The penalty is an excise tax that is assessed in the same manner as an assessable penalty under the enforcement provisions of subtitle F of the Internal Revenue Code.

Although assessable and collectible under the Code, the IRS authority to use certain collection methods is limited. Specifically, the filing of notices of liens and levies otherwise authorized for collection of taxes does not apply to the collection of this penalty. In addition, the statute waives criminal penalties for non-compliance with the requirement to maintain minimum essential coverage.

Individuals who cannot afford coverage because their required contribution for employer-sponsored coverage or the lowest cost bronze plan in the local Exchange exceeds eight percent of household income for the year are exempt from the penalty. In years after 2014, the eight percent exemption is increased by the amount by which premium growth exceeds income growth. For employees, and individuals who are eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination of whether coverage is affordable to the employee and any such individual is made by reference to the required contribution of the employee for self-only coverage.

Taxpayers with income below the income tax filing threshold shall also be exempt from the penalty for failure to maintain minimum essential coverage.<sup>10</sup> All members of Indian tribes are exempt from the penalty. No penalty is assessed for individuals who do not maintain health insurance for a period of three months or less during the taxable year. Individuals may also apply to the Secretary of HHS for a hardship exemption due to hardship in obtaining coverage. Residents of the possessions of the United States are treated as being covered by acceptable coverage.

The provision is effective for taxable years beginning after December 31, 2013.

#### *B. Employers Shared Responsibility for offering Minimum Essential Coverage*<sup>11</sup>

An applicable large employer that does not offer minimum essential coverage for all its full-time employees, offers minimum essential coverage that is unaffordable, or offers minimum essential

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<sup>10</sup> \$9,350 for a single person or a married person filing separately and \$18,700 for married filing jointly. IR-2009-93, Oct. 15, 2009.

<sup>11</sup> Sections 1513, 10106 and 10108 of the Affordable Care Act, adding and amending Code Sec. 4980H, and Section 1003 of the Reconciliation Act of 2010, further amending Code Sec. 4980H.

coverage that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60 percent, is required to pay a penalty if any full-time employee is certified to the employer as having purchased health insurance through a state exchange for which a tax credit or cost-sharing reduction is allowed or paid to the employee.

An employer is an applicable large employer with respect to any calendar year if it employed an average of at least 50 full-time employees during the preceding calendar year. An employer is not treated as employing more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year and the employees that cause the employer's workforce to exceed 50 full-time employees are seasonal workers. A seasonal worker is a worker who performs labor or services on a seasonal basis (as defined by the Secretary of Labor), including retail workers employed exclusively during the holiday season and workers whose employment is, ordinarily, the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year.

In counting the number of employees for purposes of determining whether an employer is an applicable large employer, a full-time employee (meaning, for any month, an employee working an average of at least 30 hours or more each week) is counted as one employee and all other employees are counted on a pro-rated basis in accordance with regulations prescribed by the Secretary. The number of full-time equivalent employees that must be taken into account for purposes of determining whether the employer exceeds the threshold is equal to the aggregate number of hours worked by non-full-time employees for the month, divided by 120.

An applicable large employer who fails to offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan for any month is subject to a penalty if at least one of its full-time employees is certified to the employer as having enrolled in health insurance coverage purchased through a State exchange for which a premium tax credit or cost-sharing reduction is allowed or paid to such employee or employees.<sup>12</sup>

The penalty for any month is an assessable amount equal to the number of full-time employees over a 30 employee threshold during the applicable month (regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) multiplied by one-twelfth of \$2,000. In the case of persons treated as a single employer under the provision, the 30 employee reduction in full-time employees is made from the total number of full-time employees employed by such persons (i.e., only one 30-person reduction is permitted per controlled group of employ-

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<sup>12</sup> Interestingly, the term minimum essential coverage does not require the employer to provide certain types of coverage or maintain certain cost-sharing limits, such as would apply to an essential health benefits plan eligible for certification by an Exchange as a qualified health plan. Minimum essential coverage merely needs to be a group health plan offered by an employer.

ers) and is allocated among such persons in relation to the number of full-time employees employed by each such person.

An applicable large employer who offers, for any month, its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan is subject to a penalty if any full-time employee is certified to the employer as having enrolled in health insurance coverage purchased through a State exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to such employee or employees.

The penalty is an amount that is imposed for each employee who receives a premium tax credit or cost-sharing reduction for health insurance purchased through a State exchange. For each full-time employee receiving a premium tax credit or cost-sharing subsidy through a State exchange for any month, the employer is required to pay an amount equal to one-twelfth of \$3,000.

The penalty for each employer for any month is capped at an amount equal to the number of full-time employees during the month, regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) in excess of 30, multiplied by one-twelfth of \$2,000.<sup>13</sup>

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<sup>13</sup> Under the Act, employers are not required to purchase health insurance for their employees, but the Act imposes a non-deductible penalty on large employers that fail to offer minimum essential coverage to their employees and their dependents. A "large employer" is defined as having more than fifty (50), full-time employees. The number of full-time employees (defined as an employee who works an average of at least 30 hours per week) is determined on an average basis over the preceding year. If a group of employers is treated as a single employer under the qualified retirement plan group rules, then the group will be treated as one employer for purposes of determining the number of employees under the Act.

The tax penalty assessed on applicable large employers that do not offer minimum essential coverage actually involves separate penalties for the two distinct circumstances resulting in employer liability. The initial question in determining which penalty, if any, is applicable is whether the employer offers the opportunity to enroll in minimum essential coverage to its employees and their dependents. For any month in which an applicable large employer fails to offer the opportunity to enroll in minimum essential coverage, and the employer has at least one full-time employee who has been certified to the employer as having enrolled for that month in a qualified health plan offered through a health insurance exchange who receives a premium tax credit or cost-sharing reduction, the employer will be assessed a penalty equal to the product of the number of the employer's full-time employees (over a 30-employee threshold) multiplied by one-twelfth of \$2,000 (or \$166.67).

The second penalty addresses so-called "offering" employers. An applicable large employer offering coverage will be subject to a penalty in any month in which the employer does offer the opportunity to enroll in minimum essential coverage, but has at least one full-time employee who has been certified to the employer as having enrolled for that month in a qualified health plan offered through a health insurance exchange who receives a premium tax credit or cost-sharing reduction.

In other words, if an employer offering health insurance had 50 full-time employees, with 30 employees receiving premium credits or cost-sharing subsidies, the potential penalty on the employer for those individuals would be  $30 \times \$250$  (1/12 of \$3,000) = \$7,500 monthly, or \$90,000 annually.

If that same employer did not offer coverage, the potential penalty on the employer would be  $20$  ( $50 - 30$ )  $\times$  \$166.67 (1/12 of \$2,000) = \$3,333.40 monthly, or \$40,000 annually.

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It must be determined whether the employer contributes to 60 percent or more of the plan costs. If not, then the employee will be eligible for the premium tax credit or cost-sharing reduction if his or her income falls between 100 percent and 400 percent of the federal poverty level. If the employer does contribute to 60 percent or more of the plan costs, it must be determined whether such coverage is "unaffordable" for the employee. Coverage is generally unaffordable if the premium payments required of the employee exceed 9.5 percent of the employee's household income and his or her income falls between 100 percent and 400 percent of the federal poverty level for the applicable family size.<sup>13</sup>

The penalty applicable to an employer who does offer coverage, but because such coverage is "unaffordable," has at least one employee receiving the premium tax credit or cost-sharing reduction, equals the product of the number of employees receiving premium assistance credit or cost-sharing reductions for such month multiplied by one-twelfth of \$3,000 (or \$250). However, this penalty is capped at an amount equal to the product of \$166.67 and the total number of full-time employees for that month. Thus, the penalty imposed on an "offering" employer can never exceed the penalty imposed on a non-offering employer with the same number of employees.

Companies should note that even though they may meet the full-time employee threshold to be a "large employer," they will not be considered such under these penalty provisions unless they have at least one full-time employee who is enrolled in a health plan through an insurance exchange and receives a premium assistance tax credit or cost-sharing reduction. In other words, even though a company may meet the full-time employee threshold to be a "large employer," it will not be penalized for failing to offer its employees affordable health insurance unless it has at least one full-time employee who is enrolled in a health plan through an insurance exchange and receives a premium assistance tax credit or cost-sharing reduction.

And as previously discussed, individuals who are eligible for employer-sponsored coverage can only obtain premium credits for exchange plans if their income is between 100 to 400 percent of the federal poverty level and (1) if the employee's required contribution exceeds 9.5 percent of the employee's household income or (2) if the plan offered by the employer pays for less than 60 percent of covered health care expenses

In any case, whether a large employer offers health insurance to its employees or not, it will only be required to pay a financial penalty if at least one of its full-time employees obtains health insurance through an exchange and receives a premium credit or cost-sharing subsidy for the purchase of health insurance through a state exchange. If a large employer does not offer coverage, but no full-time employee receives a premium credit or cost-sharing subsidy, no penalty would be assessed.

In this example, then, the employer penalty would be limited to \$3,333.40 monthly or \$40,000 annually.<sup>14</sup>

For calendar years after 2014, the \$3,000 and \$2,000 dollar amounts are increased by the percentage by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2013 rounded down to the nearest \$10.

The penalty amounts imposed under this provision are payable on an annual, monthly or other periodic basis as the Secretary of Treasury may prescribe. The penalty amounts imposed under this provision for employees receiving premium tax credits are not deductible under Code section 162 as a business expense.<sup>15</sup>

Under the provision, as under current law, an employer is not required to offer health insurance coverage. If an employee is offered health insurance coverage by his or her employer and chooses to enroll in the coverage, the employer-provided portion of the coverage is excluded from gross income. The tax treatment is the same whether the employer offers coverage outside of a State exchange or the employer offers a coverage option through a State exchange.

As a general matter, if an employee is offered affordable minimum essential coverage under an employer-sponsored plan, the individual is ineligible for a premium tax credit and cost sharing reductions for health insurance purchased through a State exchange. If an employee is offered minimum essential coverage by their employer that is either unaffordable or that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60percent, however, the employee is eligible for a premium tax credit and cost sharing reductions, but only if the employee declines to enroll in the coverage and purchases coverage through the exchange instead.

Unaffordable is defined as coverage with a premium required to be paid by the employee that is more than 9.5 percent of the employee's household income (as defined for purposes of the pre-

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<sup>14</sup> After 2014, these penalty amounts will be indexed by a premium adjustment percentage for the calendar year.

<sup>15</sup> The Act uses the term "assessable payment" throughout the provision, except for two places where it specifically refers to the assessable payment as a "tax" and one place where it refers to it as "assessable penalties." The assessable payment has also been referred to as a "tax" and "shared responsibility penalty" in other parts of the Act. The Joint Committee Report describes the assessable payment as a penalty that is an excise tax and refers to it as both a "penalty" and an "excise tax" (Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as Amended, in Combination With the "Patient Protection and Affordable Care Act" (JCX-18-10)). Regardless of how the assessable payment is referred to (as a "tax" or as a "penalty"), the Act makes it clear that it is not deductible by the employer (similar to the excise taxes imposed by other provisions in chapter 43 of the Internal Revenue Code) and that it is assessed and collected in the same manner as assessable penalties.

mium tax credits). The employee must seek an affordability waiver from the State exchange and provide information as to family income and the lowest cost employer option offered to them. The State exchange then provides the waiver to the employee. The employer penalty applies for any employee(s) receiving an affordability waiver.

For purposes of determining if coverage is unaffordable, required salary reduction contributions are treated as payments required to be made by the employee. However, if an employee is reimbursed by the employer for any portion of the premium for health insurance coverage purchased through the exchange, including any reimbursement through salary reduction contributions under a cafeteria plan, the coverage is employer provided and the employee is not eligible for premium tax credits or cost-sharing reductions. Thus, an individual is not permitted to purchase coverage through the exchange, apply for the premium tax credit, and pay for the individual's portion of the premium using salary reduction contributions under the cafeteria plan of the individual's employer.

An employer must be notified if one of its employees is determined to be eligible for a premium assistance credit or a cost-sharing reduction because the employer does not provide minimal essential coverage through an employer-sponsored plan, or the employer does offer such coverage but it is not affordable or the plan's share of the total allowed cost of benefits is less than 60 percent. The notice must include information about the employer's potential liability for payments under Code section 4980H. The employer must also receive notification of the appeals process established for employers notified of potential liability for payments under section 4980H. An employer is generally not entitled to information about its employees who qualify for the premium assistance credit or cost-sharing reductions; however, the appeals process must provide an employer the opportunity to access the data used to make the determination of an employee's eligibility for a premium assistance credit or cost-sharing reduction, to the extent allowable by law.

Also, a Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid, and an employer is not required to pay a penalty for any employees enrolled in Medicaid.

### *C. Automatic Enrollment for Employees of Large Employers*

Employers who have more than 200 full-time employees, and provide one or more health benefits plans or options, will be required to automatically enroll full-time employees in one of the employer's health benefits plans or options and to continue the enrollment of current employees in such a plan or option. Employers also will be required to give adequate notice to employees of the automatic enrollment protocol and an opportunity to opt out of such coverage.

New full-time employees will automatically be enrolled in one of the plans (subject to any waiting period authorized by law) and current employees will continue to be enrolled. The law does not supersede any state law which establishes, implements, or continues in effect any standard or

requirement relating to employers in connection with payroll unless the state law would prevent an employer from instituting the automatic enrollment program.

The automatic enrollment program must provide the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in and include written notice at the time of hiring (for current employees not later than March 1, 2013):

- 1) informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance;
- 2) if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60%, that the employee may be eligible for a premium tax credit under Code Sec. 36B and a cost sharing reduction under the Affordable Care Act Sec. 1402 if the employee purchases a qualified health plan through the Exchange; and
- 3) if the employee purchases a qualified health plan through the Exchange and the employer does not offer a free choice voucher, that the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes.

For those employers that offer more than one health benefit plan or benefit option, the automatic enrollment requirement does not dictate the particular option or plan into which the employer is required to automatically enroll the new employee. On its face, the statute leaves that determination to the employer.

#### D. Employer Health Insurance Coverage Reporting<sup>16</sup>

Under this provision, each applicable large employer subject to the employer responsibility provisions and each offering employer must report certain health insurance coverage information to both its full-time employees and to the IRS. An offering employer is any employer who offers minimum essential coverage to its employees under an eligible employer-sponsored plan and who pays any portion of the costs of such plan, but only if the required employer contribution of any employee exceeds eight percent of the wages paid by the employer to the employee. In the case of years after 2014, the eight percent is indexed to reflect the rate of premium growth over income growth between 2013 and the preceding calendar year. In the case of coverage provided by a governmental unit, or any agency or instrumentality thereof, the reporting requirement applies to the person or employee appropriately designated for purposes of making the returns and statements required by the provision.

The information required to be reported includes: (1) the name, address and employer identification number of the employer; (2) a certification as to whether the employer offers its full-time

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<sup>16</sup> Sections 1514, 10106 and 10108(1) and (2) of the Affordable Care Act.

employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; (3) the number of full-time employees of the employer for each month during the calendar year; (4) the name, address and taxpayer identification number of each full-time employee employed by the employer during the calendar year and the number of months, if any, during which the employee (and any dependents) was covered under a plan sponsored by the employer during the calendar year; and (5) such other information as the Secretary may require.

Employers who offer the opportunity to enroll in minimum essential coverage must also report: (1) in the case of an applicable large employer, the length of any waiting period with respect to such coverage; (2) the months during the calendar year during which the coverage was available; (3) the monthly premium for the lowest cost option in each of the enrollment categories under the plan; (4) the employer's share of the total allowed costs of benefits under the plan; and (5), in the case of an offering employer, the option for which the employer pays the largest position of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under each option.

The employer is required to report to each full-time employee the above information required to be reported with respect to that employee, along with the name, address and contact information of the reporting employer, on or before January 31 of the year following the calendar year for which the information is required to be reported to the IRS.

The provision amends the information reporting provisions of the Internal Revenue Code to provide that an employer who fails to comply with these new reporting requirements is subject to the penalties for failure to file an information return and failure to furnish payee statements, respectively.

If feasible, in the case of an applicable large employer or offering employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include the information required by the provision with the information return and payee statement required under new section 6055.

The provision is effective for periods beginning after December 31, 2013.

#### *E. Healthcare Coverage Reporting*

Similarly,<sup>17</sup> insurers (including employers who self-insure) that provide minimum essential coverage to any individual during a calendar year must report certain health insurance coverage information to both the covered individual and to the IRS. In the case of coverage provided by a governmental unit, or any agency or instrumentality thereof, the reporting requirement applies to

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<sup>17</sup> Section 1502(a) of the Affordable Care Act adding Internal Revenue Code Section 6055.

the person or employee who enters into the agreement to provide the health insurance coverage. The information required to be reported includes: (1) the name, address, and taxpayer identification number of the primary insured, and the name and taxpayer identification number of each other individual obtaining coverage under the policy; (2) the dates during which the individual was covered under the policy during the calendar year; (3) whether the coverage is a qualified health plan offered through an exchange; (4) the amount of any premium tax credit or cost-sharing reduction received by the individual with respect to such coverage; and (5) such other information as the Secretary may require.

To the extent health insurance coverage is through an employer-provided group health plan, the insurer is also required to report the name, address and employer identification number of the employer, the portion of the premium, if any, required to be paid by the employer, and any other information the Secretary may require to administer the new tax credit for eligible small employers. The insurer is required to report the above information, along with the name, address and contact information of the reporting insurer, to the covered individual on or before January 31 of the year following the calendar year for which the information is required to be reported to the IRS.

An insurer who fails to comply with these new reporting requirements is subject to the financial penalties for failure to file an information return and failure to furnish payee statements, respectively (The penalty for failure to comply timely with specified information reporting requirement is \$50 per failure, not to exceed \$100,000 for a calendar year.) The IRS is required to provide annual notice to each individual who files an income tax return and who fails to enroll in minimum essential coverage. The notice is required to include information on the services available through the exchange operating in the individual's State of residence.

The provision is effective for calendar years beginning after 2013.

F. *Inclusion of Cost of Employer-Sponsored Health Coverage on Form W-2*

Employers will be required to report the aggregate cost of employer-sponsored health coverage on employees' Forms W-2. The amounts reported will be for information purposes only, and will not be included in employees' taxable wages. The health coverage that will need to be reported will generally include any group health plan coverage made available by an employer to its employees. Specific exceptions will apply to the following types of coverage:

- standalone dental and vision benefits;
- standalone coverage for a specified disease or illness;
- standalone hospital indemnity insurance; and
- coverage for long-term care and certain other types of insurance (e.g., accident or disability income insurance, liability and supplemental liability insurance, workers' compensation insurance, and credit-only insurance).

The aggregate cost of employer-sponsored health coverage will be determined under rules similar to those used for calculating COBRA premiums. Employee premium contributions will be included in the amount reported. However, employee salary reduction contributions to a health flexible spending arrangement (FSA) will not be included in the reported amount. Employers will report these amounts in Box 12 of employees' Form W-2, using Code DD.

Employers will have to modify their payroll systems or procedures in order to comply with this new reporting requirement. The adjustments will need to take into account the fact that different amounts will need to be reported for different employees based on a variety of factors, including:

- the group health plan in which the employee is enrolled;
- the benefit package option the employee elects; and
- the coverage tier selected (e.g., self-only, employee plus spouse, family, etc.).

The reporting requirement applies to taxable years beginning after December 31, 2010, and will apply to all employers that provide group health benefits to their employees, even if the employer's group health plan is a grandfathered health plan. However, the IRS has stated in Notice 2010-69 that the reporting requirement is not mandatory for Forms W-2 issued for 2011, indicating that additional guidance is anticipated before the end of 2010.

## II. Tax Credits and Coverage Cost Sharing Reductions

### A. Health Insurance Premium Assistance Credit.

The Act creates a tax credit (the premium assistance credit) for eligible individuals and families who purchase health insurance through an exchange. The premium assistance credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of certain health insurance plans through an exchange. Under the provision, an eligible individual enrolls in a plan offered through an exchange and reports his or her income to the exchange. Based on the information provided to the exchange, the individual receives a premium assistance credit based on income and the Treasury pays the premium assistance credit amount directly to the insurance plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium tax credit amount and the total premium charged for the plan. Individuals who fail to pay all or part of the remaining premium amount are given a mandatory three-month grace period prior to an involuntary termination of their participation in the plan.

For employed individuals who purchase health insurance through a State exchange, the premium payments are made through payroll deductions. The premium assistance credit is available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level (FPL) for the family size involved who do not received health insurance through an employer or a spouse's employer. Individuals who are listed as dependants on a return are ineligible for the premium assistance credit.

Premium assistance credits are available on a sliding scale basis for individuals and families with household incomes between 100 and 400 percent of FPL to help offset the cost of private health insurance premiums. The premium assistance credit amount is determined based on the percentage of income the cost of premiums represents, rising from two percent of income for those at 100 percent of FPL for the family size involved to 9.5 percent of income for those at 400 percent of FPL for the family size involved. Beginning in 2014, the percentages of income are indexed to the excess of premium growth over income growth for the preceding calendar year.

The premium assistance credit operates on a sliding scale that begins at two percent of income for taxpayers at 100 percent of the FPL and phases out at 9.5 percent of income for those at 300 - 400 percent of the FPL. For instance, if the credit were in effect for 2010, and the premium for the second lowest cost silver health plan for family coverage was \$11,500, and a family of four had annual income of \$88,000 (approximately 400 percent of the current FPL), the credit would be  $\$3,140 = \$11,500 - 8,360(88,000 \times .095)$  since the taxpayer would be expected to pay 9.5 percent of income, or \$8,360, for health insurance premiums. In contrast, if the family's annual income was \$29,000 (approximately 133 percent of the current FPL), the credit would be \$10,920 ( $\$11,500 - 580(29,000 \times .02)$ ) because the taxpayer would be expected to pay only two percent of income, or \$580, for health insurance premiums.

It results in maximum annual premium payments, for qualified individuals, set at a percentage of their income, to help them obtain minimum essential coverage through an exchange. Individuals with income at or below 133 percent of the FPL will pay no more than 2 percent of their income towards premiums for their purchase of health insurance. Individuals with income between 133.1 and 300 percent of the FPL will pay between 3 percent and 9.5 percent of their income towards these premiums, with the percentage of income towards premiums increasing as income levels increase. In other words, the amount of premium support decreases as income levels increase. Individuals with income between 300 and 400 percent of the FPL will pay no more than 9.5 percent of their income towards these premiums.<sup>18</sup> Premium assistance credits are not available for months in which an individual has a free choice voucher.

The premium assistance credit amount is tied to the cost of the second lowest-cost silver plan (adjusted for age) which: (1) is in the rating area where the individual resides, (2) is offered through an exchange in the area in which the individual resides, and (3) provides self-only coverage in the case of an individual who purchases self-only coverage, or family coverage in the

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<sup>18</sup> In 2014, states with Medicaid programs are required to extend Medicaid eligibility to all non-elderly citizens and certain legal aliens earning up to 133 percent of the FPL plus an extra 5 percent that is to be disregarded from individuals' income when determining Medicaid eligibility, or 138 percent. Thus, an individual earning 110% of the FPL who applied for a premium credit and coverage through an exchange in 2014 would be eligible for Medicaid, with the exchange required to have them enrolled in Medicaid. Section 1004(e) of P.L. 111-152.

case of any other individual. If the plan in which the individual enrolls offers benefits in addition to essential health benefits, even if the State in which the individual resides requires such additional benefits, the portion of the premium that is allocable to those additional benefits is disregarded in determining the premium assistance credit amount.

Generally, if an employee is offered minimum essential coverage in the group market, including employer provided health insurance coverage, the individual is ineligible for the premium tax credit for health insurance purchased through a State exchange. If an employee is offered unaffordable coverage by his or her employer or the plan's share of provided benefits is less than 60 percent, the employee can be eligible for the premium tax credit, but only if the employee declines to enroll in the coverage and satisfies the conditions for receiving a tax credit through an exchange. Unaffordable is defined as coverage with a premium required to be paid by the employee that is 9.5 percent or more of the employee's household income, based on self-only coverage. The percentage of income that is considered unaffordable is indexed in the same manner as the percentage of income is indexed for purposes of determining eligibility for the credit (as discussed above).

The Secretary of the Treasury is informed of the name and employer identification number of every employer that has one or more employees receiving a premium tax credit. An employer must be notified if one of its employees is determined to be eligible for a premium assistance credit because the employer does not provide minimal essential coverage through an employer-sponsored plan, or the employer does offer such coverage but it is not affordable. The notice must include information about the employer's potential liability for payments and that terminating or discriminating against an employee because he or she received a credit or subsidy is in violation of the Fair Labor Standards Act.

#### B. Cost-Sharing Subsidy

Additionally, the Act provides that low to moderate income individuals who qualify for premium credits and are enrolled in an exchange-offered qualified health plan at the silver coverage level may be eligible for further financial assistance to pay any required cost-sharing for their health plan.<sup>19</sup> Beginning in 2014, health plans providing the essential health benefits package are prohibited from imposing annual cost-sharing requirements on an insured that exceeds the out-of-pocket limits applicable to high deductible health plans (HDHPs) as defined under the health savings account (HSA) section of the Internal Revenue Code.<sup>20</sup>

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<sup>19</sup> A plan at the silver coverage level is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of benefits provided under the plan.

<sup>20</sup> "Actuarial value" is a summary measure of a health plan's benefit generosity. It is expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges.

A cost-sharing subsidy is provided to reduce annual out-of-pocket cost-sharing for individuals and households between 100 and 400 percent of FPL (for the family size involved). For individuals with household income of more than 100 but not more than 200 percent of FPL, the out-of-pocket limit is reduced by two-thirds. For those between 201 and 300 percent of FPL by one-half, and for those between 301 and 400 percent of FPL by one-third.

These provisions are not effective until 2014, but based on the 2010 limit, for example, the out-of-pocket maximum for HSA-qualified HDHPs is \$5,950 for single coverage and \$11,900 for family coverage.<sup>21</sup> Thus, a two-thirds reduction would be an out-of-pocket maximum of \$2,000 for single coverage and \$4,000 for family coverage; a one-half reduction would be \$3,000 and \$6,000, respectively; and a one-third reduction would be \$4,000 and \$8,000, respectively.

The federal government will pay insurers for the value of these reductions made for their qualified enrollees.

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Medical loss ratio is the share (expressed as a percentage) of total premium revenue spent on medical claims, as opposed to administration or profit.

Coinsurance is a clause in a medical insurance policy requires the patient to pay x percent of the cost of medical treatment, or a fixed payment per prescription. This is often coupled with a deductible where the patient pays the first y dollars of a given medical treatment or the first y dollars of medical treatment within a given period (usually a calendar year).

For instance, an insured may be required to pay 20% of a doctor's office visit, after the yearly deductible is met. If the deductible is \$100 and the office visit is \$250, the patient pays \$100 for the deductible and \$30 of the remaining \$150 as coinsurance. Coinsurance is also referred to as copayment.

The deductible amount is the amount that the insurance policy requires a health insurance plan enrollee to pay for services before benefits begin and they assume liability for all or part of the remaining cost of covered services. It is the amount or period for which the insurance policy will not pay the benefits and such amount will be deducted by the insurance company before calculating the insurance settlement. It is a method to share the cost of health care with the beneficiaries. Information about co-payments or deductibles can be found in the policy and health insurance card. The amount of deductible varies with the type of plan.

Medical loss ratio (MLR) typically is considered a measurement of premium value, determined by calculating the percentage of premiums spent on medical claims. Compared with a “low” medical loss ratio, a “high” MLR indicates a greater share of premiums spent on medical care than on administrative expenses or profit.

<sup>21</sup> Internal Revenue Service (IRS) Rev. Proc. 2009-29, Section 2, available at <http://www.irs.gov/pub/irs-drop/rp-09-29.pdf>.

The cost-sharing subsidy that is provided must further reduce cost-sharing for low income individuals as specified below. For individuals between 100 and 150 percent of FPL (for the family size involved) the plan's share of the total allowed cost of benefits provided under the plan must be 94 percent. For those between 151 and 200 percent of FPL, the plan's share must be 87 percent, and for those between 201 and 250 percent of FPL the plan's share must be 73 percent. For those between 251 and 400 percent of FPL, the subsidy must bring the value of the plan to not more than 70 percent actuarial value. The amount received by an insurer as a cost-sharing subsidy on behalf of an individual, as well as any out-of-pocket spending by the individual, counts towards the out-of-pocket limit.

The cost-sharing subsidy is available only for those months in which an individual receives an affordability credit under new Internal Revenue Code section 36B. As with the premium assistance credit, if the plan in which the individual enrolls offers benefits in addition to essential health benefits, even if the State in which the individual resides requires such additional benefits, the reduction in cost-sharing does not apply to the additional benefits. The Secretary of HHS notifies the plan that the individual is eligible and the plan reduces the cost-sharing by reducing the out-of-pocket limit under the provision. The plan notifies the Secretary of cost-sharing reductions and the Secretary makes periodic and timely payments to the plan equal to the value of the reductions in cost-sharing. The provision authorizes the Secretary to establish a capitated payment system with appropriate risk adjustments.

An employer must be notified if one of its employees is determined to be eligible for a cost-sharing subsidy. The notice must include information about the employer's potential liability for payments under section 4980H and explicit notice that hiring, terminating, or otherwise discriminating against an employee because he or she received a credit or subsidy is in violation of the Fair Labor Standards Act.

An employer is generally not entitled to information about its employees who qualify for the premium assistance credit or the cost-sharing subsidy. Employers may, however, be notified of the name of an employee and whether his or her income is above or below the threshold used to measure the affordability of the employer's health insurance coverage.

The Secretary of the Treasury is informed of the name and employer identification number of every employer that has one or more employee receiving a cost-sharing subsidy.

### C. Free Choice Vouchers

Employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage must provide qualified employees with a voucher whose value can be applied to purchase of a health plan through the Exchange. Qualified employees are employees whose required contribution for employer sponsored minimum essential coverage exceeds eight percent, but does not exceed 9.8 percent of the employee's household income for the taxable year and the employee's total household income does not exceed 400 percent of the

poverty level for the family. In addition, the employee must not participate in the employer's health plan. The value of the voucher is equal to the dollar value of the employer contribution to the employer offered health plan. In the case of years after 2014, the eight percent and the 9.8 percent are indexed to the excess of premium growth over income growth for the preceding calendar year.

Vouchers can be used in the Exchange towards the monthly premium of any qualified health plan in the Exchange. If an individual receives a voucher the individual is disqualified from receiving any tax credit or cost sharing credit for the purchase of a plan in the Exchange. Similarly, if any employee receives a free choice voucher, the employer is not be assessed a shared responsibility payment on behalf of that employee. The amount of the voucher will not be taxable to the employee to the extent it does not exceed the total premium amount. The amount of the voucher is deductible by the employer as a compensation expense. The Congressional Budget Office (CBO) estimates that 100,000 workers will be helped by this provision.<sup>22</sup>

#### *D. Tax Credits for Small Employers*

Small employers will be eligible for a tax credit if they offer health insurance to their employees and cover at least half of the premium cost for such insurance. A "small employer" is one with twenty-five or less full-time employees whose average wages do not exceed \$50,000 annually. The credit is graduated and will only apply in-full to those small employers with fewer than 11 full-time employees whose average annual full-time wages do not exceed \$25,000.

This credit will be accessible in two phases. The first phase occurs during years 2010, 2011, 2012, and 2013, during which a small employer must simply purchase health insurance coverage through a state-licensed insurer. Beginning in 2014, an employer must purchase insurance through an Exchange. An employer may only claim a credit for two years under the second phase. During the first phase, the credit equals 35 percent of the employer's non-elective contributions to employee health insurance premiums. In the second phase, this amount increases to 50 percent. However, it is phased out as the employer's number of employees and average wages increase.

#### *E. Therapeutic Project Tax Credit*

The Act provides a credit for businesses with 250 or fewer employees that make a qualified investment in acute and chronic disease research during 2009 or 2010. Control group rules apply in determining the number of employees. The credit will equal 50 percent of the qualified investment. The Secretary of the Treasury is authorized to provide a grant in lieu of the credit. The credit has a \$1 billion cap. The Department of the Treasury in consultation with HHS will

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<sup>22</sup> See the CBO March 20, 2010, estimate in a letter to the Honorable Nancy Pelosi, <http://cbo.gov/ftpdocs/113xx/doc11379/Manager%27sAmendmenttoReconciliationProposal.pdf>.

award certification for eligibility. The Act provides for elimination of double benefits by denying tax credits, deductions, and favorable basis adjustments for expenditures funded through these credits or grants.

The provision is effective for amounts paid or incurred after December 31, 2008, in taxable years beginning after December 31, 2008.

### III. Health Insurance Coverage and State Exchanges

#### A. Establishment of American Health Benefit Exchange

By January 1, 2014 each state must establish an American Health Benefit Exchange (Exchange) that facilitates the purchase of Qualified Health Plans and provides for the establishment of a Small Business Health Options Program (a SHOP Exchange) that is designed to assist small employers in facilitating the enrollment of their employees in Qualified Health Plans offered in the small group market in the state. An Exchange may be either a governmental agency or a non-profit entity. Grant funding is available to the Secretary to make awards to states for the establishment of Exchanges. Grants may be renewed if it is determined by the Secretary that the state is making progress toward implementing an Exchange and the Act's requirements relating to, generally, the broadened availability of coverage and other benchmarks as Secretary may establish, but no grant may be awarded after January 1, 2015. A state may elect to provide only one Exchange in the state for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers if the Exchange has adequate resources to assist such individuals and employers.

Exchanges must perform a lengthy list of functions. At a minimum, an Exchange must:

- implement procedures to certify, recertify and decertify Qualified Health Plans;
- provide for the operation of a toll-free hotline;
- maintain a website through which individuals can view standardized comparative information on plans;
- assign a rating to each exchange plan based on criteria developed by the Secretary;
- use a standardized format for presenting exchange plan options, including the use of the newly created uniform coverage outline;
- inform individuals of eligibility requirements for Medicaid, CHIP or any other state or local program and, if through the screening process the exchange determines they are eligible for one of those programs, enroll them;
- provide for a calculator to determine the actual cost of coverage to individuals after taking into account any premium credits and cost-sharing subsidies;
- certify whether individuals are exempt from the individual mandate excise tax and transfer the list of such individuals to the Treasury Secretary;

- provide to employers the name of the employees who dropped the employer's coverage and received premium tax credits because the employer's plan was unaffordable or did not provide the required minimum actuarial value, and
- establish the Navigator program.

A state may elect to authorize its Exchange to contract with an eligible entity to carry out one or more responsibilities of the Exchange. The term eligible entity means (i) a person that has demonstrated experience on a state or regional basis in the individual and small group health insurance markets and in benefits coverage and that is not an insurer or treated under the IRC as a member of the same controlled group of corporations as (or under common control with) an insurer or (ii) the state Medicaid agency under the Social Security Act.

The Secretary is required to, as soon as practicable after enactment, to issue regulations setting standards for meeting the requirements governing establishment and operation of Exchanges. In issuing these regulations, the Secretary must consult with the NAIC and its members and with insurers, consumer organizations and such others as the Secretary selects in a manner designed to ensure balanced representation among interested parties. Each state must elect whether to implement the standards promulgated by the Secretary. States choosing to meet these standards must either enact the Federal standards or enact state law or regulations that the Secretary determines meet the standards and take other necessary actions to implement the Act's other requirements before January 1, 2014.

If a state does not elect to implement the standards or the Secretary determines, on or before January 1, 2013, that an electing state will not have any required Exchange operational by January 1, 2014 or has not taken the necessary actions to implement the standards or certain other of the Act's requirements, then the Secretary must, either directly or through agreement with a nonprofit entity, establish and operate such Exchange within the state. A state Exchange will be presumed to meet the standards if the state was operating an Exchange before January 1, 2010 and covering a sufficient percentage of its population, although the Secretary may determine otherwise.

Subject to the Secretary's approval, an Exchange may operate in more than one state if each state in which such Exchange operates permits such operation. A state may also establish one or more "subsidiary Exchanges" if each such Exchange serves a geographically distinct area that is at least as large as a rating area.

The Act requires Exchanges to be self-sustaining beginning on January 1, 2015. To this end, Exchanges may generate funding to support their operations, including by charging assessments or user fees to participating Insurers. An Exchange must publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, as well as the administrative costs of such Exchange, on a website. The Act requires that, in carrying out their activities, Exchanges consult with "stakeholders," including "educated health care consumers" who are enrollees in Qualified Health Plans, individuals and entities with experience in facilitating enrollment

in Qualified Health Plans, representatives of small businesses and self-employed individuals, state Medicaid offices and advocates for enrolling hard-to-reach populations.

Significantly, the Act does not prevent the continued operation of health insurance markets outside of the Exchanges. None of the Exchange-related provisions is to be construed to prohibit an insurer from offering a health plan to individuals or employers outside of an Exchange, prohibit an individual from enrolling in, or an employer from selecting for its employees, a health plan offered outside of an Exchange or compel an individual to enroll in a Qualified Health Plan or to participate in an Exchange.

B. Health Insurance Exchange Eligibility Rules

Enrollment in a Qualified Health Plan through an Exchange is permitted to qualified individuals and employees of qualified employers. A qualified individual may enroll in any Qualified Health Plan, except that in the case of a catastrophic plan only certain individuals are eligible to enroll. A qualified individual enrolled in any Qualified Health Plan may pay any applicable premium owed by such individual directly to the insurer issuing such Qualified Health Plan. A qualified employer may provide support for coverage of employees under a Qualified Health Plan by selecting any level of coverage to be made available to employees through an Exchange. Each qualified employee of a qualified employer that elects a level of coverage may choose to enroll in a Qualified Health Plan that offers coverage at that level.

A qualified individual is a resident of the state of the Exchange who is seeking to enroll in a Qualified Health Plan in the individual market offered through the Exchange and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, excluding incarcerated persons.

A qualified employer is a small employer that elects to make all of its full-time employees eligible for one or more Qualified Health Plans offered in the small group market through an Exchange. Initially, only small employers could opt to offer coverage to their workers through an exchange. They would have to make all of their full-time employees exchange eligible. Before 2016, states will have the option to define small employers either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, each state may allow Qualified Health Plans to be offered in the large group market through an Exchange, and in this case the term qualified employer will include a large employer that elects to make all of its full-time employees eligible for one or more Qualified Health Plans offered in the large group market through the Exchange. This provision does not require insurers to offer coverage in the large group market through an Exchange; however, if a state permits coverage in the large group market to be sold through an Exchange, all plans in the large group market, whether or not offered through an Exchange, will be subject to the rating restrictions that otherwise apply only in the individual and small group market (permitting premiums to vary only according to certain factors such as age and rating area).

If an insurer offers an individual plan on an Exchange, the insurer must consider all enrollees in all health plans other than grandfathered plans offered by such insurer in the individual market in the state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool. If an insurer offers coverage on an Exchange in the small group market, the insurer must consider all enrollees in all health plans other than grandfathered plans offered by such insurer in the small group market in the state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool. A state may require the individual and small group insurance markets within a state to be merged if the state determines it to be appropriate.

### *C. Qualified Health Plans*

In general, exchange plans must be qualified health plans, but not all Qualified Health Plans must be offered in the exchange.

A Qualified Health Plan is a health plan that is certified as meeting a specified list of requirements related to marketing, choice of providers, plan networks, and other features, or is recognized by each exchange through which such plan is offered; and provides the essential health benefits package. A Qualified Health Plan issuer must be licensed and in good standing with each state in which it offers coverage; must offer at least one Qualified Health Plan each providing silver and gold levels of coverage; must charge the same premium for a plan whether it is offered in or out of the exchange (including through an insurance agent); and must comply with regulations applicable to exchanges. Qualified Health Plans will include Qualified Health Plans offered through the CO-OP program.<sup>23</sup>

Specifically, a Qualified Health Plan is defined as a health plan that (i) provides the essential health benefits package, (ii) is offered by a health insurance issuer that, among other conditions (a) agrees to offer at least one Qualified Health Plan in the “silver” level and at least one plan in the “gold” level on each Exchange in which the plan is offered and (b) agrees, with respect to each Qualified Health Plan it issues, to charge the same premium rate without regard to whether the plan is offered through an Exchange or outside an Exchange and without regard to whether the plan is offered directly from the issuer or through an agent; and (iii) has in effect a certification, issued or recognized by each Exchange through which it is offered, that it meets such requirements.

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<sup>23</sup> Certain plans not offered on the Exchanges will generally be treated as qualified health plans as well, including nonprofit plans offered through the CO-OP program, multi-State plans and qualified direct primary care medical home plans. Qualified health plans may vary premiums as appropriate by rating area according to new rules provided under the Act.

#### D. Essential Health Benefits Package

An Essential Health Benefits package must generally (1) offer coverage for specific categories of benefits, (2) meet certain cost-sharing standards, and (3) provide certain levels of coverage. At a minimum, coverage must be offered for the following items and services, although plans may offer benefits beyond this requirement:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services (including behavioral health treatment);
- prescription drugs; rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness and chronic disease management; and
- pediatric services (including oral and vision care).

The scope of benefits offered in an Essential Health Benefits package must be equivalent to the scope of benefits provided under the typical employer-sponsored plan. The Chief Actuary of the Centers for Medicare & Medicaid Services (CMS) must certify that this standard is met and this certification must be reported by Congress by the Secretary.

The Act grants the Secretary some discretion to determine specific elements of the Essential Health Benefits package. When designing the benefits package, the Secretary must factor in the following considerations.

- The package must reflect an appropriate balance among the essential benefits.
- The package must not be designed regarding reimbursement rates or coverage decisions in ways that discriminate against individuals because of their age, disability, or expected length of life.
- The package should reflect the health needs of women, children, persons with disabilities, and other diverse segments of the population.
- Essential Health Benefits cannot be denied to individuals based on age, life expectancy, current or predicted disability, degree of medical dependency, or quality of life.
- The package must provide coverage for emergency room services in situations where the service provider does not have a contractual relationship with the plan. Cost sharing for such out-of-network service may not exceed what would apply if the service were performed in-network.
- If a stand-alone dental plan is offered through an Exchange, other health plans offered through that exchange need not provide for the pediatric dental care that is otherwise required as an essential benefit.

The Secretary must also periodically review the Essential Health Benefits package and provide a report to Congress that contains an assessment of whether changes are merited either because enrollees face difficulty accessing services or because of medical advances. The report must describe how the Essential Health Benefits will be modified to address these issues, and must also assess the relationship between additional benefits and additional costs. To the extent such review identifies gaps or necessary changes, the Secretary must periodically update the definition and scope of the Essential Health Benefits to address those issues.

The Essential Health Benefits package will be subject to cost-sharing limits that are equal to the amount of out-of-pocket expenses that would qualify a plan as a “high deductible health plan” under the Internal Revenue Code as of 2014. These limits for fiscal year 2010 are set at \$5,950 for self-only coverage and \$11,900 for family coverage. For this purpose, the term “cost-sharing” includes deductibles, coinsurance, copayments or similar charges and any other expenditure required of an insured individual that is a qualified medical expense for such essential health benefits covered under the plan (The Internal Revenue Code defines “qualified medical expenses as the amounts paid by an insurance beneficiary for medical care that are not compensated by an insurer). It does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services. Small group health plans providing the Essential Health Benefits package will be further prohibited from imposing a deductible greater than \$2,000 for self-only coverage, or \$4,000 for any other coverage in 2014 (annually adjusted thereafter).

The Essential Health Benefits package plan must offer one of four specific levels of coverage. A plan in the bronze level provides a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan. Silver-level plans, gold-level plans and platinum-level plans are designed to provide benefits actuarially equivalent to 70 percent, 80 percent and 90 percent, respectively, of the full actuarial value of the benefits provided under the plan.

Any issuer that offers coverage in any of these four levels will be required to offer the same level of coverage in a plan specifically designed for individuals under age 21.

An Exchange may certify a health plan as a Qualified Health Plan if (i) such health plan meets the requirements for certification to be promulgated by the Secretary and (ii) the Exchange determines that making such health plan available through it is in the interests of qualified individuals and qualified employers in the state or states in which the Exchange operates. An Exchange may not, however, exclude a health plan: (i) on the basis that such plan is a fee-for-service plan, (ii) through the imposition of premium price controls or (iii) on the basis that the plan provides treatments necessary to prevent patients’ deaths in circumstances the Exchange determines are inappropriate or too costly.

The Secretary is required to establish, by regulation, criteria for the certification of health plans as Qualified Health Plans. The criteria must require that, to be certified a plan must, at a minimum:

- meet marketing requirements and not employ marketing practices or benefit designs that have the effect of discouraging enrollment by individuals with significant health needs;
- ensure a sufficient choice of providers;
- provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;
- include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals;
- be accredited with respect to local performance on clinical quality measures such as patient experience ratings as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access and patient information programs by any entity recognized by the Secretary for the accreditation of health insurers or plans, or receive such accreditation within a period established by an Exchange for all Qualified Health Plans;
- implement a quality improvement strategy;
- utilize a uniform enrollment form for use by qualified individuals and qualified employers (either electronically or on paper) in enrolling in Qualified Health Plans offered through such Exchange and that takes into account criteria that the NAIC develops and submits to the Secretary;
- utilize a standard format established for presenting health benefits plan options; and
- provide information to enrollees and prospective enrollees and to each Exchange in which the plan is offered on measuring the quality of health plan performance.

Additionally, to promote coverage transparency, the Exchange must require health plans seeking certification as Qualified Health Plans to submit to the Exchange, the HHS Secretary, and the state insurance commissioner (and make available to the public), accurate and timely disclosure concerning claims payment policies, financial information, enrollment and disenrollment data, information regarding the number of claims denied, rating practices, cost-sharing and payments with respect to any out-of-network coverage, enrollee and participant rights and other information as determined appropriate by the Secretary. The information required to be submitted under the coverage transparency rule must be provided in plain language. The term “plain language” is defined as language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretaries of HHS and Labor must jointly develop and issue guidance on best practices of plain language writing.

The Exchange must require health plans seeking certification as Qualified Health Plans to submit a justification for any premium increase before implementing the increase. Such plans must

prominently post such information on their websites, and the Exchange must take this information into consideration together with the information and recommendations the state is required to make to the Exchange relating to patterns or practices of excessive or unjustified premium increases when determining whether to make such health plan available through the Exchange. The Exchange must also take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including any information reported by the states. This requirement is in addition to the requirement that the Secretary, in conjunction with the states, continue to review increases in premiums for coverage offered through and outside of the Exchanges and require justification for “unreasonable” increases.

In an effort to improve patient safety, the Act prevents Qualified Health Plans from contracting with certain hospitals or other healthcare providers unless they implement certain mechanisms to improve health care quality. Beginning on January 1, 2015, a Qualified Health Plan may contract with a hospital with greater than 50 beds only if the hospital (i) utilizes a patient safety evaluation system and (ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post-discharge reinforcement by an appropriate health care professional. A Qualified Health Plan may also contract with other healthcare providers only if such providers implement such mechanisms to improve health care quality as the Secretary require by regulation.

States may require Qualified Health Plans offered in the state to offer benefits in addition to the essential health benefits. In this instance, however, the state must assume the cost by making payments to an individual enrolled in a Qualified Health Plan offered in the state or making payments directly to the Qualified Health Plan in which such individual is enrolled, on the individual’s behalf. This is intended to defray the cost for any of these additional benefits.<sup>24</sup>

An Exchange, or a Qualified Health Plan offered through an Exchange, may not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for other minimum essential coverage or such coverage becomes affordable.

In an effort to provide market-based incentives to improve the quality of health care, the Act requires the Secretary to develop guidelines concerning methods of payment for providing increased reimbursements for activities designed to improve such quality and requiring qualified health plans to provide periodic reports to the applicable Exchange regarding these activities. These activities include:

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<sup>24</sup> Originally, the Act had this provision apply only to exchange enrollees who were receiving federal premium credits and cost-sharing subsidies. However, the scope of this provision was expanded to all exchange enrollees per §10104(e)(1). The Act makes clear that federal assistance is not available for the costs attributable to state-mandated benefits (§1401(a): IRC §36B (b)(3)(D), and Act §1402(c)(4)).

- quality reporting, effective case management, care coordination, chronic disease management and medication and care compliance initiatives designed to improve health outcomes;
- comprehensive programs for hospital discharge including patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional, designed to prevent hospital readmission;
- use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage to improve patient safety and reduce medical errors;
- wellness and health promotion activities; and
- use of language services and community outreach to reduce health and health care disparities.

Qualified Health Plans must comply with mental health parity rules that currently apply only to Group Health Plans. This means that a qualified health plan that offers both medical and surgical benefits and mental health or substance use disorder benefits may not impose limits on mental health or substance use disorder benefits that are more restrictive than the limits imposed on medical and surgical benefits.

#### E. Abortion Coverage

A state may “opt out” of abortion coverage for qualified health plans offered through an Exchange by enacting a law prohibiting such coverage. Conversely, a state may repeal such a prohibition and provide that Qualified Health Plans offered through an Exchange in that state may cover abortion services. Abortion services are not required to be part of the Essential Health benefits package, but may be provided by health insurance issuers to beneficiaries as part of qualified health plans. If a qualified health plan provides coverage for abortions for which funding is not permitted under existing federal law, the health insurance issuer may not use any premium credit, advance payment or cost sharing reduction contemplated by the Act for purposes of paying for such services. The health insurance plan issuer must, in that case, collect from each enrollee a distinct payment for an amount regarding services other than abortion services and an amount equal to the actuarial value of providing abortion coverage as estimated by the plan issuer and deposit these payments into separate allocation accounts. The executive order signed by the President on March 24, 2010, emphasizing strict compliance by the administration with existing law that limits the use of federal funds for abortions, directs the Secretary and the Director of the Office of Management and Budget (OMB) to develop within 180 days a model set of segregation guidelines to be used by state health insurance commissioners in determining plans’ compliance with the Act’s segregation requirements and directs the Secretary to issue regulations providing guidance on complying with such requirements.<sup>25</sup>

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<sup>25</sup> See Executive Order – Patient Protection and Affordable Care Act’s Consistency with Longstanding Restrictions on the Use of Federal Funds for Abortion, (March 24, 2010).

Moreover, no qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of such provider's or facility's unwillingness to provide, pay for, provide coverage of or referral for abortions.

F. Marketing Mechanisms

The Act prescribes mechanisms for soliciting interest and enrollment in coverage through an Exchange, including requirements concerning information about available coverage. The information requirements are intended to create transparency in the process of shopping for health care coverage that will require further rulemaking or guidelines on the part of the Secretary.

The Exchange must provide for an initial open enrollment period, as determined by the Secretary (the determination must be made not later than July 1, 2012), and annual open enrollment periods, for calendar years after the initial enrollment period.

The Secretary must develop a system rating qualified health plans offered through an Exchange in each benefits level on the basis of relative quality and price.

The Secretary must develop an enrollee satisfaction survey system to evaluate enrollee satisfaction with qualified health plans offered through the Exchanges, applicable to plans with over 500 enrollees in the previous year.

G. Internet Portal

The Secretary must operate an internet portal, assist states in developing and maintaining their own portals and provide a model template for a portal for use by Exchanges, which must be designed to help direct qualified individuals and qualified employers to qualified health plans, and to assist individuals in determining their eligibility for public programs, including existing state high risk pools, new high risk pools, Medicaid, Medicare and the Children's Health Insurance Program. The portals are to assist individuals and employers in determining their eligibility to participate in an Exchange or for a premium tax credit or cost-sharing reduction, and must present standardized information (including quality ratings and enrollee satisfaction, described above) regarding qualified health plans offered through an Exchange to assist consumers in making health insurance choices. The portal template to be provided by the Secretary must include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide and a copy of the plan's written policy.

H. Navigator Program

Each Exchange must establish a navigator program under which it awards grants to entities to carry out certain duties. An entity serving as a navigator must:

- conduct public education activities to raise awareness of the availability of qualified health plans;
- distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits and cost-sharing reductions;
- facilitate enrollment in qualified health plans;
- provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman, or any other appropriate state agency, for enrollees with grievances, complaints or questions; and
- provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

To be eligible for designation as a navigator and receipt of grant funds, an entity must demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers) or self-employed individuals likely to be qualified to enroll in a qualified health plan. Navigators may include, but are not limited to, trade, industry and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, licensed insurance agents and brokers and other entities that are capable of carrying out Navigator duties.

The Secretary must establish standards for navigators, including provisions to ensure that navigators are qualified and licensed if appropriate to engage in the prescribed navigator activities and to avoid conflicts of interest. Under such standards, a navigator cannot be an insurer or receive any consideration directly or indirectly from any insurer in connection with the enrollment of any individuals or employees in a qualified health plan. Grants made to navigators must be made from the operational funds of the Exchange, not from federal funds received by the state to establish the Exchange.

Exchanges must also provide a calculator to help determine the actual cost of coverage (after any tax credits and cost-sharing reductions) and provide a toll-free hotline to answer requests for assistance. The Secretary must establish procedures through which a state may allow agents or brokers to enroll individuals and employers in any Exchange-offered qualified health plans and to assist individuals in applying for premium tax credits and cost-sharing reductions for such plans.

#### I. Accounting Records

Each Exchange must keep an accurate accounting of all activities, receipts and expenditures and must annually submit a report concerning such accounting, and will be subject to annual audits by the Secretary. The Secretary, in coordination with the Inspector General of HHS, may investigate the affairs of an Exchange, examine the properties and records of an Exchange, require periodic reports in relation to activities undertaken by an Exchange and impose penalties for se-

rious misconduct. Not later than January 1, 2019, the Comptroller General of the United States must conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges, including:

- surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans;
- expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans and the manner in which Exchanges meet their goals;
- where appropriate, recommendations for improvements in the operations or policies of Exchanges;
- a survey of the cost and affordability of Exchange-offered insurance for small business; how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government healthcare programs; and
- the adequacy of provider networks of federal healthcare programs.

Any health insurance coverage offered by a private Insurer must not be subject to any federal or state law if a qualified health plan offered under the CO-OP Program or a multi-state qualified health plan sponsored by the Director of OPM is not subject to such law: (i) guaranteed renewal; (ii) rating; (iii) preexisting conditions; (iv) non-discrimination; (v) quality improvement and reporting; (vi) fraud and abuse; (vii) solvency and financial requirements; (viii) market conduct; (ix) prompt payment; (x) appeals and grievances; (xi) privacy and confidentiality; (xii) licensure; and (xiii) benefit plan material or information.

#### J. CO-OP Program

The Secretary must establish a “Consumer Operated and Oriented Plan” (CO-OP Program) under which grants and loans may be made to assist in the creation or expansion of qualified nonprofit health insurance issuers. These nonprofits will offer qualified health plans in the individual and small group markets in states where they are licensed. The authorized grants and loans are intended to fulfill two purposes: (1) assist the cooperatives with their start-up costs; and (2) help them comply with state solvency requirements. The Act appropriates \$6 billion to carry out the CO-OP Program.

In awarding grants and loans the Secretary must adhere to certain guidelines. The Secretary must take into account the recommendations of the CO-OP Advisory Board. Although the Secretary generally has the discretion in the awarding of grants and loans, priority must be given to nonprofit health insurance issuers that (1) operate on a statewide basis, (2) use an integrated delivery system, or (3) have significant support from the private sector. The Secretary must ensure that funding is available to establish at least one qualified nonprofit issuer in each State. If one or more States are left without a nonprofit issuer, the Secretary may use funds to either encourage the establishment of a nonprofit issuer in such a State, or to expand the reach of a nonprofit issuer established in another State.

Additionally, the Secretary must require each nonprofit issuer receiving a grant or loan to agree to satisfy the requirements for qualified nonprofit health insurance issuers, as well as other provisions of the agreement with the Secretary, and refrain from using the grants or loans to fund legislative lobbying or other marketing efforts.

The Secretary must, no later than July 1, 2013, provide 5-year loans and 15-year grants through the CO-OP Program to persons applying to become qualified nonprofit Insurers. No later than that date, and prior to awarding loans and grants under the CO-OP Program, the Secretary is required to promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with state solvency regulations for health insurers and other similar state laws. Loans must be repaid within five years, and grants must be repaid within 15 years.

A qualified nonprofit health insurance issuer is an insurer:

- that is a nonprofit, member corporation under state law;
- substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group market;
- that was not an insurer or a related entity or predecessor of such an insurer on July 16, 2009;
- that is not sponsored by a state or local government, or by any political subdivision or any instrumentality of such government or political subdivision;
- the governance of which is subject to a majority vote of its members;
- whose governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference;
- that is required to operate with a strong consumer focus, including timeliness, responsiveness and accountability to members, as provided in regulations promulgated by the Secretary;
- whose profits are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of healthcare delivered to its members;
- that complies with all of the state requirements for insurers of qualified health plans; and
- that does not offer a health plan in a state until that state has implemented the market changes required by the Act.

No representative of insurers, their predecessors or related entities, and any federal, state, or local government or representative of insurers may serve on the board of directors of qualified nonprofit health insurance issuers or with private purchasing councils established by qualified nonprofit health insurance issuers. The Secretary may not: (i) participate in any negotiations among one or more qualified nonprofit health insurance issuers and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; or (ii) establish or maintain a price structure for reimbursement of any health benefits covered by qualified nonprofit health insurance issuers.

A qualified nonprofit health insurance issuer that receives a loan or grant under the CO-OP program will qualify as a tax-exempt entity if it meets certain conditions enumerated in the Act, including the following:

- no part of the net earnings of the organization inures to the benefit of any private shareholder or individuals;
- no substantial part of its activities is carrying on propaganda or otherwise attempting to influence legislation;
- the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office; and
- the organization complies with the requirements of the Act applicable to it and the terms of any loan or grant it receives.

Qualified nonprofit health insurance issuers participating in the CO-OP Program may establish a private purchasing council (a “Council”) to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology and actuarial services. The Council is not allowed to set payment rates for participating health care facilities or providers. Qualified nonprofit health insurance issuers and the Council will be subject to federal antitrust laws.

The CO-OP program advisory board will consist of 15 members appointed by the Comptroller General of the United States. The qualifications required of advisory board members are those described in the Social Security Act for members of the Medicare Payment Advisory Commission, including individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives and physicians and other health professionals, experts in the area of pharmacy economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Individuals who are directly involved in the provision or management of the delivery of items and services must not constitute a majority of the membership of the board.

#### *K. Basic Health Programs for Low Income Individuals*

In order to provide health coverage to low-income individuals who are not eligible for Medicaid, the Secretary must establish a basic health program under which a state may elect to offer standard Health Plans for eligible individuals in lieu of making qualified health plans available to them on the state Exchange.

A basic health program eligible individual is an individual who is a resident of a state and is not eligible for the state's Medicaid program; whose household income is between 133 percent and 200 percent of the poverty level; who is not eligible for minimum essential coverage (including Medicare or Medicaid) or is eligible for an employer-sponsored plan that is not affordable coverage; and who has not attained age 65 as of the beginning of the plan year. A basic health program eligible individual will not be eligible for enrollment in a qualified health plan offered through an Exchange.

Likewise, a "standard health plan" will be a plan established and maintained by the state under which eligible individuals are residents of the state who are not eligible to enroll in Medicaid; whose household income exceeds 133 percent but does not exceed 200 percent of the poverty level for the size of the family involved; who are not eligible for minimum essential coverage; or are eligible for an employer-sponsored plan; and have not attained the age of 65 as of the beginning of the plan year. Such a plan will provide coverage equal to at least the essential health benefits, and have a medical loss ratio<sup>5</sup> of at least 85 percent (a medical loss ratio refers to the percentage of premiums collected by an insurer that is used to pay medical claims). To the extent practicable, a state should make multiple standard health plans available to basic health program eligible individuals to ensure individuals have a choice of such plans; a state may also negotiate a regional compact for standard health plans with other states. Standard health plans may be offered (under contract with the state) by HMOs, insurers or networks of health care providers. A state must coordinate the basic health program with other programs, including the state Medicaid program and the CHIP program.

If a state elects to establish a state basic health program, the state basic health program must meet the following requirements, as certified by the SHHS: (i) the premium (after premium tax credits and cost-sharing reductions) of the standard health plan for a basic health program eligible individual and her dependents does not exceed the premium that the individual would have been required to pay if the individual had enrolled in the applicable second-lowest cost "silver" plan on the state Exchange; (ii) the cost-sharing does not exceed the cost-sharing required under a "platinum" plan in the case of a basic health program eligible individual with household income not in excess of 150% of the poverty line, or under a "gold" plan for other basic health program eligible individuals; and (iii) the standard health plan covers at least the essential health benefits.

The Act provides that a state basic health program establish a competitive process for entering into contracts with standard health plans including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits. The competitive process will consider the following:

- innovative features including, but not limited to care coordination and care management (emphasizing chronic conditions);
- incentives for use of preventive services, and establishment of patient/doctor relationships that maximize patient involvement in health care decision-making;

- contracting with managed care systems or with systems that offer as many of the attributes of managed care as feasible in the local health care market; and
- specific performance measures and standards for coverage of providers that focus on quality of care and improved outcomes, in addition to requiring providers to report measures and standards.

Under the law, states will be instructed to seek participation by multiple health plans to allow enrollees a choice between two or more plans, whenever possible. States will also be allowed to negotiate a regional compact with other states to include coverage of eligible individuals in all such states. State administrators will be encouraged to find ways to integrate their negotiations with any Medicaid or other state administered health care programs to maximize efficiency and improve the continuity of care between all state administered health programs.

If the Secretary determines that a state's basic health program meets the foregoing requirements of the program, HHS must make a payment to the state, generally equal to 95 percent of the premium tax credits and the cost-sharing reductions for basic health program eligible individuals enrolled in a standard health plan that would have been provided to such enrollees if they had been allowed to enroll in qualified health plans through an Exchange. The amounts received by a state may be used only to reduce the premiums and cost-sharing of, or to provide additional benefits for, basic health program eligible individuals enrolled in standard health plans. The Secretary must conduct an annual review of each state basic health program to ensure compliance with the requirements of the program, including: (i) eligibility verification requirements for participation in the program; (ii) use of Federal funds; and (iii) quality and performance standards.

#### L. State Waivers

A state may apply to the Secretary for the waiver of all or any requirements with respect to qualified health plans, Exchanges, cost-sharing reductions, premium tax credits, employers' obligations regarding health coverage, individuals' obligation to maintain minimum essential coverage and the penalties relating to them for plan years beginning on or after January 1, 2017. Applications for waivers must include, among other things, a comprehensive description of the state legislation and program to implement a plan meeting the requirements for a waiver, and a 10-year budget plan (must be budget-neutral for the federal Government).

The Secretary is required to promulgate regulations relating to the process for obtaining waivers (including a public notice and comment period) no later than 180 days after the Enactment Date. The Secretary is required to report annually to Congress concerning actions taken by the Secretary with respect to applications for waivers. Waivers may be granted only if the Secretary determines that the state plan: (i) will provide coverage that is at least as comprehensive as the essential health benefits offered through Exchanges as certified by the Chief Actuary of the CMS; (ii) will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as those provided under the Act; (iii) will provide coverage to at least as many of its residents as the Act would; and (iv) will not increase the Federal deficit. No

waiver may extend over a period of longer than five years unless the state requests continuation of such waiver.

*M. Multi-State Coverage Programs*

The Act provides for two ways in which a qualified health plan may be offered in multiple states:

- healthcare compacts offering qualified health plans in the individual market in two or more states; and
- multi-state qualified health plans in the individual and small group market sponsored by the Director of Office of Personnel Management (OPM).

The Secretary must, no later than July 1, 2013 and in consultation with the NAIC, issue regulations for the creation of healthcare choice compacts under which two or more states may enter into an agreement permitting the offering of one or more qualified health plans in the individual market in such states. Healthcare choice compacts may not take effect before January 1, 2016.

Under a compact, two or more states that have enacted a law authorizing them to do so after March 23, 2010 may enter into an agreement under which a qualified health plan can be offered in the individual markets in all such states but, except as set forth below, be subject only to the laws and regulations of the state in which the plan was written or issued. The insurer of the qualified health plan offered in multiple states pursuant to such an agreement, however, (i) would continue to be subject to certain laws and regulations of the state in which the purchaser resides, including standards related to market conduct, unfair trade practices, network adequacy, contract dispute resolution and consumer protection (including standards relating to rating); (ii) would be required to be licensed in each state in which it offers the plan under the compact or to submit to the jurisdiction of each such state with regard to the foregoing standards; and (iii) would be required to notify consumers that the policy may not be subject to all the laws and regulations of the state in which the purchaser resides.

The Secretary may approve interstate health care choice compacts only if it is determined that the health care choice compact will provide, among other things, coverage that: (i) is at least as comprehensive as the essential health benefits offered through Exchanges, with coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the Act would provide; (ii) covers at least a comparable number of a state's residents as the Act would provide; (iii) will not increase the Federal deficit; and (iv) will not weaken enforcement of the state laws and regulations relating to market conduct, unfair trade practices, network adequacy and consumer protection standards that continue to apply to Insurers offering plans under the compact in any state that is included in such compact.

The Act provides for at least two qualified health plans to be offered on Exchanges in multiple states, and eventually nationwide, through a federal contract. The Act requires the Director of OPM (the Director) to enter into contracts with Insurers (including a group of insurers under

common ownership or affiliated by “use of a nationally licensed service mark”), without regard to otherwise applicable competitive bidding requirements, to offer at least two multi-state qualified health plans through each Exchange in each state. Such plans may provide individual or small group coverage. Each contract must be for at least a one-year term, and may be made automatically renewable. The Director is required to ensure that at least one contract is entered into with a nonprofit entity and that at least one of the multi-state qualified health plans offered on an Exchange does not provide coverage of Federal funding-prohibited abortion.

An insurer is eligible to enter into a contract with the OPM for the provision of qualified health plans if it:

- agrees to offer a multi-state qualified health plan that meets the requirements described in the next paragraph in each Exchange in each state;
- is licensed in each state and complies with state law not inconsistent with the Act;
- complies with the minimum standards for carriers offering health benefits plans under the existing Federal Employees Health Benefit Program to the extent that such standards do not conflict with the Act; and
- meets such other requirements as determined appropriate by the Director, in consultation with the Secretary.

In addition, the Act contains a phase-in provision for Insurers that do not offer coverage in all states, providing that the OPM must enter into contracts with Insurers that do not meet the requirements set forth in (i) and (ii) above if the Insurer offers a particular plan in a sufficient portion of the states, determined by reference to the number of years for which the plan has been offered by the Insurer (60 percent of all states in the first year, 70 percent in the second year, 85 percent in the third year and 100 percent thereafter).

Multi-state qualified health plans must meet various requirements (in the Director’s determination), including: (i) offer a benefits package that is uniform in each state and consists of the essential health benefits; (ii) meet all requirements of the Act with respect to a qualified health plan; (iii) comply with the rating rules restricting the factors that may be taken into account to vary premiums; and (iv) be offered in all geographic regions and in all states that have adopted adjusted community rating before the Enactment Date.

An individual enrolled in a multi-state qualified health plan will be eligible for credits and cost-sharing assistance in the same manner as an individual who is enrolled in a qualified health plan. State requirements that additional benefits be offered beyond the essential health benefits must not affect the amount of premium tax credit provided with respect to such plan; rather, that state is required to make payments to or on behalf of an individual enrolled in a multi-state qualified health plan offered in such state to defray the cost of any such additional benefits.

The Director is required to implement this program in a manner similar to the manner in which the Director implements contracts with health insurers under the Federal Employees Health Ben-

efit Program, including requirements as to (i) medical loss ratios, (ii) profit margins, (iii) the premiums to be charged, and (iv) such other terms and conditions of coverage as are in the interests of enrollees in such plans.

#### N. Reinsurance Provision

In general, issuers of health benefit plans that are offered in the individual market would be required to contribute to a temporary reinsurance program for individual policies that is administered by a nonprofit reinsurance entity. Such contributions would begin January 1, 2014, and continue for a 36-month period. The provision requires each State, no later than January 1, 2014, to adopt a reinsurance program based on a model regulation and to establish, or enter into a contract with one or more applicable reinsurance entities to carry out the reinsurance program under the provision. For purposes of the provision, an applicable reinsurance entity is a not-for-profit organization (1) the purpose of which is to help stabilize premiums for coverage in the individual market in a State during the first three years of operation of an exchange for such markets within the State, and (2) the duties of which are to carry out the reinsurance program under the provision by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program. A State may have more than one applicable reinsurance entity to carry out the reinsurance program in the State, and two or more States may enter into agreements to allow a reinsurer to operate the reinsurance program in those States.

An applicable reinsurance entity established under the provision is exempt from Federal income tax. The provision is effective on the date of enactment.

#### IV. Insurance Market Reforms

Under the Affordable Care Act, the application of market reforms to private health plans usually refers to such plans by market segment (non-group, small group, large group) or as qualified health plans. Non-group and small group plans may be offered inside and outside of an exchange. Large group plans may be offered outside of an exchange, but may only be offered through an exchange at the discretion of each state. Qualified health plans primarily will be offered through an exchange, but may be offered outside of it, and generally will provide non-group or small group coverage. However, given that states may allow large groups to offer coverage through an exchange, such large group plans must be qualified health plans.

Private health insurance can be provided to groups of people that are drawn together by an employer or other organization. Such groups are generally formed for some purpose other than obtaining insurance, like employment. When insurance is provided to a group, it is referred to as “group coverage” or “group insurance.” A common distinction made between private health coverage offered to groups is how such coverage is funded. That is, the plan sponsor may either purchase group health insurance from a state-licensed insurance carrier, or fund the health benefits directly. The former refers to fully insured plans; the latter, self-insured plans.

Self-insurance refers to coverage that is provided by the organization seeking coverage for its members. Such organizations set aside funds and pay for health benefits directly, though enrollees are usually charged a premium. Under self-insurance, the organization itself bears the risk for covering medical expenses. Because self-insured plans are not purchased from an insurance carrier licensed by the state, they are exempt from state requirements and subject only to federal regulation. With fully insured plans, the insurance carrier charges the plan sponsor a fee for providing coverage for the benefits specified in the insurance contract. The fee typically is in the form of a monthly premium. The sponsor, in turn, may decide that each person or family who wishes to enroll must pay part of the premium cost. With the fully insured plan, the private insurer bears the insurance risk; that is, the insurer is responsible for covering the applicable costs associated with covered benefits.

The principle federal laws that govern employee benefit plans are the Internal Revenue Code of 1986, the Public Health Service Act, the Health Insurance Portability and Accountability Act of 1996, and the Employee Retirement Income Security Act (ERISA) of 1972. Fully insured health plans are governed by state insurance regulations. Self-insured plans are regulated by ERISA and are not subject to state insurance regulations. ERISA and state authority, however, apply to both public and private fully-insured health plans.

The main practical effect of the difference in treatment is that employers who serve as the insurer for their employees are exempt from the benefit mandates and other insurance regulations that many states impose (such as requirements to cover certain treatments, procedures, or types of providers).

Confusion about the implications of ERISA may stem in part from the terminology that is used to describe its provisions and from subtle distinctions about the roles of employers and insurers. Many employers that bear insurance risk still use insurers to carry out some functions, such as developing networks of providers, negotiating payment rates, processing claims, and so forth. In those cases, the insurance company is called a third-party administrator.<sup>26</sup>

A number of the insurance market reforms contained within the Affordable Care Act have already taken effect. A temporary insurance program for high risk individuals with pre-existing conditions has been established for those who have been uninsured for six months or who have a pre-existing condition. A temporary program providing reimbursement of certain expenses to plan sponsors of group benefits plans has been established to provide health benefits to early retirees between the age of 55 and the age of Medicare eligibility. Health and Human Services was to establish an Internet portal to help beneficiaries and small businesses identify affordable health insurance coverage options in each state by July 1, 2010.

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<sup>26</sup> William Pierron and Paul Fronstin, ERISA Pre-emption: Implications for Health Reform and Coverage, Issue Brief No. 314 (Washington, D.C.: Employee Benefit Research Institute, February 2008), [www.ebri.org](http://www.ebri.org).

Additionally, several of these provisions take effect for plan years beginning on or after September, 23, 2010, including requirements that:

- lifetime or annual benefit limits cannot be imposed by group health plans. A phase-in rule applies for annual benefit limits and “essential health benefits”;
- health insurance issuers in the group and individual market may not rescind an enrollee’s coverage, except where an individual has engaged in fraud or made an intentional misrepresentation of material fact as prohibited under the terms of the plan or coverage;
- all plans are required to cover, without any cost-sharing, preventive services and immunizations that are recommended by the U.S. Preventive Services Task Force and the Centers for Disease Control (CDC) and certain child preventive services recommended by the Health Resources and Services Administration;
- group health plans with dependent child coverage must make available coverage for the enrollee’s adult children who are younger than age 26, regardless of whether or not the dependent is a full-time student, disabled, or married;
- HHS must develop standards for use by group health plans and health insurers in compiling and providing a summary of benefits and explanation of coverage that are uniform in format, use easily understood language, and include uniform definitions of standard insurance and medical terms;
- insured group health plans must comply with existing nondiscrimination rules for self-funded plans, including nondiscrimination rules for eligibility and benefits;
- HHS must establish reporting requirements for use by group health plans and health insurers offering group or individual health insurance coverage that includes information on plan or coverage benefits and healthcare provider reimbursements;
- insurers offering group or individual health insurance must annually report on the percentage of health premiums used for claims reimbursement and must maintain certain minimum medical loss ratios;
- group health plans and health insurers must implement a process for appeals of coverage determinations and claims, including an internal and external claims appeal process and employee notification; and
- health insurance plans must allow enrollees to select any participating primary care provider available, including pediatricians, must cover emergency services provided at hospital emergency departments without prior authorization and regardless of the hospital's participation in the plan provider network, and women must have access to obstetrical/gynecological specialist services without referral from another primary care provider.

These provisions are described in more detail in the following sections.

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## Immediate Actions to Preserve and Expand Coverage

### A. Insurance Access for Uninsured Individuals with a Preexisting Condition

The Affordable Care Act establishes a temporary insurance program for high risk individuals with pre-existing conditions who have been uninsured for six months or who have a pre-existing condition. Funding for this program is capped at \$5 billion and it terminates on January 1, 2014.

On July 1, the Pre-Existing Condition Insurance Plan (PCIP) program went into effect. HHS' Office of Consumer Information and Insurance Oversight (OCIIO) issued an interim final regulation which addresses eligibility qualifications for participating in the program and the premiums that are allowed to be charged.

The Affordable Care Act requires HHS to establish, either directly or through contracts with states or nonprofit entities, a temporary high risk health insurance pool program to provide affordable health insurance coverage to uninsured individuals with preexisting conditions. The HHS is directly running a PCIP in 21 states, while 29 states have decided to run their own PCIP. This program will continue until Jan. 1, 2014, when Health Insurance Exchanges will be available for these individuals to obtain health insurance coverage.<sup>27</sup>

The interim final regulation specifies that an individual eligible to enroll in a PCIP must be a citizen or lawfully present in the U.S., have not had creditable coverage during the six-month period prior to applying for coverage through the PCIP, and have a preexisting condition. An individual must prove that he or she has a preexisting condition. The interim regulation states that a PCIP may determine that an individual has a preexisting condition if they satisfy any one of the following criteria:

- the individual provides documented evidence that an insurer has refused, or has evidence that the insurer has provided a clear indication that it would refuse, to issue individual coverage on grounds related to the individual's health;
- the individual provides documented evidence that he or she has been offered individual coverage but only with a rider that excludes coverage of benefits associated with a pre-existing condition; or

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<sup>27</sup> Some 35 states have high risk pools for those individuals who cannot buy health insurance coverage in the private, individual market due to their pre-existing conditions. Of these, 29 states offer high-risk pools to comply with the Health Insurance Portability and Accountability Act. States generally are responsible for implementation and enforcement of HIPAA's individual market health insurance reforms, with the Department of Health and Human Services acting as a backup if a state "substantially" fails to act. HIPAA requires (1) health insurance issuers offering coverage in the individual market to guarantee issue, without any preexisting condition exclusions, of health insurance in the individual market to eligible individuals (called the federal fallback position), or (2) states to offer an alternative mechanism to the guarantee issue requirement. Forty-one states offer an alternative mechanism (including 29 with a high risk pool), and nine states use the federal fallback rules.

- the individual provides documented evidence that he or she has a medical or health condition specified by the state and approved by the HHS.

The regulation requires that premium rates for PCIPs must be at “a standard rate for the standard population.” This refers to the premium rates offered in the individual market in the state where the PCIP operates. The OCIO noted that existing state high risk pools’ premiums typically average between 105 percent to 250 percent of the standard rate of the individual market. However, the Affordable Care Act requires that premiums in the PCIP program be at the standard rate, rather than at a higher proportion of that rate. In essence, PCIPs are not allowed to charge enrollees premiums at a rate that exceeds 100 percent of the standard individual market rate in the PCIP service area.

#### B. *Reinsurance for Early Retirees*

The Affordable Care Act established a temporary program to provide reimbursement for certain expenses to plan sponsors of group benefits plans providing health benefits to early retirees between the age of 55 and the age of Medicare eligibility. The reimbursement is for 80 percent of plan claims that are between \$15,000 and \$90,000. The reimbursement must be used to lower plan costs or to reduce participant premiums, copayments, deductibles, coinsurance, or other out-of-pocket expenses. The Act required HHS to implement the Program no later than June 21, 2010 and to end the Program no later than January 1, 2014.

Under the Program, HHS upon receiving a valid claim for health benefits, will make a reimbursement payment to plan sponsors in an amount equal to 80 percent of the portion of health benefit costs (net of negotiated price concessions) attributable to claims that exceed \$15,000 but are below \$90,000 (indexed for plan years starting on or after October 1, 2011). HHS has interpreted this rule to mean cumulative health benefits incurred in a given plan year and paid for a given early retiree, that fall between the \$15,000 lower limit and the \$90,000 ceiling will be eligible for reimbursement. In determining the amount of claims, costs paid by the early retiree (or spouse, surviving spouse or dependent) in the form of deductibles, copayments, or coinsurance, will be included in the amounts paid by the plan. Claims for an early retiree under various benefit options (e.g. one option for the retiree, another for a dependent) will not be separately counted. Only one lower limit and one ceiling applies to each early retiree under each employment-based plan for a given plan year.

Sponsors may apply for plan years that begin before June 1, 2010 and end after that date. For claims incurred before June 1, 2010, the amount of such claims up to \$15,000 count toward the lower limit and the ceiling, but the amounts that exceed \$15,000 are not eligible for reimbursement and do not count toward the ceiling. The reimbursement to be paid is based solely on claims incurred on and after June 1, 2010 and that fall between the lower limit and the ceiling for the plan year. The interim final regulations clarify that reimbursement will be made under the Program only for claims that are incurred and paid during the plan year.

The Program is available to employment-based plans, which the regulations define broadly to include, a group health plan, whether a single employer plan, multiemployer plan, multiple employer welfare arrangement, or the plan of a state or local government or political subdivision of such government or an employee organization, a voluntary employees' beneficiary association, in any case whether self-funded, insured or otherwise, that provides health benefits to retirees, but excludes federal government plans.

The Act defines health benefits to include medical, surgical, hospital, prescription drug and such other benefits determined by the Secretary. The regulatory definition of "health benefit" clarifies that such benefits include benefits for the diagnosis, cure, mitigation, or prevention of physical or mental disease or condition with respect to any structure or function of the body. The list of benefits that HHS has authority to determine are proper under the Program is not exhaustive, though it is generally intended to include major medical benefits. Certain benefits, such as stand-alone dental and vision benefits are not included.

Under the Act, early retirees are individuals who are at least age 55 but not eligible for coverage under Medicare, and who are not active employees of an employer maintaining or contributing to an employment-based plan. The regulation clarifies that spouses, surviving spouses and dependents are also included in the definition of early retiree, so that even if they are under age 55 and/or eligible for Medicare, they may nonetheless be included in the Program.

Applicants must include a summary of how the applicant will use the reimbursement to meet the requirements of the Program, including how the reimbursement will be used to reduce plan participant or sponsor costs. Reimbursements may be used to pay for increases in sponsor's premiums or other health benefit costs or to reduce participants' costs. The summary must also explain how the reimbursement will be applied to maintain the sponsor's level of effort in contributing to support the employment-based plan. Funds dispersed under the Program may not be used as general revenue.

The employment-based plan must have in place programs and procedures that have generated or have the potential to generate cost-savings. Generally, the sponsor of the employment-based plan must be able to show that its programs and procedures have generated or had the potential to generate cost savings for plan participants with chronic and high-cost conditions, namely those that are likely to generate \$15,000 or more in health benefit claims for one participant in a plan year. The sponsor need not have programs and procedures in place to address all such costly conditions, but it must take a reasonable approach to identifying which conditions it must address.

### *C. Internet Portal for Health Coverage Information*

An internet portal is established to help beneficiaries and small businesses identify affordable health insurance coverage options in each state. HHS was required to establish this internet por-

tal no later than July 1, 2010. The website must, to the extent practicable, provide ways for residents of any State to receive information on at least the following coverage options:

health insurance coverage offered by issuers (excluding coverage that only provides for the treatment of a single disease or conditions (i.e., cancer insurance); or an unreasonably limited set of diseases and conditions (as determined by the Secretary);

- a) Medicaid coverage;
- b) coverage under the state Children’s Health Insurance Program;
- c) coverage under the state’s health benefits high risk pool, if one exists in the state;
- d) coverage under the high risk pool; and
- e) coverage within the small group market for small businesses and their employees.

The website is required to provide information on eligibility, availability, premium rates, cost sharing, and the percentage of total premium revenues spent on health care, rather than administrative expenses, by the issuer. The information must be presented in a standardized format established no later than 60 days after the date of enactment.

#### *D. Administrative Simplification for Electronic Healthcare Transactions*

To make the health system more efficient by reducing the clerical burden on providers, patients, and health plans, the Act prescribes greater uniformity of standards, mandates the creation of specific operating rules, and accelerates their adoption. It does so primarily by adding new provisions on standardizing electronic administrative transactions to Social Security Act which sets forth standards for information transactions and data elements. In addition, it establishes a process to regularly update these standards and operating rules and requires health plans to certify compliance or face financial penalties.

The Secretary will adopt standards and operating rules for typical electronic administrative transactions between insurers and providers. The term “operating rules” is defined as “necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”

In general, the standards and operating rules should, as feasible, make it possible to determine an individual’s eligibility and financial responsibility for specific health care services in “real time”— prior to or at the point of care. They should also be comprehensive, not needing paper or other backup communications for clarification. The process for claims and denials (including appeals) must include timely acknowledgement, response, and status reporting. All data elements must be described unambiguously. Data elements must be required or conditioned upon set values in other fields, and additional conditions may not be imposed except where otherwise required by law or to avoid fraud or abuse. The goal is to reduce the number and complexity of forms overall.

Input must be solicited from a number of entities to determine whether there could be greater uniformity in financial and administrative "activities and items," and whether those activities should be considered "transactions" for which standards and operating rules should be created - if that would improve the health care system's operation and reduce administrative costs. These entities include the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee, as well as standard-setting organizations and other stakeholders, who must be consulted not later than January 1, 2012, and at least every three years thereafter.

Specifically, input must be solicited before January 1, 2012, in the following areas:

- 1) Could the application process for enrolling health care providers by health plans be made electronic and standardized? Could a uniform application form be used?
- 2) Should the standards and operating rules that are adopted apply to the healthcare transactions associated with automobile insurance, worker's compensation, and other programs?
- 3) Could standardized forms apply to financial audits required by health plans, federal and state agencies (including state auditors, the Office of the Inspector General, and the Centers for Medicare & Medicaid Services), and other relevant entities?
- 4) Could there be greater transparency and consistency in the processes used to establish claim edits used by health plans?
- 5) Should health plans be required to publish their timeliness of payment rules?

By January 1, 2011, the ICD-9-CM Coordination and Maintenance Committee must meet to receive input from stakeholders (including health plans, health care providers, and clinicians) regarding the crosswalk between ICD-9 and ICD-10 that is currently posted on the website of the CMS, and make recommendations about appropriate revisions to the crosswalk. Those crosswalk revisions need to be posted on the CMS website, and any revised crosswalk must be treated as a code set for which a standard has been adopted under this section. Subsequent ICD revisions will follow the same procedure: obtaining input from stakeholders, treatment as an adopted standard, and posting of a crosswalk between the previous and subsequent ICD revisions on the CMS website before the new ICD revision is implemented.

In order to create as much uniformity as possible, a single set of operating rules for each transaction must be adopted by the Secretary. These operating rules need to be both consensus-based and in compliance with standards issued under HIPAA.

### Individual and Group Market Reforms

#### A. No Lifetime or Annual Coverage Limits

Under the Act, in general, group health plans or health insurance issuers offering group or individual plans may not impose a lifetime or annual dollar limit on benefits for any individual, except on specific covered benefits that are not "essential health benefits." Any such limitation

must also comply with other federal or state laws, such as the Americans with Disabilities Act. The restriction on annual dollar limits is phased in over three years, as described below.

These restrictions do not prevent a group health plan from excluding all benefits for a specific condition. Also, it seems that the restrictions do not preclude a group health plan from imposing limitations other than dollar limits. For example, a group health plan apparently could impose a limitation on the number of chiropractic visits covered in a year and could impose treatment limitations based on lack of medical necessity.

The restrictions on annual limits do not apply to health care flexible spending arrangements ("FSAs"), health savings accounts ("HSAs"), or medical savings accounts ("MSAs"). In addition, health reimbursement arrangements ("HRAs") that are integrated with a group health plan may limit the annual amount of benefits available for reimbursement if the combined benefits under the integrated plan would satisfy these requirements.

Regulations have not yet been issued defining "essential health benefits," but the Act itself provides that any such definition shall, at a minimum, include coverage of:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services;
- chronic disease management; and
- pediatric services, including oral and vision care.

The regulation provides that plans should make a good faith effort to comply with a reasonable definition of "essential health benefits" until regulations further defining this term are issued. These essential health benefits are not required to be provided by employer plans, but if such benefits are provided by an employer plan, lifetime and annual limits cannot be imposed in violation of the new regulations.

To mitigate potential premium increases, while at the same time ensuring access to essential health benefits, the prohibition on annual limits for essential health benefits is phased in over a three-year period. For plan years beginning on or after September 23, 2010 but before January 1, 2014, a plan may not impose annual limits on essential health benefits that are less than the applicable amounts:

- 1) \$750,000 for plan or policy years beginning on or after September 23, 2010 but before September 23, 2011;
- 2) \$1.25 million for plan or policy years beginning on or after September 23, 2011 but before September 23, 2012; and
- 3) \$2 million for plan or policy years beginning on or after September 23, 2012 but before January 1, 2014.

These minimum limits apply on an individual basis and apply only with respect to limits on essential health benefits. Because these are minimums, a plan may choose to impose a higher limit or no limit for a plan year. A plan that currently imposes a higher annual dollar limit on benefits than the permitted limit shown above may lower that limit to the permissible level. However, a plan that lowers the restricted annual limit will lose its grandfathered plan status and become subject to all of the Act's mandates.

In response to concerns that the restricted annual limit minimums could adversely impact participants in limited benefit plans or so called "mini-med" plans, the regulations direct HHS to implement a program under which these requirements may be waived if compliance would result in a significant decrease in access to benefits or a significant increase in premiums.

If an employee's past claims have exceeded the plan's lifetime limit, but the employee is otherwise still eligible for coverage under that plan, the regulations require that the plan inform the employee that the lifetime limit no longer applies. If the employee is no longer enrolled in the plan, the regulations require the plan to offer the employee an enrollment opportunity as a special enrollee. Thus, the employee must be given the opportunity to enroll in all of the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, the regulations provide that any difference in benefits or cost-sharing requirements constitutes a different benefit package. The notice and enrollment opportunity must be provided beginning no later than the first day of the first plan year beginning on or after September 23, 2010, and coverage must begin as of that date. The enrollment opportunity must last at least 30 days.

The prohibition on lifetime limits and the annual limit restrictions apply to grandfathered group health plans. Limits on annual limits will not apply to existing "grandfathered" plans offering individual coverage.

#### *B. Prohibition on Rescission*

A group health plan or health insurance issuer must not rescind coverage unless the individual, or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A health insurance issuer in the group and individual markets cannot cancel, or fail to renew, coverage for an individual or a group for any reason other than those enumerated in the statute, which include nonpayment of premiums, fraud or intentional misrepresentation of material fact, withdrawal of a product or withdrawal of an

issuer from the market, movement of an individual or an employer outside the service area, or for bona fide association coverage or cessation of association membership reasons.

The regulations provide rules regarding rescissions of health coverage for group health plans and health insurance issuers offering group or individual health insurance coverage. Recession refers to a retroactive termination or discontinuance of coverage on the part of the insurer or plan provider, which means that the insurer or plan provider is no longer responsible for medical care claims that it had previously accepted and paid. Rescission not only leaves the former enrollee without health coverage, but it also treats that person as if he or she were never enrolled in the rescinded plan. Consequently, the former enrollee would be responsible for all health expenses incurred when he or she was previously covered.

The new rule on rescissions is more protective of individuals than the preexisting standard under State insurance law or Federal common law. That is, under prior law, a plan could potentially rescind coverage for an employee's unintentional or inadvertent misrepresentations regarding health status or preexisting conditions.<sup>28</sup> Under the new standard for rescissions, plans and issuers cannot rescind coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact prohibited by the terms of the plan or insurance contract.

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<sup>28</sup> As added by the Affordable Care Act, PHSa section 2712 and the final regulations create a statutory Federal standard and enforcement power in the group and individual markets where it did not exist. Prior to this provision taking effect, varying court-made Federal common law existed for ERISA plans. State rules pertaining to rescission have been found to be preempted by ERISA by five circuit courts (5th, 6th, 7th, 9th and 11th as of 2008). Each styled a remedy looking to State law, the majority of Federal courts or the Restatement of Contracts.

According to a House Energy and Commerce Committee staff memorandum, rather than reviewing medical histories when applications are submitted, some insurers engage in “post-claims underwriting.” Under this practice, if the policyholders file expensive claims, the insurance companies initiate investigations to scrutinize the details of the policyholder's application materials and medical records, and if discrepancies, omissions, or misrepresentations are found, the insurer rescinds the policies, returns the premiums, and refuses payment for medical services. The Committee apparently found evidence of insurance companies rescinding coverage even when discrepancies were unintentional or caused by others, for conditions that were unknown to policyholders, and for discrepancies unrelated to the medical conditions for which patients sought medical care. According to the Committee, the existing regulatory framework governing the individual insurance market in this area was a haphazard collection of inconsistent State and Federal laws. Protections for consumers and enforcement actions by regulators vary, depending the where individuals lived. Because of these varying standards, many patients lack adequate protections against rescission, prompting the need for and benefits from this statutory change and implementing regulations.

See Terminations of Individual Health Insurance Policies by Insurance Companies, Hearing before the House Committee on Energy and Commerce, Subcommittee On Oversight and Investigations, June 16, 2009, at [energy.commerce.house.gov/Press\\_111/20090616/rescission\\_supplemental.pdf](http://energy.commerce.house.gov/Press_111/20090616/rescission_supplemental.pdf).

This standard applies to all rescissions, whether in the group or individual insurance market, and whether insured or self-insured coverage. Thus, the rules apply regardless of whether the rescission would affect an individual with single coverage, an individual within a family, or an entire group of individuals. The rules apply to representations made by the individual or a person seeking coverage on behalf of the individual. For example, the rules apply to representations made by a plan sponsor while seeking coverage for an employment-based group. It prohibits not only rescissions based on unintentional omissions or misstatements with respect to medical conditions or treatment, but also rescissions based on unintentional omissions or misstatements with respect to other eligibility conditions, such as a full-time employment requirement.

A plan or policy is still permitted to rescind coverage based on an omission to the extent that the omission constitutes fraud or an intentional misrepresentation of material fact prohibited by the terms of the plan or insurance contract.

The Act and regulations provide that a group health plan, or health insurance issuer offering group health insurance coverage, must provide at least 30 calendar days advance notice to an individual before coverage may be rescinded (even though prior notice must be provided in the case of a rescission, applicable law may permit the rescission to void coverage retroactively). The notice must be provided regardless of whether the rescission is of group or individual coverage; or whether, in the case of group coverage, the coverage is insured or self-insured, or the rescission applies to an entire group or only to an individual within the group. Plans must also comply with more protective state laws, such as those providing that rescissions are only permitted in cases of fraud or only within a contestability period.

The regulations provide that a cancellation or discontinuance of coverage that takes effect retroactively does not constitute rescission to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Likewise, a cancellation or discontinuance of coverage that has only prospective effect is not a rescission. A prospective cancellation is subject to separate HIPAA rules governing guaranteed renewal. Cancellations of coverage are addressed under other Federal and State laws, including sections 2703(b) and 2742(b) of the Public Health Service Act, which limit the grounds for cancellation or non-renewal of coverage.

### *C. Preventative Health Services Coverage*

As provided by the Affordable Care Act, all plans are required to cover, without any cost-sharing, preventive services and immunizations that are recommended by the U.S. Preventive Services Task Force and the Centers for Disease Control (CDC). Also required to be covered, without any cost-sharing, are certain preventive services for children, as recommended by the Health Resources and Services Administration.

The U.S. Preventive Services Task Force (USPSTF), first convened by the U.S. Public Health Service in 1984, and since 1998 sponsored by the Agency for Healthcare Research and Quality

(AHRQ), is an independent panel of private-sector experts in prevention and primary care. The USPSTF conducts assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. Its recommendations are considered the "gold standard" for clinical preventive services for more information, see [www.ahrq.gov/clinic/USpstfix.htm](http://www.ahrq.gov/clinic/USpstfix.htm).

The Advisory Committee on Immunization Practices (ACIP) consists of 15 experts in fields associated with immunization, who have been selected by the Secretary of the U. S. Department of Health and Human Services to provide advice and guidance to the Secretary, the Assistant Secretary for Health, and the Centers for Disease Control and Prevention (CDC) on the control of vaccine-preventable diseases. In addition to the 15 voting members, ACIP includes eight ex officio members who represent other federal agencies with responsibility for immunization programs in the United States, and 26 non-voting representatives of liaison organizations that bring related immunization expertise (for more information, see [www.cdc.gov/vaccines/recs/acip/#about](http://www.cdc.gov/vaccines/recs/acip/#about)).

The Departments of Health and Human Services, Labor, and the Treasury issued interim final regulations requiring private health plans that do not qualify as grandfathered under the Affordable Care Act to cover evidence-based preventive services and eliminate cost sharing requirements for such services. Under the regulations, non-grandfathered plans beginning with the first plan year beginning after September 22, 2010 must cover preventive services that have strong scientific evidence of their health benefits and may no longer charge a patient a copayment, coinsurance or deductible for these services when they are delivered by a network provider.

Specifically, the regulations require that a group health plan and a health insurance issuer offering group or individual health insurance coverage provide benefits for and prohibit the imposition of cost-sharing requirements concerning "recommended preventive services," including evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF with respect to the individual involved, and immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the ACIP with respect to the individual involved. Such a recommendation is considered to be "in effect" after it has been adopted by the Director of CDC. Also included are, with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the HRSA, and with respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA.

The regulations make clear that a plan or issuer is not required to provide coverage for recommended preventive services delivered by an out-of-network provider and may impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider. The regulations also address and clarify various other concerns relating to the application of the new preventive care mandate including:

- the cost-sharing requirements when a recommended preventive service is provided during an office visit;

- that a plan or issuer may rely on established techniques and the relevant evidence base to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline;
- that a plan or issuer continues to have the option to cover preventive services in addition to those required to be covered and may impose cost-sharing requirements on these additionally covered preventive services at its discretion;
- that a plan or issuer may impose cost-sharing requirements for a treatment that is not a recommended preventive service even if the treatment results from a recommended preventive service; and
- that a plan or issuer is not required to provide coverage or waive cost-sharing requirements for any item or service that has ceased to be a recommended preventive service provided other provisions of law do not independently require coverage of that requirement and appropriate advance notice is provided in accordance with the Affordable Care Act and other provisions of law.

#### D. *Extension of Dependent Coverage*

The Affordable Care Act requires group health plans and health insurers offering group or individual health insurance with dependent child coverage to provide optional coverage for the enrollee's adult children who are younger than age 26, regardless of marital status of the adult child. The Act requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26. Both married and unmarried children qualify for this coverage. This rule applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans unless the adult child has another offer of employer-based coverage (such as through his or her job). Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer. It does not require a plan to offer dependent coverage if it was not previously doing so.

The agency regulations were required to "define the dependents to which coverage shall be made available." Many group health plans that provide dependent coverage limit the coverage to health coverage excludible from employees' gross income for income tax purposes. Thus, dependent coverage is limited to employees' spouses and employees' children that qualify as dependents for income tax purposes. Consequently, these plans often condition dependent coverage, in addition to the age of the child, on student status, residency, and financial support or other factors indicating dependent status. However, with the expansion of dependent coverage required by the Act to children until age 26, conditioning coverage on whether a child is a tax dependent or a student, or resides with or receives financial support from the parent, did not make sense given the correlation between age and these factors. The regulations, therefore, prohibit plans or coverage from using these requirements to deny dependent coverage to children. Put differently, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of the relationship between the child and the participant (in the individual market, the primary subscriber). And, since the statute does not distinguish

between coverage for minor children and coverage for adult children under age 26, these factors also may not be used to determine eligibility for dependent coverage for minor children.

The regulations also provide that the terms of the plan or policy for dependent coverage cannot vary based on the age of a child, except for children age 26 or older. Surcharges for coverage of children under age 26 are not allowed except where the surcharges apply regardless of the age of the child (up to age 26) and that, for children under age 26, the plan cannot vary benefits based on the age of the child. The Affordable Care Act, as originally enacted, required plans and issuers to make dependent coverage available only to a child “who is not married.” This language was removed by section 2301(b) of the Reconciliation Act. Accordingly, plans and issuers may not limit dependent coverage based on whether a child is married. A plan or issuer, though, is not required to cover the spouse of an eligible child. And nothing within this section of the Affordable Care Act requires a plan or issuer to make available coverage for a child of a child receiving dependent coverage.

Employers may exclude from the employee’s income the value of any employer-provided health coverage for an employee’s child for the entire taxable year the child turns 26 if the coverage continues until the end of that taxable year. This means that if a child turns 26 in March, but stays on the plan past December 31st (the end of the taxable year for most people), the health benefits up to December 31st can be excluded for tax purposes.

The requirement to make available dependent coverage for children who have not attained age 26 generally applies to all group health plans and health insurance issuers offering group or individual health insurance coverage whether or not the plan or health insurance coverage qualifies as a grandfathered health plan under section 1251 of the Affordable Care Act, for plan years (in the individual market, policy years) beginning on or after September 23, 2010. For plan years beginning before January 1, 2014, these interim final regulations provide that a grandfathered health plan that is a group health plan that makes available dependent coverage of children may exclude an adult child who has not attained age 26 from coverage only if the child is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent. In the case of an adult child who is eligible for coverage under the plans of the employers of both parents, neither plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll in the plan of the other parent’s employer.

#### *E. New Uniform Standards for Health Plan Summary of Benefits and Coverage*

The Employee Retirement Income Security Act (ERISA) requires group health plans to provide a summary plan description (SPD) to plan participants and contains rules governing the form and content of SPDs, as well as timing and other issues. The Public Health Service Act does not provide for similar health plan summary rules. States often impose some rules on health plans as to certificate requirements but these rules are not uniform. ERISA also imposes monetary penalties (up to \$110 per day) for failing to provide SPDs in a timely manner.

Within 12 months after enactment of the Affordable Care Act, the Secretary of Health and Human Services has been ordered to develop standards that can be used by group health plans and health insurance issuers offering group or individual coverage in providing benefits summaries and coverage explanations that accurately explain the benefits and coverage provided under the plan. These summaries and explanations are to be provided to plan applicants and enrollees, as well as to policy or certificate holders. Plans are required to start using these new standards within 24 months after the date of enactment.

The HHS Secretary must consult with the National Association of Insurance Commissioners and with a working group including consumer advocacy organizations, patient advocates, and others, as well as other qualified individuals, in developing the standards.

The Affordable Care Act imposes a 4-page length limit on the new summary of benefits and coverage. Also, the new document is to be presented in a “uniform format” that does not include print smaller than 12-point fonts and is to be presented in a “culturally and linguistically appropriate manner.” The document must use terminology that is understandable by the average plan enrollee. Despite the page limitations, the summary must include the following:

- uniform definitions of standard insurance and medical terms (consistent with definitions to be developed by the HHS Secretary) so that health plan consumers can compare coverage and understand the coverage terms and any exceptions to the coverage terms;
- a coverage description, including cost sharing for (1) each of the categories of essential health benefits and (2) other benefits identified by the HHS Secretary;
- coverage exceptions, reductions, and limitations;
- cost-sharing provisions, including descriptions of deductibles, coinsurance, and co-pays;
- renewability and coverage continuation provisions;
- a “coverage facts label” that includes examples illustrating common benefit scenarios, such as pregnancy or chronic medical conditions, as well as any related cost-sharing (all based on recognized clinical practice guidelines);
- a statement as to whether the plan (1) provides minimum essential coverage and (2) ensures that its share of the total allowed benefit cost under the plan is no less than 60 percent of those costs;
- a statement that the outline is a policy summary and that consumers should consult the plan’s coverage document to determine the plan’s governing contractual provisions; and
- a contact number for additional questions and an Internet website where actual plan policies and certificates can be reviewed and obtained by consumers.

The new standards for the summary of benefits and coverage preempt any state-provided standards regarding benefit and coverage summaries that provide less information to consumers than what is required to be provided by this section. A group health plan or health insurance issuer covered by the summary of benefits and coverage rules faces penalties for willfully failing to

provide required information. Under the Act, a fine of up to \$1,000 can be imposed for each failure.

The provision is effective for plan years beginning on or after the date that is six months after the date of enactment.

F. *Additional Information Regarding Transparency in Coverage*

Group health plans and health insurance issuers offering group or individual health insurance coverage that are seeking certification as qualified health plans under the Health Insurance Exchanges are required to provide specified information under the transparency in coverage rules as added by Affordable Care Act. Generally, this required information, involving claims and enrollment, is to be provided to the Health Insurance Exchange, the Secretary of Health and Human Services, and the state insurance commissioner and also made available to the general public. (See previous discussion on Exchanges, *supra*, concerning the requirement to disclose claims payment policies, financial information, enrollment and disenrollment data, information regarding the number of claims denied, rating practices, cost-sharing and payments with respect to any out-of-network coverage, enrollee and participant rights and other information as determined appropriate by the Secretary.)

However, the Affordable Care Act further clarifies that a health plan or health coverage that is not offered through a Health Insurance Exchange is obligated to submit the required information *only* to the Secretary of Health and Human Services and the state insurance commissioner. This information should also be made available to the general public.

G. *Prohibition on Discrimination in Favor of Highly Compensated Individuals*

Self-insured healthcare plans have been subject to nondiscrimination rules since 1980. Health plans that are not insured, or partially insured, must comply with the nondiscrimination requirements that limit discrimination in favor of highly compensated individuals. Under section 105(h) of the Internal Revenue Code, in any "self insured medical reimbursement plan" that fails to meet the nondiscrimination requirements, highly compensated individuals will be taxed on the "excess reimbursement." In order to gain tax exclusion for the highly compensated, a self-insured plan may not discriminate as to eligibility for participation or as to the benefits provided to participants. A "highly compensated individual" is defined in code Section 105(h)(5) generally as an individual who is: (i) one of the five highest paid officers; (ii) a shareholder who owns more than 10 percent of the stock of the employer; or (iii) among the highest paid 25 percent of all employees (other than the employees described in clause (ii) who are not participants).

However, because of the preemption provisions of ERISA, there were no federal laws for fully insured health plans that prevented discrimination in favor of highly compensated individuals. Put differently, employers could establish fully-insured medical reimbursement plans for certain employees, such as highly-compensated key employees.

The Affordable Care Act extends the substantive nondiscrimination rules of IRC section 105(h) to insured arrangements by providing that nondiscrimination rules "similar" to those applicable to self-insured plans are to apply to insured group health plans. The penalties for failure to comply with the nondiscrimination requirements as applied to insured arrangements, however, are significantly different from the penalties that apply to discriminatory self-insured plans under section 105(h). Specifically, an employer that maintains a discriminatory insured plan may incur tax penalties. These include a monetary penalty of \$100 per day per employee discriminated against.

Furthermore, in addition, a civil action may be brought by participants, beneficiaries, plan fiduciaries and/or the Department of Labor to compel the plan to provide nondiscriminatory benefits. It is not clear whether a plan that violated the nondiscrimination requirements of the Act could be compelled to provide enhanced benefits to a nondiscriminatory group of employees or whether it would be sufficient for the discriminatory benefits to be eliminated.

The nondiscrimination requirements apply to insured group health plans other than "grandfathered" plans for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans). There is no exemption or other protection provided for existing arrangements. Presumably, if an existing employment agreement provides for discriminatory fully insured group health plan benefits to a highly compensated individual, the new penalties will begin to accrue on the first day of the first plan year beginning on or after Sept. 23, 2010, unless the plan is grandfathered.

#### H. Quality of Care, Individual and Group Markets

The Affordable Care Act requires HHS within two years of its enactment to develop quality reporting requirements for group health plans and insurers offering individual or group coverage.

The requirements, which are to be developed in consultation with experts in healthcare quality and other stakeholders, are to be developed for group health plans and issuers offering group or individual coverage regarding plan or coverage benefits as well as "healthcare provider reimbursement structures" that do the following:

- improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives;
- implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
- implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage, and

- implement wellness and health promotion activities.

On an annual basis, group health plans and insurers offering group or individual coverage shall provide to plan participants and to HHS a report detailing whether the coverage under the plan satisfies the reporting requirements listed above. The report must be made available to enrollees during each open enrollment period, and HHS must make the reports available to the public on an Internet site. HHS may develop and impose penalties for noncompliance and also may provide exceptions for plans and insurers that “substantially” meet the goals of the reporting requirements.

#### I. Insurer Cost Reductions through Constraints on Loss Ratios

There is no existing provision in federal law requiring a minimum medical loss ratio in insured health care plans. This ratio is calculated as the cost of healthcare services provided as a percentage of premium revenues. In general, the higher the medical loss ratio, the more an insurer spends on claims reimbursements and the less it spends on administration and marketing, or retains as profit. A variety of methods are used to calculate a medical loss ratio. The National Association of Insurance Commissioners (NAIC) has developed a standard that calculates the loss ratio by dividing incurred claims by earned premium. In this calculation, the earned premium is not reduced for the premium tax paid.

Under the Affordable Care Act, health insurers offering group or individual insurance coverage must submit an annual report to HHS for each group and individual coverage for each medical plan year. Reports also must be made for grandfathered plans. This report must describe the ratio of the incurred claims plus a loss adjustment expense to earned premiums, or the “medical loss ratio” (MLR).

The report must include the percentage of total premium revenue that such coverage expends on the following:

- reimbursement for clinical services;
- activities that improve health care quality; and
- all other non-claims costs, including an explanation of the nature of such costs, but excluding Federal and State taxes and licensing or regulatory fees.

The Secretary is directed to make the reports available to the public on an HHS internet site.

Minimum loss ratios are established for large group plans, small group plans, and individual plans:

- The minimum loss ratio for large group plans (plans with 101 or more employees (Act Sec.1304 (b) (1) of the Affordable Care Act)) is 85 percent, or a higher percentage if a state requires it.

- The minimum loss ratio for individuals and small group plans (plans with 100 or fewer employees (Act Sec.1304 (b) (2) of the Affordable Care Act)) is 80 percent or a higher percentage if a state requires it. HHS may adjust the percentage if it determines that an 80 percent loss ratio would destabilize the individual market.

No later than January 1, 2011, health insurers providing coverage that does not meet the minimum loss ratios must provide an annual rebate to each enrollee under such coverage, on a pro rata basis, calculated by multiplying the amount by which the coverage fails to meet the minimum loss ratio by the total amount of premium revenue. For this purpose premium revenue excludes federal and state taxes, licensing and regulatory fees, and payments or receipts for risk adjustments, risk corridors, and reinsurance.

Starting January 1, 2014, the calculation of the minimum loss ratios will be averaged based on premiums expended for claims and total premium revenue in each of the previous three years of the plan. In determining minimum loss ratios, each state should ensure adequate participation by health insurers, competition in the health insurance market, and value for consumers so that premiums are used for clinical services and quality improvements. HHS is charged with producing regulations for enforcing the loss ratio requirements and may establish appropriate penalties.

The NAIC is charged with establishing uniform definitions for annual insurers' reports and standard methodologies for calculating measures of activities that improve health care quality. The methodologies developed must take into account special circumstances of small plans, different types of plans, and newer plans. HHS may adjust the minimum loss ratios on account of the volatility of the individual market due to the establishment of the State Exchanges.

On December 3, 2010 HHS issued an interim final regulation that adopts and certifies in full all of the recommendations in the model regulation of the NAIC regarding MLRs. It is being published to implement section 2718(a) through (c) of the PHS Act, relating to bringing down the cost of health care coverage through a new MLR standard. It implements the requirements for reporting the data to be considered in determining that ratio. It addresses the requirements for health insurance issuers ("issuers") in the group or individual market, including grandfathered health plans, to provide an annual rebate to enrollees, if the issuer's MLR fails to meet minimum requirements: Generally, 85 percent in the large group market and 80 percent in the small group or individual market. The interim final regulation provides a process and criteria for the Secretary of Health and Human Services to determine whether application of the 80 percent MLR in the individual market in a State may destabilize that individual market. Finally, enforcement of the reporting and rebate requirements of section 2718(a) and (b) are addressed, as specifically authorized in section 2718(b) (3). This interim final regulation is generally applicable for plan years beginning on or after January 1, 2011. Self-insured plans are not a health insurance issuer, as defined by section 2791(b) (2) of the PHS Act, and thus are not subject to the regulation.<sup>29</sup>

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<sup>29</sup> The NAIC voted to adopt a model regulation containing the definitions and methodologies for calculating medical loss ratios. Under the regulation, the "numerator used to determine the medical loss ratio for

the plan year is calculated as incurred claims plus any expenses to improve quality.” The denominator is calculated as earned premiums less federal and state taxes and licensing or regulatory fees. Thus, the more expenses used for improving quality the higher the loss ratio and the easier it will be to meet minimum standards.

The model regulation also included “credibility adjustments” for small insurers, which would allow as much as an 8.3 percent addition to the medical loss ratio for insurers with between 1,000 and 2,499 lives. The adjustment would be reduced for larger insurers and would be eliminated for insurers with 75,000 or more lives.

The model regulation defined quality improvement expenses as follows:

“Quality improvement expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve healthcare quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.”

NAIC also stated that quality improvement expenses “should be grounded in evidence-based medicine, widely accepted best clinical practices, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies, or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality.”

The NAIC listed the following as categories of activities that would “improve health outcomes” (and thus can be used as quality improvement expenses):

- patient centered intervention, including:
  - making/verifying appointments;
  - medication and care compliance initiatives;
  - arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center);
  - programs to support shared decision making with patients, their families and the patient’s representatives; and
  - reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;
- incorporating feedback from the insured to effectively monitor compliance;
- providing coaching or other support to encourage compliance with evidence based medicine;
- activities to identify and encourage evidence based medicine; and
- use of the medical homes model.

The NAIC also identified the following to be excluded as quality improvement expenses:

Lastly, the language each U.S. hospital must establish, update, and make public an annual list of the hospital's standard charges for items and services provided by the hospital.

The provision takes effect for plan years beginning on or after the date that is six months after the date of enactment.

J. Claims Appeal Process

The Affordable Care Act requires group health plans and health insurers to implement an effective process for appeals of coverage determinations and claims, including an internal claims appeal process and employee notification. The law provided that this appeals process must include, at a minimum, the following:

- an established internal claims appeal process;
- a notice to participants, in a “culturally and linguistically appropriate manner,” of available internal and external appeals processes, including the availability of assistance with the appeals processes; and
- a provision allowing an enrollee to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage during the appeals process.

Until the Department of Labor (DOL) finalizes standards for an appeals process, plans must provide claims and appeals processes required in existing DOL regulations.<sup>30</sup>

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- all retrospective and concurrent utilization review;
  - fraud prevention activities;
  - the cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
  - provider credentialing;
  - marketing expenses;
  - most accreditation fees; and
  - costs associated with calculating and administering individual enrollee or employee incentives.

<sup>30</sup> In 2000, the Department of Labor issued final regulations requiring that every employee benefit plan establish and maintain reasonable claims procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (DOL Reg. Sec. 2560.503-1).

According to the 2000 guidelines, the claims procedures may not require more than two appeals of an adverse benefit determination prior to bringing a civil action under Employee Retirement Income Security Act (ERISA) Sec. 502(a).

If a plan offers voluntary levels of appeal, failure to use voluntary appeals will not exhaust normal administrative remedies and will not count against any statute of limitations regarding claims appeals.

Health insurers offering individual coverage and any issuers not subject to existing DOL claims appeals rules may initially use claims and appeals procedures under any other applicable law, such as individual state insurance requirements. Insurers are required to update these procedures when the HHS issues new standards. Group health plans and insurers have two options regarding the implementation of external reviews:

- Plans and insurers must comply with State external review requirements that are binding and at a minimum include the consumer protections in the Uniform External Review Model Act from the National Association of Insurance Commissioners; or
- If state requirements do not meet the above minimums or if the plan is self-funded and not subject to state insurance regulations, then the plan must implement an external review process that is similar to that in the Uniform External Review Model Act and that meets standards established by the Department of Health and Human Services.

The Departments of Health and Human Services, Labor, and Treasury jointly issued interim final regulations implementing these claims appeals requirements. The interim final regulations set forth six new requirements in addition to those in the existing DOL claims procedure regulation in order to implement an effective internal claims and appeals process.

First, the definition of an adverse benefit determination is broader than the definition in the DOL claims procedure regulation, in that an adverse benefit determination for purposes of these interim final regulations also includes a rescission of coverage. An adverse benefit determination eligible for internal claims and appeals processes under these regulations includes a denial, reduction, or termination of, or a failure to provide or make a payment for a benefit, including the following:

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In addition, a claimant may elect to submit a benefit dispute to a voluntary level of appeal only after exhaustion of the required appeals permitted above. Finally, the claimant must be provided upon request sufficient information to make an informed judgment about whether to submit to the voluntary level of appeal, and no fees or costs may be imposed as part of a voluntary level of appeal.

Plans are permitted to require some limited forms of mandatory arbitration. However, the regulations clarify that any process used by a plan to resolve a claim dispute, including arbitration, must be conducted without imposing fees on the claimant. These restrictions apply only to group health plans and plans providing disability benefits.

A plan may require arbitration as one (or both) of the permitted levels of review of a denied claim, provided, first, that the arbitration is conducted in accordance with the requirements of the regulations applicable to such appeals and, second, that the claimant is not prevented from challenging the arbitrator's decision.

- a determination of an individual's eligibility to participate in a plan or health insurance coverage;
- a determination that a benefit is not a covered benefit;
- the imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- a determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

Second, the regulations provide that a plan must notify a claimant of a benefit determination, whether adverse or not, with respect to a claim involving urgent care (as defined in exist DOL claims procedure regulations) as soon as possible, but not later than 24 hours after the receipt of the claim by the plan or health insurance coverage, unless the claimant fails to provide sufficient information to determine whether benefits are covered or payable.

Third, the regulations provide additional criteria to ensure that a claimant receives a full and fair review. In addition to complying with the requirements of the existing DOL claims procedure regulation, a plan must provide the claimant, free of charge, with any new or additional evidence considered by the plan in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond. Additionally, before the plan can issue an adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale.

Fourth, new criteria are provided with respect to avoiding conflicts of interest. The plan or issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Thus, decisions regarding hiring, compensation, termination, promotion, or other similar matters must not be made based upon the likelihood that the individual will support a denial of benefits.

Fifth, the Act and the regulations require a plan to provide a notice to enrollees "in a culturally and linguistically appropriate manner." This provision applies to internal and external claims appeals processes. Plans and issuers are considered to provide relevant notices in a culturally and linguistically appropriate manner if notices are provided in a non-English language based on thresholds of the number of people who are literate in the same non-English language. In the group market, the threshold differs depending on the number of participants in the plan. For a plan that covers fewer than 100 participants, the threshold is 25% of participants being literate only in the same non-English language. For a plan that covers 100 or more participants at the beginning of a plan year, the threshold is the lesser of 500 participants, or 10% of all plan participants. Additionally, a plan must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved. This includes the date of service, the health care provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes.

Sixth, if a plan fails to strictly adhere to all the requirements of the internal claims and appeals process, the claimant “is deemed to have exhausted the internal claims and appeals process, regardless of whether the plan or issuer asserts that it substantially complied with these requirements or that any error it committed was de minimis.” Upon such a failure, the claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

The regulations provide a basis for determining when plans must comply with a State external review process and when they must comply with the Federal external review process. For health insurance coverage, if a State external review process includes, at a minimum, the consumer protections in the NAIC Uniform Model Act in place on July 23, 2010, then the issuer must comply with the applicable State external review process and not with the Federal external review process. In such a case, to the extent that benefits under a group health plan are provided through health insurance coverage, the issuer is required to satisfy the obligation to provide an external review process, so the plan itself is not required to comply with either the State external review process or the Federal external review process. According to the preamble to the regulations, “[t]he Departments encourage States to establish external review processes that meet the minimum consumer protections of the NAIC Uniform Model Act. The Departments prefer having States take the lead role in regulating health insurance issuers, with Federal enforcement only as a fallback measure.”

These interim final regulations do not preclude a State external review process from applying to and being binding on a self-insured group health plan under some circumstances. For a State external review to apply instead of the Federal process, the State external review process must include the several elements from the NAIC Uniform Model Act.

These rules generally apply to group health plans and group health insurance issuers for plan years beginning on or after Sept. 23, 2010.

Federal agencies will apply a grace period to comply with several of the internal claims appeals process requirements until July 1, 2011.<sup>31</sup> During the grace period, the Department of Labor and the IRS will not take any enforcement action against a group health plan, and HHS against a self-funded non-governmental health plan, that is working to implement the new standards, but does not have them in place. The standards that the agencies will not immediately enforce include:

- the timeframe for making urgent care claims decisions;
- providing notices in a culturally and linguistically appropriate manner; and
- requiring broader content and specificity in notices

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<sup>31</sup> See <http://www.dol.gov/ebsa/pdf/ACATEchnicalRelease2010-02.pdf>.

### K. Patient Protections

The Act imposes requirements on plans with respect to (i) an individual's choice of healthcare professionals (for plans with a provider network) and (ii) benefits for emergency services. Grandfathered plans are exempt from both sets of requirements.

The Act and regulations impose, with respect to a group health plan, or group or individual health insurance coverage, a set of three requirements relating to the choice of a health care professional and requirements relating to benefits for emergency services. The three requirements relating to the choice of health care professional apply only with respect to a plan or health insurance coverage with a network of providers. Thus, a plan or issuer that has not negotiated with any provider for the delivery of health care but merely reimburses individuals covered under the plan for their receipt of health care is not subject to the requirements relating to the choice of a health care professional. However, all plans or health insurance coverage are subject to requirements relating to benefits for emergency services. These sections are generally effective for plan years (or, in the case of the individual market, policy years) beginning on or after September 23, 2010.

The regulations provide that if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee.

If a plan or issuer requires or provides for the designation of a participating primary care provider for a child by a participant, beneficiary, or enrollee, the plan or issuer must permit the designation of a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. The general terms of the plan or health insurance coverage regarding pediatric care otherwise are unaffected, including any exclusions with respect to coverage of pediatric care.

The regulations also provide rules for a group health plan, or a health insurance issuer offering group or individual health insurance coverage, that provides coverage for obstetrical or gynecological care and requires the designation of an in-network primary care provider. Specifically, the plan or issuer may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for a female participant, beneficiary, or enrollee who seeks obstetrical or gynecological care provided by an in-network health care professional who specializes in obstetrics or gynecology. These plans and issuers must also treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, by the professional who specializes in obstetrics or gynecology as the authorization of the primary care provider. For this purpose, a health care professional specializing in obstetrics

or gynecology is any individual who is authorized under applicable State law to provide obstetrical or gynecological care, and is not limited to a physician.

The regulations provide that a group health plan and a health insurance issuer covering emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network). For a plan or health insurance coverage with a network of providers that provide benefits for emergency services, the plan or issuer may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services. Finally, the regulations provide that cost-sharing requirements expressed as a copayment amount or coinsurance rate imposed for out-of-network emergency services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network. The regulations also provide that a plan or health insurance issuer must pay for out-of-network emergency services (prior to imposing in-network cost-sharing), the greatest of: (1) the median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate.

In applying the rules relating to emergency services, the Act and regulations define the terms emergency medical condition, emergency services, and stabilize in accordance with their meaning under Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act. The provisions relating to emergency services do not apply to grandfathered health plans; however, other Federal or State laws related to emergency services may apply regardless of grandfather status.

Note: Group health plans must communicate applicable mandatory notices to employees related to specific provisions of the Affordable Care Act. The mandatory notices, which must be provided by the first day of the plan year occurring after September 23, 2010, are:

*Grandfather Status* – To maintain status as a grandfathered health plan, a written notice must indicate the plan believes it is a grandfathered health plan and provide contact information for questions and complaints.

*Lifetime Limit* – Written notice must state that the lifetime limit on the dollar value of all benefits no longer applies and that an employee or dependent whose coverage ended by reaching the limit under the plan is again eligible to enroll in the plan. The notice must also specify a 30-day opportunity for these individuals to enroll.

*Dependent Coverage to Age 26* – A plan must provide written notice of a 30-day opportunity to enroll children who will now be eligible for coverage.

*Patient Protection* – When applicable, written notice must indicate rights related to

(1) choosing a primary care provider or pediatrician, or (2) obtaining obstetrical or gynecological care without prior authorization. This provision does not apply to grandfathered plans.

Model notices for all of the above are available from the Department of Labor at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

L. *Review of Premium Increases*

The Affordable Care Act requires the Secretary of HHS, in conjunction with the states, to establish an annual review process beginning with the 2010 plan year that will require insurers to submit a justification for any “unreasonable” premium increases prior to implementation. Insurers also will be required to “prominently” post information regarding premium increases on their websites.<sup>32</sup>

HHS will establish a program of grants (\$250 million from 2010 through 2014) available to the states to assist them with carrying out the review process. The review process will require a state, through its Commissioner of Insurance, to provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the state and to make recommendations, as appropriate, about whether particular health insurance issuers should be excluded from participation in the state's Exchange based on a pattern of excessive or unjustified premium increases.

Beginning with the 2014 plan year HHS, in conjunction with the states, will be required to monitor premium increases of health insurance coverage offered both inside the Exchange and outside of the Exchange. In determining whether to exercise its option to permit large employers to participate in the Exchange, the State must take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange.

Along with providing funding for reviews of premium increases and making recommendations to the Secretary, the grant monies may be used to establish medical reimbursement data centers at

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<sup>32</sup> Review of premium increases can be mandated by state law. A 2008 report indicates that 25 states give the insurance department authority to approve premium rates for all individual health insurance plans prior to the rates going into effect, with 5 states requiring prior approval of premium rates only for certain individual health insurance policies. The District of Columbia and 20 states do not approve premium rates before they go into effect (“Failing Grades: State Consumer Protections in the Individual Health Insurance Market,” June 2008, Families USA, <http://www.familiesusa.org>).

Some states that require prior approval mandate that an insurer file documentation and justification for the increase before implementation. Some states' prior approval laws include provisions to “deem” proposed premium increases as approved if the state does not respond by a given time. This type of state law allows the state to challenge the ratings and require revisions later.

academic or other nonprofit institutions for the purpose of collecting, analyzing and disseminating information regarding medical reimbursement. Such centers will engage in the following activities:

- develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;
- use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;
- regularly update such fee schedules and other database tools to reflect changes in charges for medical services;
- make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and
- regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

A medical reimbursement data center will be required to adopt by-laws that ensure that the center and its governing board are independent and free from all conflicts of interest. The by-laws will ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for healthcare services based on the center's analysis of healthcare costs.

The provision takes effect on the date of enactment, March 23, 2010.

### Additional Reforms

#### *A. Insurance Premium Rates Limitations*

This provision sets nationwide parameters and limits for premium rate-setting, prohibiting rate-setting based on individuals' health status or gender. The provision is meant to spread the risk, and the cost, across populations regardless of health status and gender, and thus keep health insurance costs affordable.

For plan years beginning on or after January 1, 2014, personal factors that an insurer may use to determine premium rates for insured individual and group health plans are limited. Premium rates for an insured qualified health benefits plan may vary only to account for the following factors:

- 1) *Age*: Within specified categories, or age bands, the highest premium rate for adults may be no more than three times the lowest premium rate. HHS, in consultation with the National Association of Insurance Commissioners will define permissible age bands.

- 2) *Rating area*: Rating areas are established by each state (one or more areas) and reviewed by HHS to ensure adequacy. They also may be established by HHS, should a state fail to establish such areas or to establish adequate areas.
- 3) *Individual or family enrollment*: Rates may vary according to whether the plan covers an individual or family. Rate variations allowed for age or tobacco use will be applied to family coverage according to the portion of the premium attributable to each covered family member.
- 4) *Tobacco use*: The highest premium rate may be no more than 1.5 times the premium rate for a nonsmoker in the same age band, rating area, and type of coverage.

If a state permits insurers in the large group market in the state to offer coverage through the state exchange, these premium limitation requirements apply to all coverage offered in that market, other than self-insured group health plans. Any standard or requirement adopted by a state, including any rating reforms as a result of this section, must apply uniformly to all health insurance issuers and group health plans in each insurance market to which the standards or requirements apply.

#### B. Guaranteed Availability and Renewal

Public Health Service Act provisions related to guaranteed issue and renewability of health insurance coverage for employers in the group market are revised and expanded to ensure availability and renewal of health insurance coverage to both employers and individuals, and to strictly limit the circumstances under which coverage may be denied or not renewed. Accordingly, health insurance issuers that offer health insurance coverage in the individual or group market in a state are required to “accept every employer and individual in the State that applies for such coverage,” except as permitted under the special rules for network plans and insurers that no longer have the financial capacity to underwrite additional coverage. Coverage enrollment may be restricted to open and special enrollment periods, and special enrollment periods must be established for COBRA qualifying events.

Subject to the following provisions regarding enrollment, and special rules for network plans and financial capacity limits, every health insurance issuer that offers health insurance coverage in the individual or group market in a state “must accept every employer and individual in the State that applies for such coverage.”

Insurance issuers may restrict enrollment in coverage to open or special enrollment periods, and must establish special enrollment periods for COBRA qualifying events in accordance with regulations to be promulgated by the Secretary of HHS. Where a health insurance issuer offers health insurance coverage in the group and individual market through a network plan, the issuer may:

- 1) limit eligible employers to those having eligible individuals who live, work or reside in the service area of the network plan; and

- 2) within the service area of the plan, deny coverage to employers and individuals if the issuer has demonstrated, if required, to the applicable state authority that -
  - a) it lacks the capacity to deliver services adequately to enrollees of any additional groups or additional individuals because of obligations to its existing group contract holders and enrollees, and
  - b) it is applying the denial of coverage uniformly to employers and individuals without regard to the claims experience of individuals, employers and their employees (and their dependents), or any health status-related factor related to those individuals, employees and dependents;
- 3) Upon denying health insurance coverage in any service area, an issuer may not offer coverage in the group or individual market within that service area for a period of 180 days after the date that coverage is denied.

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable state authority that it:

- 1) lacks the financial reserves necessary to underwrite additional coverage; and
- 2) is applying this provision uniformly to all individuals and employers in the individual or group market in the state consistent with applicable state law and without regard to the claims experience of those individuals, employers and their employees (and their dependents), or any health status-related factor relating to those individuals, employees and dependents.

A health insurance issuer, upon denying health insurance coverage in connection with group health plans in a state in accord with this provision, may not offer coverage in connection with group health plans in the individual or group market in the state for a period of 180 days after the date coverage is denied, *or* until the issuer has demonstrated to the applicable state authority, if required by state law, that the issuer has enough financial reserves to underwrite additional coverage, whichever date is later. An applicable state authority may provide that this provision be applied on a service-area-specific basis.

A health insurance issuer that offers health insurance coverage in the individual or group market must renew or continue in force such coverage at the option of the plan sponsor or individual, as applicable, subject to the following general exceptions and provisions for uniform termination of coverage, uniform modification of coverage, and coverage offered only through associations.

An issuer may not renew, or may discontinue coverage offered in connection with health insurance coverage offered in the group or individual market only based upon one or more of one of the following:

- the individual or plan sponsor has failed to pay premiums or contributions under the terms of the coverage or the issuer has not received timely premium payments;
- the individual or plan sponsor has “performed an act or practice that constitutes fraud,” or made an intentional misrepresentation of material fact under the terms of coverage;
- as to a group health plan, the plan sponsor has failed to comply with a material plan provision that relates to employer contribution or group participation rules, under applicable state law;
- the issuer ceases to offer coverage in the market in accordance with the rules requiring uniform termination of coverage, and applicable state law;
- when an issuer that offers health insurance coverage in the market through a network plan no longer has any enrollee in connection with the plan who lives, resides, or works in the issuer’s service area (or in the area in which the issuer is authorized to do business), and in the case of the small group market, the issuer would deny enrollment with regard to such plan under the special rules for network plans; or
- when the health insurance coverage is made available in the small or large group market only through one or more bona fide associations, the membership of an employer in the association (based on which the coverage is provided), ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor related to any covered individual.

When an issuer decides to discontinue offering a particular type of group or individual health insurance coverage, it may be discontinued by the issuer in accordance with applicable state law in such market, but only if:

- notice of discontinuation is given to each individual or plan sponsor provided that type of coverage in such market (and covered participants and beneficiaries) at least 90 days prior to the date of discontinuation of coverage;
- each individual or plan sponsor provided that type of coverage in such market is given the option to purchase all (or in the case of the large group market, any) other health insurance coverage currently being offered by the issuer in that market; and
- in exercising the option to discontinue the particular type of coverage and in offering to plan individuals and plan sponsors the option to purchase other coverage offered by the issuer in such market, the issuer acts uniformly without regard to the claims experience of those individuals or plan sponsors, or any health status-related factor pertaining to any covered participants or beneficiaries, or new participants or beneficiaries who may become eligible for such coverage.

If a health insurance issuer elects to discontinue offering all health insurance coverage in the individual or group market, or all markets, in a state, health insurance coverage may be discontinued by the issuer in accordance with applicable state law, only if:

- 1) the issuer provides notice to the applicable state authority and to each individual or plan sponsor (and covered participants and beneficiaries) of such discontinuation at least 180 days prior to the date of the discontinuation of coverage; and
- 2) all health insurance issued or delivered for issuance in such market(s) in the state are discontinued and such health insurance coverage in such market(s) is not renewed.

When health insurance coverage is discontinued in a market, the issuer may not provide for issuance of any health insurance coverage in the state and market involved for a period of five years beginning on the date of discontinuation of the last health insurance coverage not so renewed.

At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group plan:

- in the large group market, or
- in the case of the small group market, only if, as to coverage in such market, other than only through one or more bona fide associations, the modification is consistent with state law and effective on a uniform basis among group health plans with that product.

### C. Preexisting Condition Exclusion

The Act prohibits group health plans and health insurance issuers offering group or individual health insurance from imposing any preexisting condition exclusion. A preexisting condition is a health condition or illness that was present before an individual's effective date of coverage in the health plan, regardless of whether any medical advice was recommended or received before that date. A preexisting condition exclusion is any limitation or exclusion of benefits, including a denial of coverage, that applies to an individual due to the individual's health status before the effective date of coverage under the health plan. Before the enactment of the Affordable Care Act, in 45 States, health insurance issuers in the individual market could deny coverage, charge higher premiums, and/or deny benefits for a preexisting condition.

This new protection applies to children who are under age 19 for plan years (in the individual market, policy years) beginning on or after September 23, 2010. For individuals age 19 and over, this provision applies for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

Limits on pre-existing conditions will not apply to existing grandfathered plans offering individual coverage.<sup>33</sup>

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<sup>33</sup> Regulations implementing the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) included rules regarding the renewability and termination of coverage in the group market. To the extent that these regulations address how a health insurance product may continue or discontinue in the private market, such regulations may also indicate when a grandfathered plan continues or discontinues.

*D. Prohibiting Discrimination Based on Health Status*

Effective for plan years beginning on or after January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under terms of the plan or coverage based on any of the following factors in relation to the individual or a dependent of the individual:

- Health status.
- Medical condition (including both physical and mental illnesses).
- Claims experience.
- Receipt of health care.
- Medical history.
- Genetic information.
- Evidence of insurability (including conditions arising out of acts of domestic violence).
- Disability.
- Any other health status-related factor determined appropriate by the Secretary of HHS.

A program offered by an employer that is designed to promote health or prevent disease (wellness program) will not violate the nondiscrimination rules as long as participation in the program is made available to all similarly situated individuals and so long as the conditions for obtaining a premium discount or rebate or other reward for participation are not based on an individual satisfying a standard that is related to a health status factor.

If obtaining a premium discount or rebate or other reward for participation in a wellness program is conditioned on an individual satisfying a standard that is related to a health status factor, the wellness program will not violate the nondiscrimination rules if:

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The HIPAA regulations specify that an issuer offering group coverage “is required to renew or continue in force the coverage at the option of the plan sponsor.” In order to discontinue an insurance product, the issuer must provide “notice in writing to each plan sponsor provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 days before the date the coverage will be discontinued.” Moreover, the issuer must act “uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.”<sup>16</sup> In other words, such requirements place the decision to continue a policy on the plan sponsor. Typically, this is an employer providing health benefits to employees (and their families). And while an issuer may terminate a plan, it may do so only if it does not discriminate based on health factors, and provides advance notice of discontinuation to all enrollees and plan sponsors. Should implementation of grandfathering provisions follow this same construction, changes to a plan’s benefits or costs alone would appear to be insufficient to cause a grandfathered plan to be discontinued.

- 1) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, does not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled.
- 2) The wellness program is reasonably designed to promote health or prevent disease. A program will be in compliance if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.
- 3) The plan gives individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.
- 4) The full reward under the wellness program is made available to all similarly situated individuals. For this purpose, the wellness program must allow for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom it is unreasonable difficult, or medically inadvisable to attempt, to satisfy the otherwise applicable standard.
- 5) The plan or issuer involved must disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard).

The cost of coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

A plan may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy the otherwise applicable standard.

The following wellness plans do not violate the nondiscrimination rules if none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward) and participation in the plan is made available to all similarly situated individuals:

- 1) A program that reimburses all or part of the cost for memberships in a fitness center.

- 2) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- 3) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under the group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).
- 4) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.
- 5) A program that provides a reward to individuals for attending a periodic health education seminar (PHSA Sec. 2705(j)(2), as added by Affordable Care Act Sec. 1201(4)).

Any wellness program established prior to the date of enactment of this law that complied with all applicable regulations, and that is still operating may continue to be carried out for as long as the regulations under which it was created remain in effect.

E. Comprehensive Health Insurance Coverage

For plan years beginning on or after January 1, 2014, health insurers offering coverage in the individual or small group health insurance markets must ensure that the coverage they offer includes the essential health benefits package required under the Affordable Care Act and that the annual cost-share under the plan does not exceed limits under Affordable Care Act. (See previous discussion on essential health benefits and Qualified Health Plan, *supra*).

F. Prohibition on Excessive Waiting Periods

An individual's waiting period to be able to enroll in a group health plan may not exceed 90 days, effective for plan years beginning on or after January 1, 2014. According to existing Public Health Service Act definitions, the term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before that individual is eligible to be covered for benefits under the terms of the plan.<sup>34</sup>

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<sup>34</sup> Currently, most (74 percent) employer-sponsored group health plans impose some waiting period before workers may enroll in the plan. Waiting periods range from 30 days to six months, but the most common period is no more than 90 days, according to the Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009, [ehbs.kff.org/](http://ehbs.kff.org/). Industries with high worker turnover and many minimum wage workers, such as the retail industry, typically have longer waiting periods. Long waiting periods to obtain coverage mean that many workers and their families face long periods without health insurance and limited, if any, access to health care services.

G. Grandfathered Plans in the Individual and Group Health Markets

The Affordable Care Act provides that various requirements of the Act will not apply to certain group health plans and health insurance coverage in which a person was enrolled on the date of enactment, March 23, 2010, regardless of whether the individual renews such coverage after March 23, 2010. The statute refers to these plans and health insurance coverage as grandfathered health plans. Therefore, as long as a person was enrolled in a health insurance plan on March 23, 2010, that plan has been grandfathered.

Specifically, the language states that nothing in the Affordable Care Act requires an individual to terminate the coverage in which the individual was enrolled on March 23, 2010. Accordingly, current enrollees in grandfathered health plans are allowed to re-enroll in that plan, even if renewal occurs after the date of enactment. Family members are allowed to enroll in the grandfathered plan, if such enrollment is permitted under the terms of the plan in effect on the date of enactment. For grandfathered group plans, new employees (and their families) may enroll in such plans.

The Act also provides that to ensure access to coverage with particularly significant protections, grandfathered health plans must comply with a number of the Affordable Care Act's insurance reform provisions.

Thus, grandfathered health plans must comply with the following reforms for plan years (policy years in the individual market) beginning on or after the date of enactment:

- Development of uniform explanation of coverage documents.
- Reporting of medical loss ratio and other financial information to the Secretary, and offering premium rebates to enrollees if the plan did not meet specified medical loss ratios (rebate offers must begin no later than January 1, 2011).

Grandfathered health plans must comply with the following reforms for plan or policy years beginning six months after the date of enactment (September 23, 2010):

- Prohibition on lifetime limits on essential health benefits.
- Prohibition on health plan rescissions.
- Requirement to extend dependent coverage to children until the individual is 26 years old. Prior to 2014, a child may enroll for dependent coverage on a grandfathered group plan only if such individual is not eligible for employment-based health benefits.

Grandfathered health plans must comply with the prohibition on waiting periods of greater than 90 days for plan or policy years beginning on or after January 1, 2014.

Finally, grandfathered health plans providing group coverage will be required to comply with the following reforms:

- Prohibition on restricted annual limits on essential health benefits provided by group health plans, for plan years beginning six months on or after date of enactment.
- Prohibition on coverage exclusions for pre-existing health conditions. For most enrollees, this provision will become effective for plan years beginning on or after January 1, 2014. However, for children under age 19, this provision will become effective for plan years beginning six months on or after date of enactment.

Two of the major concerns with grandfathered plans are informing employees of the status of their plans and determining what plan changes will cause a plan to lose its grandfathered status. It is not clear within section 1251 or the Act whether changes to covered benefits, cost-sharing requirements, actuarial value, or other plan features would be allowed under a grandfathered plan. Accordingly, the Departments of Health and Human Services, Labor and Treasury issued interim final regulations addressing these and other issues concerning the grandfathering of health plans.<sup>35</sup>

The rules specify that in order for a plan to maintain grandfathered status it must include in plan materials provided to participants or beneficiaries (e.g., summary plan descriptions or certificates of coverage) a description of the benefits provided under the plan, a statement that the plan believes it is a grandfathered plan, and contact information for questions and complaints.<sup>36</sup>

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<sup>35</sup> There are currently some 186 million employees in both large and small employer based plans, according to HHS. The mid-range estimate is that 66 percent of small employer plans and 45 percent of large employer plans will have relinquished grandfathered plan status by 2013.  
[http://www.healthreform.gov/newsroom/keeping\\_the\\_health\\_plan\\_you\\_have.html](http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html).

<sup>36</sup> The following model language can be used to satisfy this disclosure requirement:

“This [group health plan or health insurance issuer] believes this [plan or coverage] is a ‘grandfathered health plan’ under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

“Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information].

“[For ERISA plans, insert: You also may contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or <http://www.dol.gov/ebsa/healthreform>. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.]

The plan must maintain records documenting the terms of the plan that were in effect on the date of enactment and any other documents necessary to verify, explain, or clarify its status as a Grandfathered Plan. These documents may include, for example, past and current plan documents, insurance policies, contracts or certificates, summary plan descriptions, and documentation regarding premiums or coverage costs and required participant contribution rates. The plan must maintain these records and make them available for examination by a participant or regulating agency for as long as the plan takes the position that it is a grandfathered plan.

At least seven types of changes will result in the “cessation of grandfather status.”

1. The elimination of all or substantially all benefits to diagnose or treat a particular condition, or any necessary element to diagnose or treat a condition. For example, if a health insurance plan decides to no longer cover the treatment costs for people with diabetes or asthma, it would cease to be a grandfathered plan. Similarly, if the plan provides benefits for attention deficient disorders, and the treatment of it involves a combination of counseling and prescription drugs, the plan could not eliminate counseling benefits without losing its grandfathered plan status.

2. Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement. Generally, a plan’s coinsurance provisions require a patient to pay a fixed percentage of a charge for health services or benefits (for example, 20 percent of a hospital bill). Any increase in this percentage from its level on March 23, 2010 will cause a plan to lose its Grandfathered Plan status.

3. Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), determined on the effective date of the increase, that exceeds the maximum percentage increase, which is medical inflation plus 15 percent. A plan will cease to be a grandfathered plan if it increases the cost-sharing amount required as of March 23, 2010 by a percentage greater than medical inflation (measured from March 23, 2010) plus 15 percentage points. For example, assume a grandfathered plan had an individual deductible of \$250 on March 23, 2010, that is subsequently increased to \$375. This increase, expressed as a percentage, is 50 percent - calculated as  $\$375 - \$250 = \$125$ ,  $\$125/\$250 = .5$ , or 50 percent. Assuming that medical inflation since March 2010 is 25 percent, the maximum percentage increase permitted is 40 percent – calculated as 25 percent + 15 percent. Because the 50 percent change is greater than the 40 percent permitted, this change would cause the plan to lose its grandfathered plan status.

4. Any increase in a fixed-amount copayment that exceeds the greater of \$5 (adjusted annually for medical inflation), or medical inflation plus 15%. A plan will cease to be a grandfathered plan if it increases the copayments in effect on March 23, 2010 by more than the greater of: (a)

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“[For individual market policies and nonfederal governmental plans, insert: You also may contact the U.S. Department of Health and Human Services at <http://www.healthreform.gov>.]”

\$5 (adjusted annually for medical inflation) or (b) a percentage equal to medical inflation, measured from March 23, 2010 plus 15 percentage points.

5. Decrease in employer contribution rate:

- a) Based on cost of coverage. A group health plan ceases to be a grandfathered health plan if the employer decreases its contribution rate based on cost of coverage (the amount of contributions made by an employer compared to the total cost of coverage, expressed as a percentage) by more than 5 percent.
- b) Based on a formula. A group health plan ceases to be a grandfathered health plan if the employer decreases its contribution rate based on a formula (such as hours worked or tons of coal mined) by more than 5 percent.

Many employers or employee organizations pay a portion of participants' premiums for coverage. The employer's or employee organization's contribution rate may be based on the cost of coverage or on a formula (e.g., calculated on the basis of hours worked or production levels). A grandfathered plan will lose its status if the employer or employee organization decreases its contribution rate toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points. For example, if an employer pays 50 percent of the premiums for coverage for all participants under a grandfathered plan, that plan would lose its status if the employer decreased its share of the premiums to 40 percent.

6. Changes in annual limits:

- a) Addition of an annual limit. A group health plan ceases to be a grandfathered health plan if it imposes a new overall annual limit on the dollar value of benefits.
- b) Decrease in limit for a plan with only a lifetime limit. A group health plan that imposed an overall lifetime limit on benefits, but no overall annual limit ceases to be a grandfathered health plan if it adopts an overall annual limit at a dollar value that is lower than the lifetime limit.
- c) Decrease in limit for a plan with an annual limit. A group health plan that imposed an overall annual limit on all benefits ceases to be a grandfathered health plan if it decreases the annual limit.

Some plans impose an annual dollar limit on the amount that they will pay for covered services. A plan will cease to be a grandfathered plan if it lowers the annual dollar limit in existence on March 23, 2010, or adds an annual dollar limit if it had neither an annual dollar limit nor a lifetime limit in place on March 23, 2010. In addition, if the plan has a lifetime limit but not an annual dollar limit in place on March 23, 2010, it cannot add an annual dollar limit that is less than the lifetime limit on that date.

7. Change Insurance Companies. Under the interim final regulations, a fully insured group health plan would lose its grandfathered status if it changed issuers or policies after March 23,

2010 regardless of whether or not the benefits or terms under the policy had actually changed in any significant way. On November 15, 2010, an amendment to the interim final regulations was issued that removes this restriction and allows a group health plan or employer to enter into a new policy, certificate or contract of insurance without the plan losing its grandfathered status if certain conditions are met. This amendment does not apply to individual policies. In order for a fully insured group health plan to maintain its grandfathered status after a change in insurer or policy, the plan must not make any other changes that would result in a loss of grandfathered status under the interim final regulations. Additionally, the group health plan must provide any new insurance company with documentation of the prior health plan coverage sufficient to determine if any change in the new policy, certificate or contract of insurance is being made that would result in a loss of grandfathered status.

The amendment applies to group health insurance changes which become effective on or after November 15, 2010. Therefore, any change of insurer or policy that became effective prior to November 15, 2010 will not be subject to the amendment and would result in a loss of grandfathered status.

Generally, other changes will not cause a plan to lose its grandfathered plan status. For instance, a plan will not lose its status because of changes to premiums or total coverage costs or changes to comply with federal or state legal requirements.

In general, the regulations apply to plan years beginning on or after Sept. 23, 2010.

## V. Medicare and Medicaid Care Delivery and Payment Reform and Related Matters

### A. Medicare Hospital Value-Based Purchasing Program (VBP)

Since FY 2005, acute care hospitals that submit required quality data have received higher payments than those hospitals that do not submit such information under Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program (often referred to as the hospital pay-for-reporting program or P4P program). There are 46 quality measures collected in the RHQDAPU program that impact the FY 2011 payment update. In November, 2007, CMS released a mandated report on the implementation of a Medicare hospital value-based purchasing (VBP) program, which recommends expanding the RQHDAPU program in order to financially reward hospitals differentially for performance; public reporting of performance would be a key component as well.<sup>37</sup>

Section 3001 of the Affordable Care Act establishes a hospital value-based purchasing program (VBP) applicable to acute care hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS). Under the VBP program, inpatient payments to these hospitals, beginning in FY

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<sup>37</sup> available at

[www.cms.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf](http://www.cms.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf).

2013, will be modified based on a hospital’s performance with respect to certain quality measures.

For the first year, the Secretary will select measures that cover at least the following five conditions or procedures: (1) acute myocardial infarction (AMI), (2) heart failure, (3) pneumonia, (4) surgeries, and (5) healthcare-associated infections. Other selected measures must relate to the Hospital Consumer Assessment of Healthcare Providers and Systems Survey. All such quality measures will have been initially implemented through the existing Medicare pay-for-reporting program. For FY 2014 and beyond, the Secretary will expand the measures to include ones focused on efficiency, for example measures of Medicare spending per beneficiary.

The Secretary will establish performance standards for the selected measures and each hospital will receive its own performance score comprised of an achievement score and an improvement score. Those hospitals with the highest total performance scores will receive the largest VBP incentive payments, while those with the lowest scores will receive a reduction in their payments.

Payment incentives and reductions will be budget-neutral, with an increasing amount of the inpatient funding pool allocated to VBP, as follows:

FY 2013:	1.0 percent
FY 2014:	1.25 percent
FY 2015:	1.5 percent
FY 2016:	1.75 percent
FY 2017 on:	2.0 percent <sup>38</sup>

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<sup>38</sup> As provided in Section 3001 of the Affordable Care Act, beginning for discharges on October 1, 2012, hospitals will receive value-based incentive payments from Medicare. The first year of the VBP program will be a data collection/performance year. Beginning in FY2013, hospital payments will be adjusted based on performance under the VBP program. Certain hospitals will be excluded in a fiscal year: those that are subject to payment reductions associated with reporting required quality data in that fiscal year; those that have been cited for deficiencies that pose immediate jeopardy to their patients; and those for which there are not sufficient number of measures or cases that apply to the hospital for a performance period. The Secretary is to select measures other than measures of readmissions for the hospital VBP program from those used in the RHQDAPU program. In FY2013, the measures are to cover at least five specified conditions.

For discharges occurring during FY2014 and subsequently, the Secretary is to ensure that measures would include appropriate efficiency measures, such as adjusted Medicare spending per beneficiary. The Secretary is required to establish VBP performance standards, including levels of achievement and improvement, and a methodology for assessing the total performance of each hospital. The performance standards are to be announced no later than 60 days prior to the beginning of the period. Hospitals with the highest scores will receive the largest VBP payments.

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*B. Medicare Penalty for High Rates of Hospital-Acquired Conditions*

Medicare pays acute care hospitals using the inpatient prospective payment system (IPPS), where each patient is classified into a Medicare severity adjusted diagnosis-related group (MS-DRG). Generally, except for outlier cases, a hospital receives a predetermined amount for a given MS-DRG regardless of the services provided to a patient. In some instances, Medicare patients may be assigned to a different MS-DRG with a higher payment rate based on secondary diagnoses. Starting October 1, 2008, hospitals did not receive additional Medicare payment for complications that were acquired during a patient's hospital stay for certain select conditions. These hospital acquired conditions (HACs) are: (1) high cost, high volume, or both; (2) identified though a secondary diagnosis that will result in the assignment to a different, higher paid MS-DRG; and (3) reasonably preventable through the application of evidence-based guidelines.

Under Section 3008 of the Affordable Care Act, Medicare will reduce payments to hospitals that are in the top quartile with respect to national rates of hospital acquired conditions (HAC), beginning in FY 2015. Specifically, Medicare will limit a hospital's reimbursement to 99 percent

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There will not be a minimum performance standard in determining the performance score for any hospital. Hospitals that meet or exceed the established standards for a performance period are to receive an increased base operating diagnosis-related group (DRG) payment for each discharge in the fiscal year. Starting in FY2013, the Secretary is to fund the VBP incentive payments by reducing the base operating DRG payments for each hospital's discharges in a fiscal year by an applicable percentage. These reductions will apply to all hospitals. The applicable percentage is 1 percent in FY2013; 1.25 percent in FY2014; 1.5 percent in FY2015; 1.75 percent in FY2016; and 2 percent in FY2017 and in subsequent years. Certain adjustments within Medicare's inpatient hospital payment system, such as those for outliers, indirect medical education, disproportionate share hospital and low volume, will not be affected. Certain payments to sole community hospitals and Medicare dependent hospitals (for FY2012 and FY2013) will also not be affected. Individual hospital performance on each specific quality measure, on each condition or procedure, and on total performance are all to be publicly reported. A process is to be established that allows hospitals to appeal their performance assessment and score; these appeals are to be resolved in a timely manner. There will be no judicial or administrative review of certain aspects of the VBP program. The Secretary is to consult with small rural and urban hospitals on the application of the VBP program to such hospitals. The RHAQDPU program is also to be modified. The Secretary will be able to require hospitals to submit data on measures that are not used for the determination of VBP payments. Effective for FY2013 payments, the Secretary is required to provide for appropriate risk adjustment for quality measures for outcomes of care. These measures are to be validated appropriately.

The Government Accountability Office (GAO) is required to conduct a study of the VBP program with an interim report to Congress due by October 1, 2015 and a final report due by July 1, 2017. The Secretary is also required to conduct a study of the VBP with a report to Congress due by January 1, 2016. No later than two years from enactment, three-year, budget neutral VBP demonstration projects are to be established in critical access hospitals (CAHs) and in hospitals excluded from VBP because of an insufficient volume; reports on the demonstration projects are due to Congress no later than 18 months after completion of the projects.

of the amount of payment that it would have otherwise received for the discharge prior to the payment-reduction policy's taking effect. A HAC is defined as a condition subject to payment restrictions under IPPS payment rules and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital.

The 1 percent payment-reduction policy will apply to acute-care hospitals paid under IPPS. However, on or before January 1, 2012, the Secretary will report to Congress on how this policy can be expanded to other providers that are currently exempt from IPPS, such as inpatient rehabilitation facilities, long-term care hospitals, hospital outpatient departments, skilled nursing facilities, and ambulatory surgical centers. The Secretary is required to publicly report hospital-specific information on HACs on the Hospital Compare website ([www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)).<sup>39</sup>

### C. Hospital Readmissions Reduction Program

Section 3025 of the Affordable Care Act requires the Secretary to calculate the actual and predicted "readmission" rates to hospitals for several different health conditions that are associated with a high number of readmissions or high costs. The Act defines a "readmission" as the admission of a patient to the same hospital from which the patient was discharged or to another hospital within a time period specified by the Secretary from the date of the patient's discharge.

For FYs 2012 through 2014, conditions subject to this provision are AMI, heart failure, and pneumonia, and the readmission period is 30 days. Beginning in FY 2015, the Secretary is authorized to expand this policy to cover four additional health conditions identified by the Medicare Payment Advisory Commission (MedPAC) in its report to Congress in June 2007. The four conditions are: chronic obstructive pulmonary disease, coronary artery bypass graft, percutaneous transluminal coronary, and other vascular procedures. Thus, starting in October 1, 2012, hospitals with high readmission rates for patients with these conditions will have their Medicare payments adjusted by the greater of a "ratio" or a "floor adjustment factor." The "ratio" is equal to 1 minus the aggregate payments attributable to excess readmissions with respect to a hospital

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<sup>39</sup> Starting for discharges during FY2015, acute care hospitals in the top quartile of national, risk-adjusted hospital acquired condition (HAC) rates for an applicable period in a fiscal year are to receive 99 percent of their otherwise applicable payment. Prior to FY2015, the hospitals are to receive confidential reports with respect to their HAC conditions which will be made publicly available on the Hospital Compare Internet website after the hospital has the opportunity to review and correct the data. There will be no administrative or judicial review of certain aspects of the program. The Secretary is required to submit a report to Congress by January 1, 2012, with recommendations with respect to expanding Medicare's HAC payment policy to other facilities, including IRFs, LTCHs, hospital outpatient departments, inpatient psychiatric facilities, cancer hospitals, skilled nursing facilities, ambulatory surgery centers and health clinics.

divided by the aggregate payments from all discharges from that hospital. The “floor adjustment factor” will be 0.99 in FY 2013; 0.98 in FY 2014; and 0.97 in FY 2015 and subsequent years.<sup>40</sup>

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<sup>40</sup> Payment system (IPPS) where each patient is assigned to a MS-DRG and paid based on an estimate of the average resources needed to care for a patient with specific diagnoses. Certain atypical cases may qualify for additional outlier payments. Certain hospitals receive additional indirect medical education (IME) payments because of their status as a teaching hospital, because they qualify for disproportionate share hospital (DSH) payments or because they treat a small number (or low volume) of Medicare patients. Certain types of hospitals that qualify as sole community hospitals (SCHs) or Medicare dependent hospitals (MDHs) receive additional hospital specific payments. Medicare pays for inpatient services in other types of hospitals such as inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), children’s hospitals, and long-term care hospitals using different reimbursement systems. According to the Medicare Payment Advisory Commission’s (MedPAC), in 2005, 6.2 percent of acute care hospitalizations of Medicare beneficiaries resulted in readmission within 7 days and 17.6 percent of hospitalizations resulted in readmission within 30 days. The 17.6 percent of hospital readmission accounted for \$15 billion in Medicare spending.

Under Section 3025 of the Affordable Care Act, starting for discharges on October 1, 2012, the Secretary is to establish a hospital readmissions reduction program for certain potentially preventable Medicare inpatient hospital readmissions covering three conditions with high volume or high rate (or both). Medicare’s base operating DRG payment amounts will be reduced by an adjustment factor. Certain components of Medicare hospital payments will be exempt from these payment reductions, including outlier, IME, DSH, and low volume payments. Hospital specific payments made to SCHs and MDHs will be exempt in FY2012 and FY2012 as well.

The adjustment factor for a hospital in a fiscal year is to be the greater of (1) a floor adjustment factor equal to a reduced percentage of the discharge payment or (2) the excess readmissions ratio for the applicable fiscal year. The floor adjustment factor will be 0.99 of the discharge payments in FY2013, 0.98 of the discharge in FY2014, 0.97 in FY2015 and in subsequent fiscal years. The excess readmissions ratio is to equal 1 minus the ratio of the aggregate payments for excess readmissions for the hospital divided by the aggregate payments for all discharges. (Each component of this formula is specified in the provision.) Excess readmissions include readmissions over an established minimum number for the specific applicable condition within a certain period for a hospital.

An applicable condition is defined as a condition or procedure that represents high volume (above a minimum threshold) or high expenditures for Medicare or meets other specified criteria that also satisfies certain measures of readmissions (that have been endorsed by a consensus-based entity with a performance measurement contract under Section 1890 of the Social Security Act). Readmissions do not include those readmissions that are unrelated to the prior discharge, such as a planned readmission or a transfer to another hospital. Beginning in FY2015, the number of applicable conditions are to be expanded beyond the initial 3 conditions to 4 additional conditions that were identified by MedPAC in its June, 2007, Report to Congress and other appropriate conditions. These additional conditions do not necessarily need to be endorsed by a consensus based organization as long as due consideration has been given to such endorsed or adopted measures.

The Act also requires the Secretary to publish hospital readmission rates on the Hospital Compare website. In addition, the Secretary must calculate and report on the readmission rates for all patients for a hospital for an applicable condition, and post this information on the Hospital Compare website.

*D. Disproportionate Share Hospital (DSH) Payments*

To account for the expected decrease in the numbers of uninsured, Section 3133 of the Affordable Care Act provides for the downward adjustment in the payments received by Medicare disproportionate share hospitals (DSH). Under this provision, starting in FY 2014 and for subsequent fiscal years, the Secretary will make DSH payments equal to 25 percent of what otherwise would be made. This reduction represents the empirically justified amount specified by MedPAC in its March 2007 report to Congress.<sup>41</sup> Hospitals will receive an additional payment for FY 2014 and each subsequent FY based on the product of three factors:

- the difference between the aggregate amount of payments made to hospitals before and after the DSH reduction;
- 1 minus the percent change in the percent of individuals under 65 who are uninsured in the most recent period for which data is available compared to 2013, minus 0.1 percent-

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Readmission information for acute care hospitals is to be made publically available after a hospital has the opportunity to review and correct the data prior to being made public. No judicial and administrative review will be permitted for certain aspects of the readmission program. Readmission data for all patients is to be submitted by acute care hospitals, IRFs, IPFs, children's hospitals, and LTCHs and be made publically available after appropriate review. The required data is to be able to be submitted by a state or other appropriate entity rather than by each hospital.

No later than two years after enactment, a program to improve readmission rates through the use of patient safety organizations is to be established for eligible hospitals. Eligible hospitals are those with historically high rates of risk adjusted readmissions that have not taken appropriate steps to reduce readmissions and improve patient safety. Eligible hospitals and patient safety organizations will be required to report on the processes used to improve readmission rates and resulting impact on such readmissions.

<sup>41</sup> Medicare's disproportionate share hospital (DSH) adjustment was included in the inpatient prospective payment system (IPPS) in 1986 on the premise that low-income patients are more costly to treat and those acute care hospitals serving a large number of such patients would be likely to have higher costs for their Medicare patients than would otherwise similar institutions. Over time, as the formulas for Medicare's DSH adjustment have been changed, the justification for the higher payments has evolved and the adjustment is viewed as a way to insure access to hospital care. Medicare's DSH payments are distributed through a hospital-specific percentage increase to its prospective payment rate. In most instances, the size of a hospital's DSH adjustment would depend upon the number of patient days provided to poor Medicare patients or Medicaid patients. In its March 2007 Report to Congress, MedPAC found that about three-quarters of the Medicare DSH payments (accounting for about \$5.5 billion in FY 2004) was not empirically justified in terms of higher patient care costs. Also, Medicare's DSH payments were poorly targeted to hospitals' shares of uncompensated care.

tage points for FY 2014 and minus 0.2 percentage points per year for FYs 2015 through 2017; and

- the percentage of uncompensated care provided by each DSH hospital compared to all such hospitals for a selected period based on appropriate data.

Beginning in FY 2018, the Act provides that factor two will be 1 minus the percent change in the percent of individuals who are uninsured in the most recent period for which data is available compared to 2013, less an additional 0.2 percentage points per year for FYs 2018 and 2019.

There will be no administrative or judicial review of any estimate used to determine the factors or any periods used to establish the factors.

#### E. Medicare Wage Index Improvement

A hospital wage index is used to adjust the standardized amount to account for the local wage variation or cost of labor in the hospital's area. Differing from other providers, acute care hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for a change in classification from a rural area to an urban area, or reassignment from one urban area to another urban area. To reclassify, a hospital had to meet certain standards, establishing that its average hourly wage (AHW) was within a certain threshold of the AHW of the area where it wanted to reclassify. Starting in FY 2010, CMS raised the reclassification threshold. MGCRB hospital reclassifications are established on a budget neutral basis so aggregate inpatient payments will not increase as a result of the reclassified hospitals' higher payments.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Section 508) provided for a one-time, three year geographic reclassification of certain hospitals who were otherwise unable to qualify for administrative reclassification to areas with higher wage index values. These reclassifications were extended several times until September 30, 2009.<sup>42</sup>

Section 3137 of the Affordable Care Act further extends the Section 508 reclassifications until September 30, 2010. Beginning on April 1, 2010, the average hourly wage data of these hospitals will be included in the reclassified area only if including the data results in a higher wage index. Certain hospitals that had a lower wage index from October 1, 2009, through March 31, 2010, than from April 1, 2010, through September 30, 2010, will be paid an additional amount to reflect such difference by December 31, 2010. The Act further requires the secretary to submit a plan to Congress by December 31, 2011 for reforming the Wage Index, and the secretary is required to consider the recommendations set forth in the Medicare Payment Advisory Commission June 2007 report titled "Report to Congress: Promoting Greater Efficiency in Medicare." Also, the Act requires that the Wage Index reclassifications continue to be determined based

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<sup>42</sup> Under the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275).

upon the figures contained in the 2010 Inpatient Prospective Payment System Final Rule (74 Fed. Reg. 43754, Aug. 27, 2009), as long as a higher Wage Index reclassification results.

F. *Market Basket Updates*

Nearly all fee-for-service Medicare providers receive predetermined payment amounts established under different, unique prospective payment systems. Each year, the base payment amounts in the different Medicare payment systems are increased by an update factor to reflect the increase in the unit costs associated with providing health care services. Medicare's annual updates are usually linked to either: (1) projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services that are purchased by the provider and intended to reflect the effect of inflation on providers' costs per service; or (2) the Consumer Price Index for All Urban Consumers (CPI-U).

Section 3401 of the Affordable Care Act provides for a reduction in the annual market basket update for inpatient prospective payment system (IPPS) hospitals by 0.25 percent, for federal FYs 2010 and 2011. For subsequent FYs, the annual market basket update for IPPS providers is reduced by the following percentages:

FY 2012-2013:	0.1 percent
FY 2014:	0.3 percent
FY 2015–2016:	0.2 percent
FY 2017–2019:	0.75 percent

The reduction in the annual market basket update for IPPS hospitals mirrors that for outpatient prospective payment system (OPPS) hospitals, except that the reduction will be applied pursuant to the calendar year for OPPS hospitals. Additionally, beginning in fiscal and calendar years 2012, the Act subjects the market basket update for IPPS and OPPS hospital providers to a “productivity adjustment,” which potentially means further reductions in payment. The productivity adjustment is the 10-year moving average of changes in economy-wide private nonfarm business productivity, as projected by the Secretary. These productivity adjustments may result in a negative market basket update, with a concomitant reduction in payment rates.

The Act includes similar market basket update reductions and productivity adjustments for long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals. Section 3004 of the Act further mandates quality reporting for long-term care hospitals and inpatient rehabilitation facilities, beginning in fiscal or rate year 2014. Failure to report the required data will result in a reduction in the hospital's annual market basket update to its standard federal rate.<sup>43</sup>

<sup>43</sup> Specifically, the Act will implement a full productivity adjustment for inpatient and outpatient hospital services, inpatient rehabilitation, long-term care hospital services, skilled nursing facilities and hospices beginning October 1, 2012, for inpatient psychiatric facilities beginning July 1, 2011, and for home health providers beginning in October 1, 2014. For providers paid through the clinical laboratory test fee sche-

### G. Medicaid DSH Payments

Disproportionate share hospital adjustment payments provide funding to hospitals that serve a significantly disproportionate number of low-income patients, or are located in an urban area, have 100 or more beds, and can demonstrate that more than 30 percent of their revenues are de-

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dule, the proposal will replace the scheduled 0.5 percent payment reduction for 2011 through 2013 with a full productivity adjustment for 2011 and subsequent years. Dialysis providers will be subject to the productivity adjustment starting in 2012; the productivity adjustments for other Part B providers will begin in 2011. The application of the update adjustments may result in a negative factor and a basis of payment that would be lower than in the preceding year.

Notwithstanding the previously described productivity factors, the MB update for acute care inpatient (IPPS) services and inpatient rehabilitation facilities (IRFs) will be reduced 0.25 percentage points starting in FY2010 (starting October 1, 2009, effective for discharges on April 1, 2010) and FY2011; 0.1 percentage points in FY2012 and FY2013; 0.3 percentage points in FY2014; 0.2 percentage points in FY2015 and FY2016; and 0.75 percentage points in FY2017 through FY2019. These same reductions also apply to the update for long-term care hospitals except that a larger reduction of 0.5 percentage points will apply starting October 1, 2010 (Rate Year 2010). The MB update for the hospital outpatient prospective system will be reduced 0.25 percentage points in 2010 and 2011 and by 0.1 percentage points in 2012 and 2013. 0.3 percentage points in 2014; 0.2 percentage points in 2015 and 2016; and 0.75 percentage points in 2017 through 2019.

The skilled nursing facility MB update will be subject to the productivity factor adjustment beginning in FY2012. Aside from the productivity factor adjustment beginning in 2015, the MB update for home health services will be reduced by 1.0 percentage point in 2011, 2012, and 2013. The hospice MB update will be subject to the productivity factor adjustment beginning in FY2013. Aside from the productivity factor adjustment, the MB update will be reduced by 0.3 percentage points in FY2013. For each of the fiscal years from FY2014 through FY2019, a 0.3 percentage point reduction to the MB will be contingent upon the level of the insured population relative to the projection of insured population for the year preceding enactment. Specifically, only if the level of non-elderly insured population is 5 or fewer percentage points above the projections would the MB update be reduced by 0.3 reduction beginning in 2012, but will be subject to the productivity factor adjustments starting in 2012. The productivity adjustment factor for ambulance services will be applied to the CPI-U used to increase the ambulance fee schedule starting in CY2011. The productivity adjustment factor will be applied to the CPI-U used to update payments for ambulatory surgical services starting in CY2011. The existing 0.5 percentage point reduction to the CPI-U update to the fee schedule for laboratory services in 2009 and 2010 will be retained. A 1.75 percentage point reduction to the update in 2011 through 2015 will be established; this reduction may result in a negative update. The productivity adjustment factor will be applied to the CPI-U starting in 2011, but in the application of the adjustment will not be able to reduce the increase to less than zero. The productivity adjustment factor will be applied to the CPI-U used to increase the fee schedules for certain durable medical equipment (DME) beginning in 2011. Certain DME would have received a payment increase of CPI-U plus 2 percentage points in 2014, but the 2 percentage point increase was eliminated. The productivity adjustment factor will be applied to the CPI-U update for prosthetic devices, orthotics, and prosthetics for the applicable fee schedule category starting in 2011.

rived from state and local government payments for indigent care provided to patients not covered by Medicare or Medicaid or other health insurance. States receive an annual DSH allotment to cover the costs of these hospitals that includes requirements to ensure that the DSH payments to individual hospitals do not exceed these actual uncompensated costs.

Section 2551 of the Affordable Care Act the Act specifies the aggregate amounts by which DSH payments must be reduced for all states each fiscal year from 2014 through 2020, as follows:

\$500 million for FY 2014  
\$600 million for FYs 2015 and 2016  
\$1.8 billion for FY 2017  
\$5 billion for FY 2018  
\$5.6 billion for FY 2019  
\$4 billion for FY 2020

The Act also requires the Secretary to develop a methodology for implementing the reductions in a manner that (1) imposes the largest percentage reductions on states having the lowest percentages of uninsured individuals or do not target their DSH payments on hospitals with high volumes of Medicaid inpatients and high levels of uncompensated care; and (2) imposes a smaller percentage reduction on low DSH states.

#### H. Payment Reductions for Healthcare-Acquired Conditions

Medicare pays acute care hospitals using the inpatient prospective payment system (IPPS), where each patient is classified into a Medicare severity adjusted diagnosis-related group (MS-DRG). Generally, except for outlier cases, a hospital receives a predetermined amount for a given MS-DRG regardless of the services provided to a patient. In some instances, Medicare patients may be assigned to a different MS-DRG with a higher payment rate based on secondary diagnoses. Starting October 1, 2008, hospitals did not receive additional Medicare payment for complications that were acquired during a patient's hospital stay for certain select conditions. These hospital-acquired conditions (HACs) are (1) high cost, high volume, or both; (2) identified through a secondary diagnosis that will result in the assignment to a different, higher paid MS-DRG, and (3) reasonably preventable through the application of evidence-based guidelines. The Act requires the Secretary, to the extent practicable, to publicly report on measures for HACs that are currently utilized by CMS for the adjustment of payment to hospitals based on rates of hospital-acquired infections. There is no corresponding HAC initiative under Medicaid.

Section 2702 of the Affordable Care Act requires the Secretary to identify current state practices that prohibit the payment for "health care acquired conditions," defined by the Act as a medical condition for which an individual was diagnosed that could be identified by a secondary diagnosis code, and incorporate practices in regulations that would be appropriate for application to the Medicaid program. The regulations must be in effect by July 1, 2011, and must prohibit payment to the states for any amounts expended for providing medical assistance for health care acquired

conditions. The regulations must also ensure that any such prohibition on payments will not result in a loss of access to care or services for beneficiaries.

#### I. Accountable Care Organizations/Shared Savings (Medicare)

Section 3022 of the Affordable Care Act allows groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as Accountable care organizations (ACOs) and be eligible to share in the cost savings they achieve for the Medicare program. Beginning no later than Jan. 1, 2012, this shared savings program will enable eligible ACOs to qualify for an annual incentive bonus if they achieve a threshold savings amount, established by the Secretary, for total per beneficiary spending under Medicare Parts A and B for those beneficiaries assigned to the ACO. In other words, these shared savings will be based on the reduction in the per capita Medicare expenditures below a certain benchmark determined by the Secretary.

The following groups of providers and suppliers that have established a mechanism for shared governance are eligible to participate as ACOs under this program - practitioners (physicians, regardless of specialty; nurse practitioners; physician assistants; and clinical nurse specialists) in group practice arrangements; networks of practices; and partnerships or joint-venture arrangements between hospitals and practitioners, among others.

ACOs must also meet the following requirements to participate:

- agree to be accountable for the quality, cost, and overall care of Medicare fee-for-service beneficiaries;
- agree to participate for at least a three-year period;
- have a formal legal structure allowing them to receive and distribute payments;
- include enough primary care ACO professionals for at least 5,000 beneficiaries;
- provide the Secretary with the necessary information regarding these ACO professionals;
- possess the leadership and management to support clinical administrative systems;
- define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care through enabling technologies; and
- show the Secretary that they meet patient-centered criteria, such as patient and caregiver assessments and individualized care plans.

In each year of the three-year agreement period, an ACO will be eligible for a shared savings payment if the estimated average per capita Medicare expenditures for Parts A and B services, adjusted for beneficiary characteristics is at least the specified percentage below the applicable benchmark. This appropriate percentage is to account for the normal variation in expenditures based on the number of beneficiaries assigned to the ACO. The ACO's benchmark for each agreement period is to be based on the most recent available three years of per beneficiary Part A and B spending for its assigned beneficiaries. This benchmark will be adjusted for beneficiary

characteristics and updated by the projected absolute growth in national per capita expenditures for Part A and B fee-for-service Medicare services, as estimated by the Secretary. The benchmark will be reset at the start of each agreement period. Subject to attaining quality performance standards, an ACO will receive a percentage of the difference between the estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and the ACO's benchmark. The remainder of the difference will be retained by the program. Thus, the payment for shared savings for ACOs that meet the quality performance standards will be equal to the difference between the estimated per capita Medicare expenditures and the benchmark. The ACOs would continue to receive the same payments they receive under the current fee-for-service system, and shared savings would be an additional payment amount. The Secretary is to establish limits on the total amount of shared savings that may be paid to an ACO. The Secretary may use a partial capitation model or other payment models. Under the partial capitation model, a qualifying ACO would be at financial risk for some, but not all, of the Part A and B items and services. The Secretary may limit participation in this model in highly integrated systems capable of bearing risk. Also, spending under this model cannot result in greater spending than would otherwise be expended if the model were not implemented.

To earn the incentive payment, the organization is to submit data pertaining to quality and fulfill certain quality requirements related to clinical processes and outcomes, patient and caregiver experience of care, and utilization measures. The Secretary has the authority to adjust the savings thresholds to account for the varying sizes of participating ACOs. If the Secretary determines that an ACO has taken steps to avoid at-risk patients in order to reduce the likelihood of increasing costs, the Secretary is authorized to impose an appropriate sanction, including terminating agreements with participating ACOs.

#### *J. Bundled Payments for Hospitals, Physicians, and Post-Acute Care (Medicare)*

Section 3023 of the Affordable Care Act requires the Secretary, no later than January 1, 2013, to establish, test and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program (the National Pilot Program on Payment bundling). This program is to be designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care around a hospitalization. The episode of care will include the three days prior to admission, the full period that a patient stays in a hospital plus the first thirty days following discharge. The Secretary will be able to expand the duration and scope of the pilot after January 1, 2016 if the Secretary, with certification from the Chief Actuary of CMS, determines that such expansion would reduce Medicare spending without reducing quality of care, among other things.

The Secretary is required to develop provider payment methods that could include bundled payments and bids from entities for episodes of care. The bundled payment is to comprehensively cover the costs of applicable services, and other appropriate services, including acute care inpatient services; physicians' services delivered in and outside of an acute care hospital setting; outpatient hospital services including emergency department services; post-acute care services, in-

cluding home health services, skilled nursing services, inpatient rehabilitation services; inpatient hospital services furnished by a long-term care hospital; among others. Participating beneficiaries are to be entitled to, or enrolled in, Medicare Part A and enrolled for benefits under Medicare Part B. Beneficiaries cannot be enrolled in Medicare Advantage or a Program for All-Inclusive Care for the Elderly (PACE). Beneficiaries can have one or more of ten conditions selected by the Secretary.

This payment methodology is also to include payment for services, such as care coordination, medication reconciliation, discharge planning and transitional care services, and other patient-centered activities, as determined appropriate by the Secretary. Payments for items and services cannot result in spending more than would otherwise be expended for such entities if the pilot program were not implemented. No later than three years after implementation, the Secretary is required to submit to Congress a final evaluation of this program.<sup>44</sup>

K. *Hospital and Physician Bundled Payment and Global Payment System for Safety Net Hospitals (Medicaid)*

Sections 2704 through 2707 of the Affordable Care Act established four demonstration projects to improve the quality of Medicaid for patients and providers.

A demonstration project is established to evaluate integrated care around a hospitalization by studying the use of bundled payments for hospital and physicians services under Medicaid.

A Medicaid global payment system demonstration project is established, in coordination with the CMS Innovation Center that would allow participating states to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure.

A Pediatric Accountable Care Organization demonstration project is established to allow qualified pediatric providers to be recognized and receive payments as ACOs under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings.

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<sup>44</sup> The 2009 Acute Care Episode (ACE) Demonstration Project was designed to align incentives and provide flexibility to hospitals and physicians by bundling all related services into an “episode of care” and paying a single, global payment that can be used as the providers of care deem most appropriate. Approximately 15 demonstration sites were selected to participate in this demonstration, beginning in 2009. Sites were selected from among states that pay claims under the diagnostic related group inpatient prospective payment system.

The goal of the demonstration is to align hospitals’ and physicians’ incentives to work together to provide coordinated, cost effective care. Participating entities are required to submit quality data relevant to the services being provided under the demonstration.

A Medicaid emergency psychiatric demonstration project is established in which participating states would be required to reimburse certain institutions for mental disease for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.

L. *Extension of Gain Sharing (Medicare)*

Certain gainsharing demonstrations to evaluate arrangements between hospitals and physicians have been authorized under Section 3027 of the Affordable Care Act.<sup>45</sup> CMS is currently operating two projects, each consisting of one hospital in New York and West Virginia. Although authorized to begin on January 1, 2007, the project began on October 1, 2008 and was scheduled to end on December 31, 2009. The Secretary was required to submit mandated reports by certain due dates. The project was appropriated \$6 million in FY2006 to be available for expenditure through FY2010. Under the Act, the authority to conduct the gainsharing demonstration project in operation as of October 1, 2008 will be extended until September 30, 2011. The due date of the required interim report is extended from December 1, 2008, to March 31, 2011 with the final report due on March 31, 2013. An additional \$1.6 million is to be appropriated in FY2010; all appropriations are available through FY2014 or until expended.

M. *Independent Payment Advisory Board*

Section 3403 of the Affordable Care Act establishes the Independent Payment Advisory Board (Board).<sup>46</sup> This independent board is responsible for developing proposals to reduce Medicare

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<sup>45</sup> Financial arrangements, known as “gainsharing,” whereby hospitals pay physicians to reduce or limit care to Medicare and Medicaid patients, are clearly prohibited under Social Security Act Section 1128A(b)(1) outside of the gainsharing demonstration project and is subject to civil money penalties. Gainsharing arrangements typically seek to align physician incentives with those of the hospital by offering physicians a share of Part A hospital cost savings, which would adversely affect patient care and reward physicians for patient referrals in violation of the anti-kickback laws.

<sup>46</sup> The Act establishes an Independent Payment Advisory Board to develop and submit detailed proposals to Congress and the President to reduce Medicare spending. The Board is to consist of 15 members with expertise in healthcare financing, delivery, and organization. All members are to be appointed by the President and confirmed by the Senate. Proposals are to primarily focus on payments to MA and PDP plans and reimbursement rates for certain providers. The Board will be prohibited from developing proposals related to Medicare benefits, eligibility, or financing. Proposals, which will only be required in certain years, will have to meet specific savings targets. Recommendations made by the Board automatically go into effect unless Congress enacts specific legislation to prevent their implementation. The first year the Board’s proposals can take effect is 2015.

The Board is to be composed of 15 members, appointed by the President with the advice and consent of the Senate. Members of the Board will serve six-year, staggered terms. Members may not serve more

cost growth and improve the quality of care provided to beneficiaries. The Board's first proposal is due January 15, 2014. If Medicare costs are projected to be unsustainable, the Board's proposals will become law unless Congress passes alternative legislation that achieves the same level of cost savings. Board proposals cannot include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria. Proposals by the Board may not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers (including hospitals, outpatient rehabilitation facilities, skilled nursing facilities, home health agencies, hospice) or suppliers (including physicians or other practitioners, facilities or other entities which furnish Medicare covered items or services.)<sup>47</sup>

than 2 full consecutive terms. The Senate Majority Leader, the Speaker of the House, the Senate Minority Leader, and the House Minority Leader will each present three recommendations for appointees to the President. The President, with the advice and consent of the Senate, is required to appoint a Chair for the Board. The Board will elect a Vice Chairman. Members can only be removed by the President for neglect of duty or malfeasance in office. In addition to the 15 members of the Board, the Secretary of Health and Human Services (HHS), the Administrator of the Center for Medicare and Medicaid Services (CMS), and the Administrator of the Health Resources and Services Administration (HRSA) will serve as ex-officio, non-voting members of the Board.

Qualifications for membership are similar to the qualifications required for members of the Medicare Payment Advisory Board (MedPAC). Individuals involved in the delivery or management of healthcare services cannot constitute a majority of the Board. In addition to these qualifications, the President is required to establish a system for publicly disclosing any financial or other conflicts of interests relating to members. Individuals that engage in any other business, vocation, or employment cannot serve as appointed members of the Board. Members will be considered officers in the executive branch for purposes of applying Title I of the Ethics in Government Act of 1978. After serving on the Board, former members will be barred from lobbying the Board and other relevant executive branch departments and agencies and relevant congressional committees for one year.

The Chair will be responsible for exercising all of the Board's executive and administrative functions, including those related to the appointment and supervision of employees and the use of funds. All requests for discretionary appropriations to fund the Board's activities must be approved by a majority vote.

<sup>47</sup> The provision requires that the Board submit proposals to the President for years in which the projected rate of growth in Medicare spending per beneficiary exceeds a target growth rate. Determinations of the projected and target growth rates are to be made by the CMS Office of the Actuary (OACT) beginning in 2013. The Board is required to submit its first proposal to the President by January 15, 2014, for implementation in 2015. If the Board fails to submit a proposal to the President by January 15, the Secretary will be required to submit a contingent proposal to Congress meeting the same requirements by January 25.

For years 2014 through 2017, the Board will be required to submit proposals for years in which the projected rate of growth in Medicare spending per beneficiary exceeds the average of the projected percentage increase in the Consumer Price Index for All Urban Consumers (CPI) and the Consumer Price Index

for Medical Care (CPI-M). Beginning in 2018, proposals will only be required for years in which the projected rate of growth in Medicare spending exceeds the Gross Domestic Product (GDP) plus 1 percent. Recommendations proposed by the Board are required to reduce Medicare spending by the lesser of 0.5 percentage points in 2015, 1.0 percentage points in 2016, 1.25 percentage points in 2017, 1.5 percentage points in 2018 and the amount by which the rate of growth in Medicare spending exceeds the target growth rate. Proposals cannot increase Medicare spending over a 10-year period.

The provision lays out a number of specific fiscal and policy criteria which the Board will be required to meet in making its recommendations. When developing and submitting proposals, the Board is required, to the extent feasible, to: (1) prioritize recommendations that would extend Medicare solvency and target reductions to sources of excess cost growth; (2) include only those recommendations that improve the healthcare delivery system, including the promotion of integrated care, care coordination, prevention and wellness and quality improvement and protect beneficiary access to care, including in rural and frontier areas; (3) consider the effects of changes in provider and supplier payments on beneficiaries; consider the effects of proposals on any provider who has, or is projected to have, negative profit margins or payment updates; (4) consider the unique needs of individuals dually eligible for Medicare and Medicaid, and (5) include recommendations for administrative funding to carry out its recommendations.

At the beginning of the year following the determination by the Secretary, the Advisory Board is to submit its recommendations to the President who is to, in turn, immediately submit them to Congress. The provision dictates certain information which must accompany the Advisory Board's submission, including a requirement for legislative language implementing the recommendations. The Act further directs the Secretary to automatically implement the Board's recommendations unless Congress, by August 15 of the year in which the recommendations are submitted, enacts legislation superseding the Board's proposal. The provision establishes special "fast track," parliamentary procedures governing congressional consideration of legislation implementing the Board's recommendations. These fast track procedures differ from the normal parliamentary mechanisms used by the chambers to consider most legislation and are designed to ensure that Congress, should it choose to do so, can act quickly on the proposal put forth by the Advisory Board.

The fast track procedures established by the provision mandate the introduction of the Board's legislative proposal by the House and Senate majority leaders "by request" on the day it is submitted to Congress. When introduced, such legislation is to be referred to the Senate Committee on Finance and to the House Committees on Energy and Commerce and Ways and Means. These committees may mark up the measure, and must report it to their respective chambers not later than April 1 or be discharged of its further consideration. The expedited procedure waives the provisions of Senate Rule XV which would ordinarily bar the Finance Committee from reporting a committee amendment containing significant matter not in its jurisdiction so long as the amendment in question "is relevant" to a proposal in the Advisory Board bill.

The provision also restricts the House or Senate from considering any amendment (including committee amendment), bill, or conference report which would repeal or change the Board's recommendations unless those changes meet the same fiscal and policy criteria (described above) which the Board was required to meet in developing its recommendations. The Act provides for this restriction to apply not only to House and Senate consideration of the Board legislation submitted by the President, but to all other legislation Congress considers as well. This restriction may be waived solely by a vote of three-fifths of

the Members duly chosen and sworn, and in addition, the substitute prohibits the consideration of legislation that would repeal or modify this restriction.

No expedited procedures are established for initial House floor consideration of the Board's legislation. In the Senate, a motion to proceed to consider the legislation is privileged and not debatable. Amendments offered to the legislation on the Senate floor must be germane and may not reduce the savings in Medicare per capita growth below established targets. Debate in the Senate on each amendment to the bill is limited and overall Senate consideration of the legislation may not exceed 30 hours, after which a final vote will be taken on it. In the event that there is a need to resolve bicameral differences on the legislation, debate on any conference report or amendment exchange is limited to no more than 10 hours, after which a final vote will occur. Should the measure be vetoed, Senate debate on a veto message is limited to one hour.

The provision establishes an additional set of fast track parliamentary procedures governing House and Senate consideration of a joint resolution to discontinue the Independent Payment Advisory Board and the "automatic" process of implementation described above. These procedures ensure that the House and Senate may act promptly on such a measure by limiting debate and amendment at the committee and floor level. The procedures also establish a supermajority requirement of three-fifths of Members duly chosen and sworn for passage of such a joint resolution in each chamber.

The Secretary is required to implement the Board's recommendations by August 15 of the year in which the proposal was submitted. Any recommendation that would change a provider's payment rate will apply on the first day of the first fiscal year, calendar year, or rate year (which varies depending on provider type) after August 15th.

Beginning in 2019, the Secretary will be prohibited from implementing the Board's recommendations if two conditions are met: (1) the Board was required to submit a proposal to Congress in the preceding year, and (2) the OACT determined that the rate of growth in per capita NHE exceeded the rate of growth in per capita Medicare spending. These restrictions are not to affect requirements pertaining to the Board's submission of proposals to Congress or the rules related to congressional consideration of these proposals.

The Board must submit a draft copy of each proposal it develops to the Medicare Payment Advisory Commission (MedPAC) and to the Secretary for review. Beginning in 2014, for any year the Board is not required to submit a proposal to the President and Congress, the Board will be required to submit to Congress advisory reports on matters related to the Medicare program. Prior to 2020, these reports may include recommendations to improve payment systems for those providers and suppliers exempted from the Board's recommendations.

Beginning in 2015, the provision also requires that the Board submit to Congress and the President advisory recommendations to slow the rate of growth in NHE. These recommendations could not target expenditures in federal health care programs. The Board will be required to coordinate these recommendations, which must be made available to the public, with those contained in other Board proposals and advisory reports. Recommendations, which are required at a minimum once every two years, could be implemented either administratively by the Secretary or legislatively by Congress. These advisory reports will not be subject to the rules for congressional consideration.

The Board's authority includes making proposals that would reduce payments to Medicare Advantage and the Part D program, such as reductions in direct subsidy payments that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount and reductions in payments to Medicare Advantage plans that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans. Proposals regarding Medicare Advantage A and Part D plans may be made by the Board without delay.<sup>48</sup>

N. *Medicare Advantage Rate Freeze and New Benchmark Computation*

Each year the Secretary must calculate monthly benchmark amounts for Medicare Advantage (MA) plans by county. These amounts are set by statutory formula and used to determine how MA plans are paid under Medicare. Before the federal healthcare reform law, MA plans were required to bid annually based on their average monthly revenue requirements for providing Medicare-covered benefits per enrollee for the following year. These monthly bid amounts reflect the cost of providing benefits as well as administrative costs, such as profits and expenses for sales, etc. MA benchmarks are calculated differently for local and regional plans. The local benchmark is based solely on statutory county-level rates. The regional benchmark consists of statutory county-level rates and a weighted average of regional plan bids. The weighted average component bases a portion of the benchmark amount on bids submitted by the plans. Medicare payments to MA plans are determined by comparing their bids to the benchmark rates. If an MA plan bid is equal to or above the benchmark, its payment is the benchmark, and it must charge an

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The provision also requires the GAO to conduct a study on changes in payment policies, methodologies, rates, and coverage policies under Medicare resulting from the Board's proposal. Specifically, the study is to provide an assessment of the effect of the Board's proposal on Medicare beneficiary's access to providers, affordability of premiums and cost-sharing, the potential impact of changes on other government or private sector purchasers of care, and the quality of care provided. The report is due by July 1, 2015. The GAO is to conduct additional studies as appropriate.

<sup>48</sup> As appropriate, each proposal is required to include recommendations that would reduce spending in Medicare Parts C and D. Reductions could be obtained by reducing Medicare payments for administrative expenses to MA and PDP plans, denying or removing high bids for drug coverage from the calculation of the monthly bid amount for Part D plans, and reducing performance bonuses for MA plans. Recommendations may not target the base beneficiary premium percentage or the full premium subsidy for Part D plans.

The Board is prohibited from making recommendations that would ration care, raise revenues, increase beneficiary premiums, increase beneficiary cost-sharing, restrict benefits, or modify eligibility. Additionally, proposals submitted before December 2018 for implementation in 2020, cannot include recommendations that would reduce payments to providers and suppliers scheduled to receive a reduction in their payment updates in excess of a reduction due to productivity.

enrollee premium equal to the difference between its bid and the benchmark. If its bid is below the benchmark its payment is its bid. MA plans that bid below the benchmark are also paid a rebate in addition to their bid equaling 75 percent of the difference between their bid and the benchmarks. Thus, the Medicare payment to MA plans that bid below the statutory benchmark is equal to each plan's bid plus 75 percent of the difference between each bid and the benchmark rate.

Under Section 1102 of the Reconciliation Act, MA payment rates in 2011 will be the same as in 2010. Beginning in 2012 a new "blended benchmark" will be used to determine payments for all MA plans except for MA plans under PACE, the Program of All-inclusive Care for the Elderly. The new blended benchmark will alter payments from 95 percent of Medicare spending in the previous year in high-cost areas to 115 percent of Medicare spending from the previous year in low cost areas. Additionally, quality measures will impact the blended benchmark calculation and the beneficiary rebate starting in 2012.<sup>49</sup>

For 2012, MA plans with a quality rating of four or five stars, based on CMS' current five-star rating system, will receive a 1.5 percent increase in their base payment. The 2013 quality bonus equals 3 percent, and for 2014 and beyond, the quality bonus payment will equal 5 percent. The Secretary will establish criteria for new MA plans (plans offered by an organization that has not had an MA contract for the preceding 3 years) to be eligible for quality bonus payments. The quality bonus for new plans will be 1.5 percent in 2012, 2.5 percent in 2013, and 3.5 percent for 2014 and beyond. For certain "qualifying" counties, the bonus percentage is doubled. A quali-

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<sup>49</sup> In general, Medicare Advantage (MA) plans will continue to be paid amounts based on a statutorily determined benchmark, with the payments further adjusted based on a variety of factors, including MA plan bids, the risk scores of MA plan enrollees, and additional factors included in the Affordable Care Act.

For 2012, benchmarks employed in the MA bidding process will be adjusted by using 50 percent of the benchmark set by the former methodology and 50 percent of the Act modified benchmark (which is the cost of traditional fee-for-service Medicare times the applicable percentage for the quartile in which the county is placed). For 2013, the benchmark will generally be 100 percent of the Act modified benchmark, although a longer phase-in is allowed for MA plans in counties that experience the greatest decline in MA payments.

Beginning in 2012, the Act modified MA benchmark in each county will be set at parity with traditional Medicare costs, meaning the average per capita cost of Medicare Part A and Medicare Part B benefits in that county. That payment amount will then be adjusted by the percentage applicable for the quartile in which the county falls. All counties have been allocated to quartiles based on the costs for traditional Medicare. For counties in the highest cost quartile, benchmarks will equal 95 percent of traditional Medicare spending; for counties in the second highest quartile, benchmarks will equal 100 percent of traditional Medicare spending; for counties in the second lowest quartile, benchmarks will equal 107.5 percent of traditional Medicare spending; and for counties in the lowest cost areas, benchmarks will equal 115 percent of traditional Medicare spending.

fyng county is a metropolitan statistical area (MSA) with a population of at least 250,000, where at least 25 percent of MA eligible individuals are enrolled in MA plans, and where traditional Medicare spending is lower than the national per capita cost.

This rebate percentage, however, is reduced over a three-year period beginning in 2012. For those plans with a quality rating of at least 4.5 stars, the rebate will be reduced to 70 percent by 2014. For those plans with a quality rating between 3.5 and 4.5 stars, the rebate will be reduced to 65 percent by 2014. And for those plans with a quality rating below 3.5 stars, the rebate will be reduced to 50 percent by 2014. Plans with low enrollment will be considered as having a quality rating of 4.5 stars and new plans will be treated as having a quality rating of 3.5 stars. Effective January 1, 2011, cost-sharing for MA enrollees may not exceed the applicable cost-sharing under Medicare Parts A and B for the following services: chemotherapy administration; renal dialysis; skilled nursing care; and any other services deemed appropriate by the Secretary. Beginning in 2014, MA plans must have a medical loss ratio of at least 85 percent or be subject to financial and other penalties. Plans that do not meet the minimum MLR threshold must pay the Secretary the difference between 85 percent and the actual MLR multiplied by the total revenue of the MA plan under Medicare Part C for the contract year. If a plan fails to meet the minimum MLR requirement for three consecutive years, it will be prohibited from obtaining new enrollment. If a plan fails to meet the MLR requirement for five consecutive years, the Secretary will terminate the MA plan contract.

O. Medicare Part D Coverage Gap Discount Program, Coverage Gap Rebate for 2010 and Closing the Donut Hole

Medicare Part D includes a gap in coverage, referred to as the “donut hole,” between the initial coverage limit and the catastrophic coverage threshold during which a beneficiary must pay 100 percent of the cost of prescription drugs before catastrophic coverage, paid for by Medicare, begins. The coverage gap has been criticized by beneficiaries and advocacy groups because many people reach the coverage gap quickly each year and must pay thousands of dollars in out-of-pocket expenses for their prescription drugs.<sup>50</sup>

Section 3301 of the Affordable Care Act, as amended by Section 1101 of the Reconciliation Act, provides that in order to cover prescription drugs that will be dispensed on or after January 1, 2011 under Medicare Part D, a drug manufacturer must participate in a new coverage gap dis-

<sup>50</sup> Medicare law sets out a defined standard benefit structure under the Part D prescription drug benefit that includes a gap in coverage, commonly referred to as the “doughnut hole.” In 2010, the standard benefit includes a \$310 deductible and a 25% coinsurance until the enrollee reaches \$2,830 in total covered drug spending (Medicare and beneficiary spending combined). After this initial coverage limit is reached, the enrollee is responsible for the full cost of the drugs until total costs hit the catastrophic threshold, \$6,440 in 2010. In general, in 2010, Part D enrollees who do not receive assistance in the form of the Part D low-income subsidy would be responsible for a total of \$4,550 in out-of-pocket costs before reaching the catastrophic phase (\$310 deductible, \$630 in co-insurance in the initial coverage phase, and \$3,610 in the coverage gap).

count program that provides a 50 percent discount on applicable drugs provided to applicable beneficiaries that fall into the coverage gap known as the “donut hole.” The program will require a manufacturer to provide beneficiaries discounted prices for applicable drugs at the pharmacy or by the mail order service at the point-of-sale.

The Medicare Part D coverage gap will be substantially reduced by 2020, with changes phased in over several years. The Act provides for a 25 percent federal subsidy for brand-name drugs for Part D beneficiaries in the coverage gap. The subsidy will operate to lower the beneficiary’s coinsurance rate while in the coverage gap from 100 percent to 75 percent, phased in gradually beginning in 2013, and increasing incrementally until it reaches the full 25 percent subsidy in 2020. Similarly, the Act provides for a federal subsidy for generic drug expenses incurred within the coverage gap. This subsidy will also be phased in gradually beginning in 2011 at a rate of 7 percent and increasing each year to reach 75 percent in 2020. The subsidy will reduce the beneficiary’s coinsurance rate for generic drugs from 100 percent to 25 percent.

This provision incorporates a voluntary agreement with the Pharmaceutical Research and Manufacturers of America (PhRMA) to provide discounts of 50 percent for brand-name drugs used by Part D enrollees in the Part D coverage gap. Manufacturers of prescription drugs will be required to enter into agreements with Medicare Part D drug plan sponsors to provide discounts on drugs provided to plan enrollees in the coverage gap period beginning January 1, 2011. The amount of the discount, in addition to the amount actually paid by the enrollee, will count toward costs incurred by the plan enrollee. Plan enrollees receiving the low-income subsidy or enrolled in an employee-sponsored retiree drug plan will not be eligible for the discount. Drugs sold and marketed in the U.S. by a manufacturer will not be covered under Part D unless the manufacturer agrees to participate in the discount program. The provision also requires the Secretary to contract with a third party entity (or entities) to administer the drug discount program and to establish performance requirements and data standards for the third-party contractor(s).

Section 1101 of the Reconciliation Act added provisions to close the coverage gap by 2020 and to provide for an immediate reduction in costs for beneficiaries who enter the coverage gap in 2010. Specifically, in 2010, Medicare Part D enrollees who enter the coverage gap will receive a rebate of \$250. Additionally, the Reconciliation Act reduces beneficiary cost sharing for brand-name drugs from 100 percent in 2010 to 25 percent by 2020. In 2011 and 2012, per the manufacturer discount provision in the Act, beneficiary cost sharing will be reduced to 50 percent of the price of the drug. In 2013 and beyond, the Medicare program will cover additional costs beyond the 50 percent discount to further reduce cost sharing; in total, beneficiary cost sharing for brand-name drugs during the coverage gap will be 47.5 percent in 2013 and 2014, 45 percent in 2015 and 2016, 40 percent in 2017, 35 percent in 2018, 30 percent in 2019, and 25 percent in 2020 and beyond (in 2020, the manufacturer discounts account for 50 percent of the reduction and the Medicare Part D program pays the remaining 25 percent). For generic drugs, which are not subject the required 50 percent discount, beneficiary cost sharing in the coverage gap will be reduced to 93 percent in 2011; in 2012 and for each succeeding year, the percentage will de-

crease by an additional 7 percent, until 2020 when cost-sharing will equal 25 percent (in 2020, the Medicare Part D program will pay 75 percent of the cost of generic drugs).<sup>51</sup>

## VI. Physician Ownership and Other Transparency, Hospital Finance and Governance, and other Matters

### A. Physician Owned Hospitals

Physicians are generally prohibited under the Stark law from referring Medicare patients for certain services to facilities in which they or their immediate family members have financial interests. However, among other exceptions, physicians are not prohibited from referring patients to hospitals in which they have ownership or investment interests that include the hospital's entire business (the so-called "whole hospital exception"). Providers that furnish substantially all designated health services to individuals residing in rural areas are exempt as well.

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<sup>51</sup> The donut hole coverage gap will be partially closed in 2010 by the Secretary providing a \$250 rebate to individuals enrolled in a Medicare prescription drug plan (PDP) who, as of the end of a calendar year quarter, have reached the coverage gap by incurring costs for covered Part D drugs exceeding the initial coverage limit. The Medicare Coverage Gap Discount Program (Gap Discount Program) is established in 2011. Under the Gap Discount Program, manufacturers of brand name drugs must enter into agreements with the Secretary to offer enrollees who reach the coverage gap a 50 percent discount off of the negotiated price for Part D drugs on the enrollees' Part D plan formulary or drugs otherwise covered by their plan. Failure to participate would remove a manufacturer's drugs from Part D coverage. The discounts are to be provided at the pharmacy or by mail order service at the point-of-sale (though in the first year, if point-of-sale discounts are not practicable, the Secretary can allow discounts to be provided as soon as practicable after point-of-sale). The Secretary will establish procedures and enter into a contract with one or more third parties to transmit information, distribute funds, and otherwise administer the program. The final 2011 Part D payment notice specifies that Part D sponsors must make these discount prices available to their Part D enrollees at the point-of-sale, and that subsequent guidance will address how Part D sponsors will be reimbursed for the discounts made available at point-of-sale. The costs paid by manufacturers are considered incurred costs for beneficiaries and applied towards their out-of-pocket threshold. Also beginning in 2011, the standard Part D benefit must provide coverage for generic drugs in the coverage gap. This coverage is phased in – the standard benefit will require enrollee coinsurance for generic drugs in the coverage gap equal to 93 percent (or be actuarially equivalent to an average expected payment of 93 percent) starting in 2011, and will reach 25 percent by 2020. The standard Part D benefit is also required to provide some coverage of brand name drugs in the coverage gap for a beneficiary who has coinsurance for these brand name drugs. This coverage is phased in as well - starting in 2013 the standard benefit will require 97.5 percent enrollee coinsurance for brand drugs in the coverage gap, and by 2020, it will require 75 percent enrollee coinsurance. This plan coverage for brand drugs in the coverage gap is provided to beneficiaries in addition to the Gap Discount Program. The \$250 rebate, the Gap Discount Program, and the other reduced coverage gap cost sharing required under the Act do not apply to Part D enrollees who receive the low income subsidy or who are enrolled in qualified retiree drug plans. In certain emergency situations, the Secretary may exempt a manufacturer from participation in the Gap Discount Program.

Entities receiving Medicare payment for covered items and services are required to provide the information on the entities' ownership, investment, and compensation arrangements. This information includes the covered items and services provided by the entity, and the names and unique physician identification numbers of all physicians (or their immediate relatives) who have an ownership or investment interest, or certain compensation arrangements.

The Affordable Care Act provides that physician-owned hospitals that do not have a provider agreement prior to December 31, 2010, are prohibited from participating in Medicare. Such hospitals that have a provider agreement prior to December 31, 2010, may continue to participate in Medicare under certain requirements addressing conflict of interest, bona fide investments, patient safety issues, and expansion limitations. Inpatient acute care hospitals have new requirements to qualify under either the rural provider or hospital ownership exceptions to the kind of physician ownership or investment interest that would result in prohibition of referrals by the physician to that entity.

References to various operative dates created an ambiguity - the Act requires that a hospital have physician owners by December 31, 2010, but also states that those owners cannot hold a percentage in excess of what was held by physicians on the date of enactment, March 23, 2010. CMS recently clarified the issue through its proposed rule and comments regarding hospital outpatient prospective payment system and ambulatory surgical center payment system, issued on July 2, 2010. CMS stated that:

"Reading these provisions together, we conclude the following: (i) if a hospital had no physician ownership or investment as of March 23, 2010, it will not qualify for the whole hospital or rural provider exceptions if it adds any physician owners or investors after that date; and (ii) if a hospital had physician ownership or investment as of March 23, 2010, it may reduce the number of physician owners or investors, provided that the percentage of the total value of physician ownership or investment interests, in the aggregate, remains the same or decreases."

Another clarification provided by CMS in this proposed rule relates to the limitation on a hospital to expand the number of operating rooms, procedure rooms and beds it had on March 23, 2010 (or if the hospital did not have a provider agreement in effect then, but does by December 31, 2010, the date of the provider agreement). CMS commented that "the limitation on expansion applies to operating rooms and procedure rooms regardless of whether a State licenses these rooms." Although CMS declined to define "procedure rooms" more broadly, as permitted by the Act, it encouraged "public comments on whether 'procedure rooms' should include rooms where additional services, such as CT or PET scans, or other services, are performed."

Along with limiting construction of new physician owned hospitals or the expansion of existing physician owned hospitals, the Act imposes reporting obligations for each hospital that is owned in whole or in part by physicians. Under the Act, such hospitals must submit an annual report

describing the identity of each physician, owner, and investor and the nature and extent of all ownership investment interests in the hospital.

*B. Transparency Reporting of Physician Ownership and Investment*

As provided in Section 6002 of the Affordable Care Act, on March 31, 2013, and every year thereafter, any applicable pharmaceutical or medical device manufacturer is required to make annual disclosure concerning payments to physicians and certain other providers. Under the Act, applicable manufacturers must report certain types of payments or other transfers of value to physicians and teaching hospitals. The report will need to include the name and address of the recipient, the amount of payments or other transfer of value, and a description of the form and nature of the payment. Under the Act, payments or other transfers of value that require disclosure include consulting fees, compensation for services, honoraria, gifts, entertainment, food, travel, and a variety of other grants and other consideration that may be given to physicians and teaching hospitals. In addition to reporting these gifts and transfers of value, beginning March 31, 2013, and every year thereafter, pharmaceutical and medical device manufacturers and applicable group purchasing organizations will be required to disclose any and all ownership held by a physician in the company. Failure to submit the required information may result in a Civil Monetary Penalty of not less than \$1,000 but not more than \$10,000 for each payment or other transfer of value or ownership or investment interest not reported.<sup>52</sup>

*C. In-Office Ancillary Services Disclosures*

New patient disclosure requirements for the in-office ancillary services' exception to the prohibition against physician self-referral for certain specified imaging services have been created under section 6003 of the Affordable Care Act. The new disclosure requirements apply to referrals for magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and any other designated health services specified under Social Security Act Section 1877(h)(6)(D) that the Secretary determines appropriate (i.e., radiology, MRI, computerized axial tomography (CAT) scans, and ultrasound services). The referring physician must inform the patient in writing at the time of the referral that he or she may obtain the imaging services for which they are being referred from (1) a person other than the referring physician, (2) a physician who is a member of the same group practice as the referring physician, or (3) an individual who is directly supervised by the physician or by another physician in the group practice. The referring physician also must provide the patient with a written list of suppliers who furnish such services in the area in which the patient resides. The written disclosure requirement will apply to services furnished on or after January 1, 2010.<sup>53</sup>

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<sup>52</sup> Several states, including Massachusetts and Vermont have passed their own transparency or disclosure laws.

<sup>53</sup> Social Security Act Sec. 1877(b)(2) states that if a physician (or an immediate family member of a physician) has a financial relationship with an entity, the physician may not make a referral to the entity for

#### D. Prescription Drug Samples

Section 6004 of the Act requires manufacturers and authorized distributors of pharmaceuticals to report to the Secretary the identity and quantity of drug samples requested and the identity and quantity of drug samples actually distributed. The report must include the name, address, professional designation, and signature of the practitioner that makes the request. The first report is due on April 1, 2012, and subsequent reports are due on April 1 of each year thereafter. The Act does not include any requirement that CMS process or disclose this information.<sup>54</sup>

#### E. Pharmacy Benefit Managers Transparency

The Act requires that pharmacy benefit managers (“PBM”) provide the Secretary with certain information including the percentage of all prescriptions that were provided through mail order pharmacies as opposed to retail pharmacies and the percentage of prescriptions for which a generic drug was available and dispensed.

PBMs serve as third-party administrators between health insurance plans, pharmaceutical manufacturers, and pharmacies. The reporting requirements applies to health benefits plans or any entity that provides pharmacy benefits management services on behalf of a health benefits plan that manages prescription drug coverage under contract with (1) a prescription drug plan sponsor of a prescription drug plan or an Medicare Advantage organization offering a Medicare Advantage prescription drug plan under Medicare Part D; or (2) a qualified health benefits plan offered through a health insurance exchange established under the Act. In addition to mail order and generic information, PBMs are also required to disclose the aggregate amount and type of rebates, discounts or price concessions that are attributable to patient utilization under the plan. Further, PBMs are required to disclose the aggregate amount of rebates, discounts or price concessions

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the furnishing of designated health services (DHS) for which payment may be made under Medicare or Medicaid, and the entity may not present (or cause to be presented) a claim to the federal health care program or bill to any individual or entity for DHS furnished pursuant to a prohibited referral. One of the many exceptions to this prohibition is for in-office ancillary services. This exception permits the furnishing of certain designated health services that are ancillary to the referring physician’s medical services and where certain supervision, location, and billing requirements are met.

<sup>54</sup> Section 503(d) of the Federal Food Drug and Cosmetic Act of 1938 (FDCA), prohibits any person from distributing drug samples. This general prohibition, however, does not apply to (1) a practitioner licensed to prescribe such drug, (2) a health care professional acting at the direction and under the supervision of such a practitioner, or (3) a pharmacy of a hospital or of another health care entity that is acting at the direction of such a practitioner and that received such sample as set forth below (FDCA Sec. 503(d)(1)). In addition, the manufacturer or authorized distributor of record of a drug may distribute drug samples by mail or common carrier to practitioners licensed to prescribe such drugs or, at the request of a licensed practitioner, to pharmacies of hospitals or other health care entities (FDCA Sec. 503(d)(2)(A)).

that are passed through to the plan sponsor and the total number of prescriptions that were dispensed. The report would exclude bona fide service fees such as distribution service fees, inventory management fees, and fees associated with administrative service agreements and patient care programs. Finally, PBMs would be required to disclose the aggregate amount of the difference between the amount the health benefit plan pays the PBM and the amount that the PBM pays retail pharmacies and mail order pharmacies, as well as the total number of prescriptions that were dispensed. This information would be held confidential and not disclosed by the Secretary.

#### F. *Standard Hospital Charges*

Section 10101 of the Affordable Care Act requires each hospital operating within the United States to establish, update, and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups. The effective date of this change is not specified in the law.

#### G. *Charitable Hospitals*

The Affordable Care Act contains specific requirements for hospitals that wish to receive or maintain their tax-exempt status under section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). In particular, Section 9007 of the Act adds new section 501(r) to the Code, which supplements the community benefit standard generally applicable to tax-exempt hospitals. For the past 40 years, the availability of tax exemption has been judged by the community benefit standard. In effect, Section 9007 codifies and elaborates on certain key aspects of the community benefit standard.

New section 501(r) applies to any organization that operates a facility required by any state to be licensed, registered, or otherwise recognized as a hospital. If an organization has more than one hospital facility, each facility must meet the requirements of new section 501(r) individually or the facility will not be treated as a tax-exempt organization under section 501(c)(3) of the Code.

The Act adds four requirements, in addition to the general requirements of section 501(c)(3) of the Code, that hospitals must satisfy in order to safeguard tax-exempt status under section 501(c)(3).

(1) **Community Health Needs Assessment.** Each tax-exempt hospital must conduct a "community health needs assessment" at least once every three years and adopt an "implementation strategy" to meet the needs identified by the assessment. The assessment itself must take into account input from a broad cross-section of the community served by the hospital, including those with special knowledge of or expertise in public health, and be made widely available to the public.

(2) **Financial Assistance Policy.** Additionally, each tax-exempt hospital must establish, implement, and make widely available written policies regarding financial assistance and emergency

medical care. The financial assistance policy must specify eligibility criteria (including whether the assistance includes free or discounted care) and state how the hospital calculates the amounts that are billed to patients. For a hospital that does not have separate billing and collections policies, the hospital must have a policy that accounts for the actions that the hospital takes in the event of non-payment. Further, the hospital must have a written policy requiring it to provide non-discriminatory emergency medical care to all individuals, regardless of an individual's eligibility for financial assistance.

(3) **Limitations on Charges.** The Act provides that each tax-exempt hospital must limit the amount it charges for emergency or other medically necessary care provided to patients eligible for financial assistance to not more than the lowest amounts charged to insured patients. The policy also must prohibit the use of "gross charges" when billing individuals who qualify for financial assistance.

(4) **Limitations on Billing and Collections Practices.** Finally, a tax-exempt hospital must meet certain billing and collections requirements. The Act provides that a tax-exempt hospital cannot take "extraordinary collection actions" (lawsuits, arrests, liens, or other similar actions) until it has made "reasonable efforts" to determine whether a patient is eligible for financial assistance. The term "reasonable efforts" is not defined by the Act.

The Act also adds a section to the Internal Revenue Code that imposes a \$50,000 excise tax for any taxable year in which a tax-exempt hospital fails to meet the needs assessment requirement of new section 501(r).

In addition to the operational changes, the IRS will review the tax-exempt status of each hospital every three years.<sup>55</sup> Tax-exempt section 501(c)(3) hospitals will also be subject to the following additional reporting requirements on their annual Form 990 filed with the IRS:

- A description of the level of charity care.
- A designation of how the hospitals meet the needs identified in the health assessment or an explanation if those needs are not being met.
- A description of unreimbursed costs of means tested and non-means tested programs.

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<sup>55</sup> In the anticipation of health care reform, the IRS incorporated the following information requests into Schedule H of the 2009 Form 990 regarding charity care and community benefit: cost, revenue offset, and net cost of charity care; lack of reimbursement from Medicaid; amount of community/health improvement services, research, cash, and in-kind contributions; and information on how the hospital's charity care policy is communicated to patients.

The Act also requires the Department of Treasury and the Department of Health and Human Services to submit an annual report to Congress on the level of charity care, bad debt expenses, and the unreimbursed costs of means tested and non-means tested government programs.

- Audited financial statements, prepared either on a separate or consolidated basis, which will be subject to the public disclosure rules applicable to Form 990 and therefore will be made available to the public.

In general, these provisions are effective for taxable years beginning after March 23, 2010, although the community health needs assessment requirement becomes effective for taxable years beginning after March 23, 2012, and the excise tax provision is effective immediately.

#### H. Sense of Senate on Medical Malpractice

Section 6801 of the Act expresses the Sense of the Senate that (1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; (2) states should be encouraged to develop and test litigation alternatives while preserving an individual's right to seek redress in court; and (3) Congress should consider establishing a state demonstration program to evaluate alternatives to the existing civil litigation system with respect to medical malpractice claims.<sup>56</sup>

#### I. Medical Tort Litigation Alternatives Demonstration Program

Section 10607 of the Affordable Care Act authorizes \$50 million over five years for grants to states "for the development, implementation and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations." The alternatives must emphasize patient safety, disclosure of health care errors, and early resolution of disputes, but the Act does not address frivolous lawsuits, limitations on non-economic damages, or other reforms. Patients must be able to opt-out of these alternatives at any time and be free to sue for malpractice. The Secretary will select the proposals in consultation with a panel of stakeholders, including attorneys representing patient and health care pro-

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<sup>56</sup> After carefully considering the economic literature and conducting its own statistical analysis of the data, CBO has not found consistent evidence that changes in the medical malpractice environment would have a measurable impact on health care spending. In part that is because the estimated effects of limits on malpractice torts vary substantially across different measures of health care spending and across different types of tort limits. In some cases, specific tort limits appear to be associated with reductions in health care spending; in other cases, there appears to be no relationship; and in still other cases, tort limits appear to be associated with higher spending (a finding that is counterintuitive). That data analysis also indicated the challenges involved in using statistical methods to separate the effects of tort reforms from the impact of other factors that might affect spending on health care. See Congressional Budget Office, *Medical Malpractice Tort Limits and Health Care Spending*, Background Paper (April 2006), for the details of that research and other studies examining defensive medicine.

viders. Preference must be given to proposals developed in consultation with “relevant stakeholders,” including attorneys representing patients and health care providers.<sup>57</sup>

J. Patient-Centered Outcomes Research Institute

Section 6301 of the Affordable Care Act establishes an independent, not-for-profit corporation as a new center for comparative effectiveness research (“CER”) in healthcare costs and quality. The Patient-Centered Outcomes Research Institute (the “Institute”), will lead efforts to prioritize and fund CER through a largely stakeholder-driven process.<sup>58</sup>

The Institute will establish and execute a national CER agenda by identifying research priorities and funding and facilitating new CER studies. These studies will consist of both systematic reviews of existing evidence and new prospective research, including clinical trials and observational studies.

The purpose of the Institute is “to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and ap-

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<sup>57</sup> These grants would exist for no more than five years. State grantees would be required to develop an alternative that (1) allows for the resolution of disputes caused by health care providers or organizations; and (2) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data. Each state would have to identify the sources from and methods by which compensation would be paid, and demonstrate that its proposed alternative to tort litigation meets certain goals and criteria. The Secretary would have to provide to the states that are applying for the grants technical assistance, including guidance on common definitions, non-economic damages, avoidable injuries, and disclosure to patients of health care errors and adverse events. The Secretary would be required to consult with a review panel composed of relevant experts appointed by the Comptroller General when reviewing states’ applications. Furthermore, each state receiving a grant would be required to submit a report to the Secretary covering the impact of the activities funded on patient safety and on the availability and price of medical liability insurance. The Secretary would be required to submit a report to Congress that examines any differences that may result in the areas of quality of care, number and nature of medical errors, medical resources used, length of time for dispute resolution, and the availability and price of liability insurance. Additionally, the Secretary, in consultation with the review panel, would be required to conduct an overall evaluation of the effectiveness of grants awarded, and to submit the findings of such evaluation to Congress.

The Medicare Payment Advisory Commission would be required to conduct an independent review of the impact of state-implemented alternatives to tort litigation on the Medicare program and its beneficiaries. The Medicaid and CHIP Payment and Access Commission would be required to conduct a similar evaluation with respect to the Medicaid and CHIP programs and their beneficiaries.

<sup>58</sup> Section 6302 of the Act terminates the Federal Coordinating Council for CER (established under the American Recovery and Reinvestment Act) on the date of enactment.

appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of medical treatments, services, and items.”

The specific duties of the Institute are to:

- Establish an objective research agenda;
- Develop research methodological standards;
- Contract with eligible entities to conduct the research;
- Ensure transparency by requesting public input; and
- Disseminate the results to patients and healthcare providers.

A variety of entities are eligible to receive funding contracts, including federal agencies, academic institutions, and private research organizations. The Agency for Healthcare Research and Quality (“AHRQ”) and the National Institutes of Health (“NIH”) will receive priority funding consideration. Data collected by the Centers for Medicare and Medicaid Services (“CMS”) will be made available to contracting research groups, and the Institute may request data from other federal, state, and private entities hosting patient registries and other databases. The Institute will emulate the peer-review processes of the NIH and AHRQ.

A standing methodology committee will lead efforts to identify and refine methodological standards for different types of CER study designs, such as pragmatic clinical trials, randomized controlled trials, and patient registries. The 15-member committee will be composed of experts in comparative effectiveness methods, biostatisticians, epidemiologists, health services researchers, and other experts. The committee must begin releasing methodological standards for conducting CER within 18 months of the establishment of the Institute. These standards will be used to select proposed studies for funding and to guide researchers as they design trials. In addition, the committee will develop tools to help researchers determine which methods are most appropriate for a particular research question.

The Institute will form a number of internal advisory panels to set research priorities and oversee clinical trials. These panels will include practicing clinicians, patient and consumer representatives, clinical and health services researchers, payers, manufacturers, and others. Notably, the health reform bill requires the Institute to provide patients and consumers with the extra support, tools, and resources necessary to be effective members of these advisory panels. In addition, there will be public comment periods to allow the general public to provide feedback to the Institute on proposed priorities and other key decisions, in an effort to make the work of the Institute and advisory panels as transparent as possible.

The law allows CMS to use CER evidence in coverage and/or reimbursement decisions as long as the coverage process is an iterative one—a standard that the current CMS national coverage determination process meets. CMS may also use CER to establish differential copayments,

which could be used in a value-based insurance design program. The bill specifically prohibits any cost-effectiveness analysis that would use any adjusted life years factor that would place lower value on the life of elderly, disabled, or terminally ill individuals compared to younger and healthier individuals.

Research findings must be released to the general public no later than 90 days after they are available. The Office of Communications and Knowledge Transfer at AHRQ will facilitate the wide dissemination of findings, with assistance from NIH. This will include consultation with medical and clinical associations to ensure that findings are translated into clinical decision support tools.

The Institute will have an internal staff led by an executive director and will utilize outside experts and consultants. In addition, the Institute will be guided by a Board of Governors, which will include the directors of NIH and AHRQ, patient advocates, consumer representatives, physicians, nurses, hospitals, private payers, drug and device industries, quality improvement organizations, and other federal and state health agencies. The Comptroller of the United States will appoint members to the Board for six year terms and will designate a chair and vice chair.

The Institute will be funded through the Patient-Centered Outcomes Research Trust Fund (PCORTF), which will consist of funding streams from general revenues, an annual \$2 fee per Medicare beneficiary transferred from the Medicare Trust Fund, and an annual \$2 fee per covered-life assessed on private health plans. The Medicare Trust Fund transfer and annual fee on insured and self-insured plans does not take effect until 2013. By 2015, total annual funding for the Institute will reach nearly \$500 million.

## VII. Financing and Revenue Provisions

### A. Excise Tax on Sales of Medical Devices

Under the provision, a tax equal to 2.3 percent of the sale price is imposed on the sale of any taxable medical device by the manufacturer, producer, or importer of such device. A taxable medical device is any device, defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act, intended for humans. The excise tax does not apply to eyeglasses, contact lenses, hearing aids, and any other medical device determined by the Secretary to be of a type that is generally purchased by the general public at retail for individual use. The Secretary may determine that a specific medical device is exempt under the provision if the device is generally sold at retail establishments (including over the internet) to individuals for their personal use. It is anticipated that the Secretary will publish a list of medical device classifications that are of a type generally purchased by the general public at retail for individual use.

Section 1405 of the Reconciliation Act repealed Section 9009 of the Affordable Care Act (relating to an annual fee on medical device manufacturers and importers) and replaced it with this excise tax.

The provision applies to sales after December 31, 2012.

*B. Increased Medicare Payroll Tax*

Employers and employees each pay a payroll tax of 1.45 percent to finance Medicare Hospital Insurance (Part A). The Act includes additional hospital insurance taxes on high-income taxpayers. Specifically, the Act imposes an additional payroll tax of 0.9 percent on high-income workers with wages over \$200,000 for single filers and \$250,000 for joint filers, effective for taxable years after December 31, 2012. Married taxpayers filing separately are subject to a \$125,000 threshold. The additional payroll tax only applies to wages above these thresholds. Thus, the HI portion of the payroll tax will increase from 1.45 percent to 2.35 percent for wage income over the threshold amounts. For wage earners, the Act requires the employer to withhold the employee's tax from wages paid to the employee in excess of \$200,000. In determining its withholding obligation, the employer is not required to consider wages that may be received by the employee's spouse that would be subject to this tax. Additional revenues from this provision are transferred to the Medicare Hospital Insurance Trust Fund (Part A). In contrast to income tax brackets and the wage cap on Social Security taxes, thresholds for the additional HI tax are not indexed for inflation.<sup>59</sup>

As stated above, the provision applies to taxable years beginning after December 31, 2012.

*C. Unearned Income Medicare Contribution Tax*

The Act includes an unearned income Medicare tax levied on income from interest, dividends, capital gains, annuities, royalties, and rents, other than such income that is derived in the ordinary course of a trade or business and not treated as a passive activity. The Act taxes this income at a rate of 3.8 percent. Because the tax applies to "gross income" from these sources, income that is excluded from gross income, such as tax-exempt interest, is not taxed. The tax is applied against the lesser of the taxpayer's net investment income or modified adjusted gross income (AGI) in excess of the threshold amounts. These thresholds are set at \$200,000 for singles and \$250,000 for joint filers. The contribution and the 0.9 percent additional HI tax on earned income apply independently.

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<sup>59</sup> There are two Medicare trust funds under present law, the Hospital Insurance (HI) fund and the Supplementary Medical Insurance (SMI) fund. The HI trust fund is primarily funded through payroll tax on covered earnings. Employers and employees each pay 1.45 percent of wages, while self-employed workers pay 2.9 percent of a portion of their net earnings from self-employment. Other HI trust fund revenue sources include a portion of the Federal income taxes paid on Social Security benefits, and interest paid on the U.S. Treasury securities held in the HI trust fund. For the SMI trust fund, transfers from the general fund of the Treasury represent the largest source of revenue, but additional revenues include monthly premiums paid by beneficiaries, and interest paid on the U.S. Treasury securities held in the SMI trust fund.

Net investment income from a passive activity as well as income from a trade or business of trading financial instruments or commodities as defined by existing mark-to-market tax rules for dealers of commodities is subject to tax. Income on an investment of working capital is also taxed. Generally, a taxpayer may reduce net investment income by any deductions properly allocable to taxed income. Some types of income are exempt from the tax, including income from the disposition of certain active partnerships and S corporations, distributions from qualified plans, and any item taken into account in determining self-employment income. The tax does not apply to nonresident aliens or trusts for which all of the unexpired interests are devoted to charitable purposes.

The Act defines modified adjusted gross income as AGI increased by any income excluded by the foreign earned income exclusion over the deductions and exclusions disallowed with respect to that income. For estates and trusts, the tax applies on the lesser of the undistributed net investment income or the excess of adjusted gross income over the dollar amounts at which the 39.6 percent tax bracket for estates and trusts begins. The Act clarifies the thresholds that apply under the Medicare tax increase on wages for married taxpayers filing separately. In this case, it is one-half of the amount for joint filers. The Act also clarifies that the Medicare tax on wages also is subject to estimated tax payment rules.

The provision applies to taxable years beginning after December 31, 2012.

#### *D. Medical Expense Deduction Reduced*

Currently, taxpayers can take deductions for unreimbursed medical expenses to the extent such expenses exceed 7.5 percent of the taxpayer's adjusted gross income. The Act raises this "floor" to 10 percent of adjusted gross income. This provision becomes effective January 1, 2013. However, the 7.5 percent adjusted gross income floor will remain at that level through 2016 for individuals age 65 or older.

#### *E. Excise Tax on High Cost Employer Sponsored Health Coverage*

Beginning in 2018, the Act imposes a nondeductible 40 percent excise tax on the "excess benefit" provided in any month under any employer-sponsored health plan. An excess benefit is a benefit the cost of which, on an annual basis, exceeds \$10,200 a year for individuals or \$27,500 for families. In 2019, these threshold amounts will be indexed annually to the Consumer Price Index for All Urban Consumers (CPI-U) plus 1 percentage point. After 2019, the threshold amounts will be indexed annually to CPI-U.

The excise tax is imposed proportionately on each coverage provider. To the extent that coverage is provided under an employer plan provided through insurance coverage, the issuer of the coverage is liable for the tax. The plan administrator must pay the tax in the case of a self-insured group health plan, a health flexible spending arrangement (FSA), or a health reimburse-

ment arrangement (HRA). The employer must pay with respect to employer contributions to a health savings account (HSA) or medical savings account (MSA).

In determining the aggregate cost, all employer-sponsored health insurance coverage is taken into account, including coverage in the form of reimbursements under a Health FSA or an HRA, contributions to an HSA, and other supplementary health insurance except dental and vision plans. Employer-sponsored health coverage is health coverage offered by an employer to an employee without regard to whether the employer provides the coverage or the employee pays the coverage with after-tax dollars. In the case of a self-employed individual, employer-sponsored health insurance coverage is coverage for which a deduction is allowable with respect to all or any portion of the coverage.

Employers will be penalized for undervaluing the insurance cost subject to the excise tax. The penalty will equal the amount of any additional excise tax that the insurer or administrator would have owed if the employer had reported correctly, plus interest to be accrued from the date the tax otherwise would have been paid to the date the penalty is paid.

The Act adjusts the threshold for the excise tax in the case of certain individuals. Retirees and “high-risk” professions – For retired individuals over the age of 55 and for plans that cover employees engaged in high-risk professions, the threshold amount is increased by \$1,650 for individual coverage and \$3,450 for family coverage. In 2018, these threshold amounts will be indexed annually to the CPI-U plus 1 percentage point. After 2019, the threshold amounts will be indexed annually to CPI-U. High-risk professions include law enforcement officers, firefighters, members of a rescue squad or ambulance crew, longshoremen, and individuals engaged in the construction, mining, agriculture (but not food processing), forestry, or fishing industries.

In addition, the Act also exempts plans that provide some already legally excepted benefits under the Health Insurance Portability and Accountability Act of 1996, including coverage only for accident and disability income, coverage for a specific disease or illness, and hospital indemnity insurance. Under the Act, the threshold amount cannot be increased by more than \$1,350 for individual coverage or \$3,000 for family coverage, even if the individual would qualify for an increased threshold both on account of his or her status as a retiree over age 55 and as a participant in a plan that covers employees in a high-risk profession.

The excise tax applies to taxable years beginning after 2017.

#### F. Annual Fee on Health Insurance Providers

An annual fee will be imposed on covered entities providing health insurance with respect to U.S. health risks. The fee does not apply to accident and disability, indemnity, long-term, or Medicare supplemental insurance. The fee is apportioned among the providers based on their relative market share and is calculated by taking the provider’s net premiums written (including net premiums of its affiliates under common control) with respect to health insurance as a percentage

of the total net premiums written with respect to health insurance for all U.S. health insurance providers.

The fee is assessed by the Secretary of Treasury by reference to the provider's market share for each calendar year and is to be paid on a date determined by the Secretary in the following year, but not later than September 30. To determine market share and the fee imposed on each covered entity, health insurance providers are required to report, by a date to be determined by the Secretary, net premiums written. A failure to report this information will result in the imposition of penalties, unless reasonable cause is shown. The Secretary is permitted to rely on any other sources of available information (annual financial statements) to verify or supplement the reports submitted by covered entities. The Act provides that the first \$25 million of net premiums written will not be taken into account and only half of net premiums between \$25 and \$50 million will be considered. For net premiums written in excess of \$50 million, 100 percent are included in the calculation. For this purpose, "net premiums written" is intended to mean premiums written, including reinsurance premiums written, reduced by reinsurance ceded and certain commissions paid.

Under the Act, covered entities subject to the fee do not include employers to the extent they self-insure employee health risks, governmental entities (other than those providing insurance through the Act's community health insurance option), certain nonprofit insurers of last resort, and certain nonprofit insurers with a medical loss ratio of 90 percent or more. The Act also creates limited exceptions for plans that serve a critical purpose, including plans serving a high percentage of seniors and disabled individuals. For tax exempt service providers, only 50 percent of net premiums written will be taken into account.

For health insurance providers, the aggregate annual fees imposed are \$8 billion for 2014, \$11.3 billion for 2015 and 2016, \$13.9 billion for 2017, and \$14.3 billion for 2018. For years after 2018, the fee is the amount applicable for the preceding year, increased by the rate of premium growth as calculated for the premium tax credits included in the Act.

The fee is first payable in 2014 relating to net premiums written in 2013.

#### *G. Fee on Pharmaceutical Manufacturers and Importers*

The Act imposes an annual fee on pharmaceutical manufacturers and importers of branded prescription drugs (including certain biological products). The aggregate annual fees imposed on covered entities will be \$2.5 billion for 2011, \$2.8 billion for 2012 and 2013, \$3 billion for 2014 through 2016, \$4 billion for 2017, \$4.1 billion for 2018, and \$2.8 billion a year thereafter. The fees will be allocated by reference to each entity's proportionate share of total branded prescription drug sales during the prior calendar year to (or pursuant to coverage under) a "specified government program," meaning Medicare Part D, Medicare Part B, Medicaid, Departments of Veterans Affairs and Defense programs, or the TRICARE retail pharmacy program. The Secretary of the Treasury will assess the fees on the basis of information provided by the Departments

of HHS, Veterans Affairs and Defense; and the Secretary may also consider any other sources of available information. The fees imposed with respect to drug sales during the prior calendar year must be paid by a date during the current year to be determined by the Secretary of the Treasury, but not later than September 30. The Act adds joint and several liability for the fee if, with respect to a single covered entity, more than one person is liable for payment under the controlled group rules.

If during a calendar year a covered entity (including its affiliates under common control) has less than \$5 million of branded prescription drug sales to a specified government program or pursuant to coverage under such a program, it will be treated as having no market share and no fee will be imposed. For sales of branded prescription drugs between \$5 million and \$125 million, only 10 percent of such sales are taken into account when determining the applicable fee. For sales between \$125 million and \$225 million, 40 percent of such sales are taken into account; and for sales between \$225 and \$400 million, 75 percent of such sales are considered. To the extent that a covered entity's sales of branded prescription drugs to a specified government program exceed \$400 million, 100 percent of such excess sales are taken into account to compute the entity's market share.

Sales of so called "orphan drugs" for rare diseases and conditions are disregarded for purposes of determining fee amount, until such drugs are approved for broad use by the Food and Drug Administration (FDA).

The Act does not contain any provisions requiring the manufacturers and importers themselves to provide information regarding their sales of branded prescription drugs. Instead, information reporting requirements with respect to sales of branded prescription drugs (taking into account certain rebates, discounts, or other price concessions) apply to the government agencies that administer the specified government programs that directly purchase such drugs or that provide coverage for the purchase of such drugs by others. The fees collected will be credited to the Medicare SMI trust fund.

The fee will first be payable in 2011 with respect to sales in 2010.

#### H. Excise Tax on Medical Device Manufacturers

The Act imposes an excise tax of 2.3 percent on the sale price of any taxable medical device sold by manufacturers and importers beginning in 2013. The Act generally applies to sales for use in the United States of any medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans. The tax does not apply to eyeglasses, contact lenses, hearing aids, and any other device deemed by the Secretary to be of the type available for regular retail purposes.

I. Excise Tax on Indoor Tanning Services

The Act imposes a 10 percent tax on amounts paid for indoor tanning services, whether or not an individual's insurance policy covers the service. The tax imposed is to be paid by the individual on whom the service is performed. The service provider is obligated to collect the tax from the customer and becomes liable for the tax if it does not do so. Indoor tanning services are defined as services that use an electronic product with one or more ultraviolet lamps to induce skin tanning.

The provision is effective for services performed on or after July 1, 2010.

J. Deduction Limits for Compensation Paid by Health Insurance Providers

The Act limits the deduction for compensation for services provided by certain individuals to a covered health insurance provider to \$500,000 per year. For this purpose, an employer is a covered health insurance provider" for a year (after 2012) if at least 25 percent of the provider's gross premium income is derived from health insurance plans that meet the minimum creditable coverage requirements in the legislation. Prior to 2012, a covered health insurance provider is any employer qualifying as a health insurance provider that receives premiums for providing health insurance coverage.

The deduction limits apply to compensation attributable to services performed by an "applicable individual." Applicable individuals include all officers, employees, directors, and other workers or service providers (such as non-employee independent contractors) performing services for or on behalf of a covered health insurance provider. Thus, the deduction restrictions will apply to any individual providing compensated services to a covered health insurance provider, not just the top executives.

Under the Act, for purposes of determining whether remuneration of a particular applicable individual exceeds \$500,000, compensation paid to the individual from any member of the controlled group of the covered health insurance provider as determined by applying rules applicable to qualified retirement plans is considered.

The deduction limits apply to both current and deferred compensation. The limit that applies to deferred compensation earned in a year is equal to the \$500,000 limit for that year, reduced by the amount of current compensation paid. Thus, if an employee receives salary of \$400,000 in 2013, the deduction for deferred compensation attributable to the same year is limited to \$100,000 in the year in which the compensation is otherwise deductible. In this example, deferred compensation for that year that exceeds \$100,000 will not be deductible in the year paid.

The provision will be effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009. Thus, the limits will apply to current compensation paid in years after 2012, but will apply to deferred compensation earned after 2009.<sup>60</sup>

K. Modification of Section 833 Treatment of Certain Health Organizations.

The Act limits the special deduction for Blue Cross Blue Shield organizations of 25 percent of the amount by which certain claims, liabilities, and expenses incurred on cost-plus contracts exceed the organizations adjusted surplus. The special deduction will be available only to those otherwise qualifying organizations that expend at least 85 percent of their total premium on reimbursement for clinical services provided to enrollees.

The provision is effective for taxable years beginning after December 31, 2009, and will raise \$400 million over 10 years.

L. Eliminate Employer Deduction for Retiree Prescription Drug Plans Eligible for Federal Subsidy.

Under prior law, employers who provide their Medicare-eligible retirees with prescription drug coverage that meets or exceeds federal standards are eligible for subsidy payments from the fed-

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<sup>60</sup> Although this limit is an amendment to the existing \$1 million limitations on executive compensation under section 162(m), this deduction limit applies differently in many respects:

- The limit is based on the year in which compensation is earned, rather than the year in which the deduction is claimed. A limit based on when compensation is earned requires determination of the period to which compensation is attributable, and has the effect of limiting deductions for both current and former service providers. It will also have the effect of limiting deductions for compensation earned when the company is considered a health insurance provider, even if the company ceases to be a health insurance provider by the time the compensation is paid.
- The limit applies to compensation to any individual service provider, including independent contractors as well as all employees, rather than just the chief executive officer and highest three officers, as disclosed in Securities and Exchange Commission (SEC) filings.
- The deduction limitations apply to covered insurance providers, regardless of whether the provider is a “publicly held corporation” that is subject to SEC registration requirements.
- The deduction limits apply to compensation paid by all entities within the insurer’s controlled group. For this purpose, controlled group status is determined using rules similar for determining controlled group status for qualified plans.
- The exceptions for certain performance-based compensation and commission compensation are inapplicable.

Employers with self-insured plans are not considered covered health insurance providers for purposes of this provision.

eral government. The subsidies were equal to 28 percent of their actual spending for prescription drug cost in excess of \$250 and not to exceed \$5,000 (in 2006 dollars). These qualified retiree prescription drug plan subsidies are excluded from the employer's gross income for the purposes of corporate income tax. Employers are also allowed to claim a business deduction for retiree prescription drug expenses even though they also receive the federal subsidy to cover a portion of those expenses. The Act will require employers to coordinate the subsidy and the deduction for retiree prescription drug coverage beginning in 2013. The amount allowable as a deduction for retiree prescription drug coverage would be reduced by the amount of the federal subsidy received.