March 2010

Health care reform has passed: what now?

With the recent enactment of sweeping health care reform legislation, the US is undertaking a major overhaul of the health care system that will affect everyone — from insurance companies and health care providers to individuals and employers. All stakeholders should expect, and begin preparing for, substantial changes in the way health care is obtained, delivered, paid for and regulated.

This summary outlines the key elements of the Patient Protection and Affordable Health Care Act[1] (the Act), how the Federal Government will pay for the increased health care spending, and a timeline for when major provisions will take effect.

What does the legislation do?

The primary goals of the Act are to: (i) expand coverage to an estimated 32 million Americans without health insurance; (ii) reform the delivery system to improve quality; and (iii) lower the overall costs of providing health care.

To accomplish the goal of expanding coverage, the legislation mandates that all Americans maintain a minimum level of health coverage. It expands Medicaid coverage and provides federal subsidies to assist low-income individuals in obtaining health insurance. The legislation also implements insurance market reforms, including a ban on exclusions for pre-existing conditions, premium rate restrictions, extension of dependent coverage through age 26, and mandatory coverage of preventive services.

The Act establishes insurance exchanges through which individuals and small employers can shop for health insurance. It also mandates, for the first time, that employers with 50 or more full-time employees provide certain minimum benefits or pay penalty fees. Employers will need to analyze the cost implications of proposed changes to their benefit plans, payroll taxes, administrative functions and other compliance obligations.

Health care cost reductions stem from cuts to Medicare and Medicaid payments, provisions to reduce fraud, waste, and abuse in those public programs, and other delivery reforms to their payment systems. These reforms present both challenges and opportunities for health care industry sectors as they analyze the impact of increased patient volume, reimbursement cuts, changes in relationships between hospitals and other providers, and modifications to their administrative operations and cost structures.

[1] H.R. 3590, the "Patient Protection and Affordable Care Act," was signed into law on March 23, 2010. H.R. 4872, the "Health Care and Education Reconciliation Act of 2010" (which modifies a number of provisions in H.R. 3590) has passed the House and the Senate and will go to the President for signature. The description of provisions in this document includes the additional modifications contained in H.R. 4872.

Key provisions of health care legislation

Coverage

Provision	Description
Immediate reforms	Eliminates lifetime or unreasonable annual limits; prohibits rescissions; mandates coverage of preventive services; extends dependent coverage up to age 26; requires insurers to meet certain medical loss ratios; establishes a temporary high-risk pool for those with pre-existing conditions; and provides reinsurance for retirees.
Insurance market reforms	Limits insurers' flexibility to vary premiums; requires guaranteed availability and renewability of policies; prohibits exclusions based on pre-existing conditions; and prohibits discrimination based on health status.
Minimum benefit standards	Establishes new benefit requirements and requires plans to pay a minimum of 60% of coverage costs. Permits high-deductible catastrophic plans for adults under age 30 who are exempt from the individual mandate due to hardship or unaffordability.
Grandfather rules	Grandfathers existing employer plans from insurance market reforms except for dependent coverage, wait periods, lifetime limits, rescissions, uniform explanation of coverage documents and medical loss ratio requirements.
Insurance exchanges	Creates state-based exchanges through which individuals and small businesses can purchase insurance. Establishes multi-state plans with rates and benefits negotiated by the Office of Personnel Management. Does not include a public insurance option.

Provision	Description
Individual mandate	Requires individuals to maintain minimum coverage beginning in 2014. Imposes a penalty that increases over time for failure to maintain coverage. Certain exceptions are available for those with hardships, religious objections, non-US citizens or incarcerated individuals.
Individual subsidies	Provides tax credits and cost-sharing reductions on a sliding scale for individuals between 133% and 400% of the federal poverty level toward the cost of coverage.
Employer mandate	Requires large employers (50+ full-time equivalents) that do not offer coverage to pay an annual fee of $2,000 per full–time employee (FTE) if at least one FTE receives a health insurance tax credit. Requires large employers offering coverage that is "unaffordable" to pay an annual fee of $3,000 times the number of FTEs receiving tax credits (with a maximum amount not to exceed $750 times the total number of all FTEs). Prohibits waiting periods over 90 days. Employers may subtract the first 30 workers in calculating penalties.
Medicaid expansion	Extends Medicaid to individuals at or below 133% of the federal poverty level. Increases federal matching payments to states to compensate for states' Medicaid costs for newly eligible individuals to 100% from 2014–2016, phasing down to 90% in 2020 and beyond. Increases Medicaid payments to primary care physicians.

Medicare and Medicaid delivery system reforms

Provision	Description
Market basket updates	Implements productivity adjustments and market basket reforms that will reduce payments for hospitals, home health care, skilled nursing facilities and other Medicare providers.
Hospital readmissions	Reduces payments to hospitals that have readmission rates above certain thresholds for patients re-hospitalized with preventable conditions.
Payment reforms	Authorizes programs to test coordinated care payment models (e.g., bundled payments across an episode of care, medical homes and accountable care organizations).
Medicare Advantage	Freezes Medicare Advantage payments in 2011. Phases in reductions in federal subsidies paid to private health plans to equal local Medicare payment rates. Requires plans to meet an 85% medical loss ratio.

Provision	Description
Part D coverage gap	Requires drug manufacturers to provide a 50% discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap ("donut hole"). Provides a $250 rebate for enrollees who hit the donut hole in 2010. Eliminates the donut hole by 2020.
Medicare commissio n	Establishes an independent payment advisory board to make binding recommendations to Congress for extending the solvency of Medicare.
DSH payments	Reduces Medicare and Medicaid payments to hospitals that serve a disproportionate share of uninsured patients, based on the reduction in the number of uninsured.
Medicaid drug rebates	Increases rebates paid by prescription drug manufacturers for certain drugs prescribed to Medicaid beneficiaries. Extends rebates to drugs purchased by Medicaid managed care plans.

Biologics and comparative effectiveness

Provision	Description
Biosimilar drugs	Establishes an approval pathway at FDA for biosimilars (i.e., generic versions of biologic drugs); provides a 12-year period of exclusivity for the licensed biologic product.
Comparative effectiveness	Establishes a private, non-profit entity to conduct research on the comparative effectiveness of diagnostics, pharmaceuticals, devices and other medical treatments.

Tax provisions

Provision	Description
Excise tax on high-cost health plans	Imposes a 40% excise tax on employer health coverage valued over $10,200 for individuals, $27,000 for families (with certain limited exceptions), effective January 1, 2018.
Medicare hospital insurance (HI) tax on high-income taxpayers	Increases the Medicare HI payroll tax by 0.9% on wages of $200,000 or more for individuals or $250,000 for couples. Imposes a 3.8% tax on the lesser of net investment income (e.g., income from interest, dividends, capital gains) or the excess of the taxpayer's modified AGI over $200,000 for individuals or $250,000 for couples.
Health insurers fee	Imposes a non-deductible annual fee on health insurers, allocated based on market share, designed to raise $60 billion from 2014–2019. Provides certain exemptions for tax-exempt and nonprofit insurers.
Drug manufacturers fee	Imposes a non-deductible annual fee on drug manufacturers, allocated based on market share, designed to raise $27 billion from 2011–2019. Excludes those with sales of $5 million or less.
Medical device manufacturers excise tax	Imposes a 2.3% excise tax on the first sale of medical devices, designed to raise $20 billion from 2013–2019. Excludes glasses, contacts, hearing aids and similar products.
Economic substance	Codifies the doctrine and imposes strict liability penalties on transactions lacking economic substance.
Charitable hospitals	Imposes additional requirements on charitable hospital organizations to retain charitable status.
Executive compensation	Places a $500,000 cap on health insurers' deduction for compensation paid to officers, directors and certain employees.
Part D deduction	Eliminates the employer deduction for Medicare Part D retiree drug subsidy, beginning in 2013.
FSA, HSA, HRA changes	Provides that the cost of over-the-counter medicines (other than prescribed drugs and insulin) may not be reimbursed through a health FSA, HSA, or HRA. Increases penalties for nonqualified distributions from HSAs and Archer MSAs to 20%. Limits individual contributions to FSAs in cafeteria plans to $2,500 annually.
Information reporting	Requires businesses to file information returns for all payments aggregating $600 or more in a calendar year to a single payee, including corporations (other than a payee that is a tax-exempt corporation).
Medical expenses	Increases the floor on the medical expense deduction for individuals from 7.5% to 10% of AGI.
Black liquor	Eliminates the cellulosic biofuels tax credit for unprocessed biofuels, such as black liquor.
Modification of IRC section 833	Requires eligible insurers to meet a medical loss ratio of 85% or higher to continue receiving the tax benefits of IRC section 833.
Indoor tanning tax	Imposes a 10% excise tax on indoor tanning services.

How is the money spent and where does it come from?

The bulk of the Act's almost $950 billion price tag comes from: (i) providing federal tax subsidies to help individuals and small businesses pay for health insurance coverage; and (ii) expanding Medicaid to cover individuals with incomes up to 133% of the federal poverty level. A mix of tax increases and Medicare spending cuts provide the funding for these coverage expansions. Notable tax increases include an excise tax on high-cost health plans; a new Medicare payroll tax for individuals with annual income over $200,000 ($250,000 for couples); and annual taxes on health insurers, drug manufacturers and sales of medical devices.

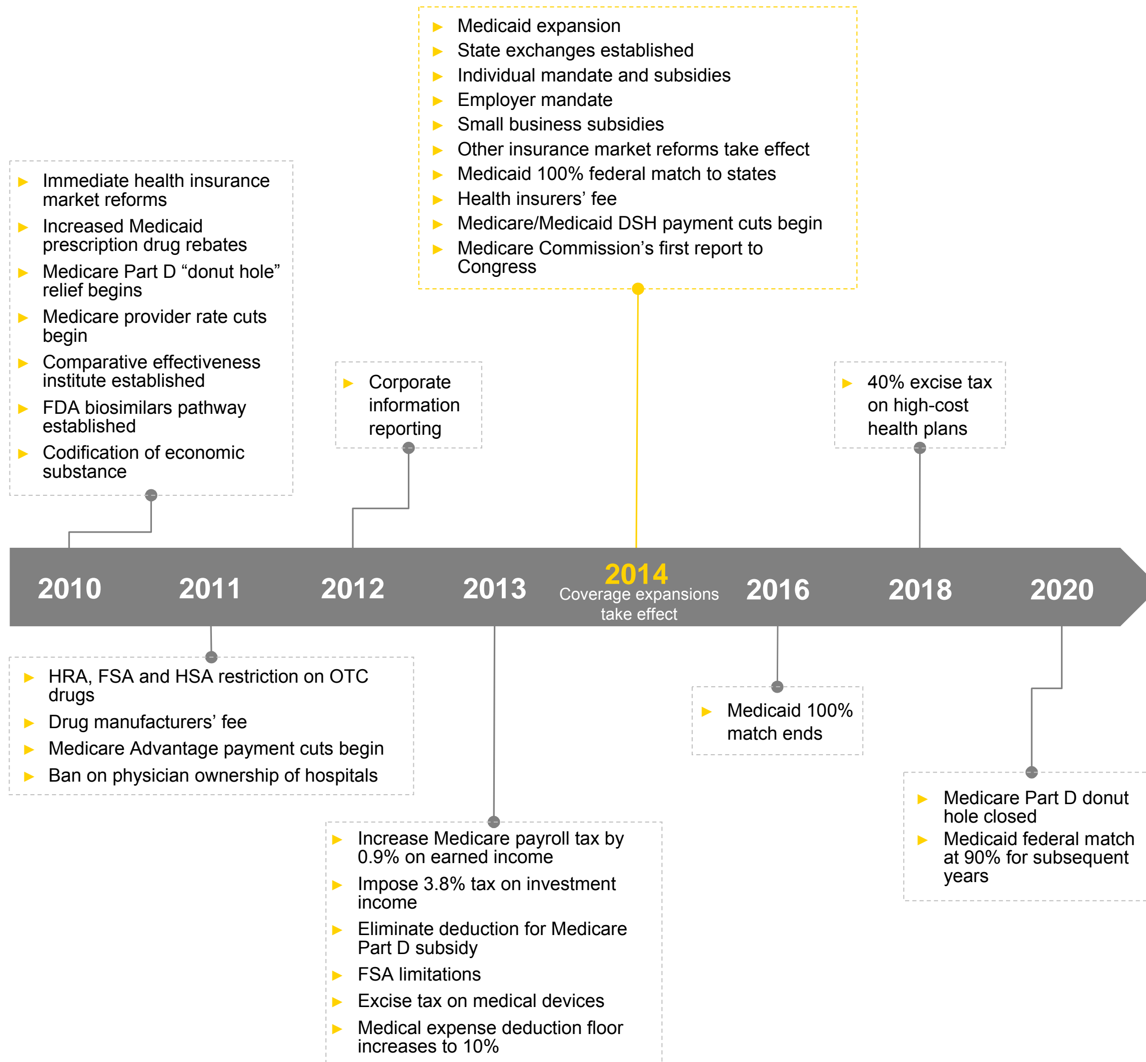
Snapshot of major spending and revenue components (2010–2019)

Spending increases	(billions)	Medicare cuts/tax increases	(billions)
Individual subsidies, exchanges and related spending	$464	**Medicare cuts**	$455
Medicaid and children's coverage expansion	$434	**Increased Medicare HI taxes**	$210
Small employer tax credits	$40	**Taxes on insurers, drug manufacturers and medical device sales**	$107
		Employers (penalties, high-cost plans, Part D deduction)	$89
		Other tax increases	**$103**
Total	**$938**	**Total**	**$964**

When do these changes take place?

While the coverage expansions and tax subsidies do not go into effect until 2014, a number of reforms take effect immediately or over the next several years. Full implementation of the Act will run through 2020. Federal agencies will be required to develop extensive regulatory guidance to flesh out the details of the numerous new programs created by the Act. The following timeline illustrates when major provisions will take effect.

Key effective dates



Conclusion

Many observers see the Act as the most sweeping domestic policy change passed since the inception of the Medicare program in 1965. Employers and the entire health care industry will need to undertake major initiatives to comply with the new coverage and payment rules. In addition, they must decide not only how to manage these compliance costs, but also the new fees and taxes imposed upon them to fund the Act's reforms.

Ernst & Young LLP can provide a wide range of services to help navigate these changes, including federal legislative and regulatory advisory services through Washington Council Ernst & Young, and assistance in analyzing and preparing for business changes resulting from health care reform, including assurance, advisory, tax, human resources and transaction advisory services.

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