

# NATIONAL HEALTH REFORM – WHAT’S TO COME?

By Jeanine Freeman, JD

**N**ational health reform has been signed into law. Two bills – HR 3590, the Patient Protection and Affordable Care Act, and HR 4872, the Health Care and Education Reconciliation Act of 2010 (the House amendments to HR 3590) – need to be read together. This article highlights a few provisions.

**Medicare payment to physicians – GPCIs – studies.** For 2010 (retroactive to January) and 2011, Iowa physicians will see a 3.26% increase in the PE GPCI; further, in 2010 (retroactive to January), the 1.0 floor on the work GPCI remains in effect. In the meantime, the Institute of Medicine (IOM), as directed by HHS Secretary Kathleen Sebelius, will examine all three GPCIs (work, PE, malpractice) and the hospital wage index. CMS, as directed by HR 3590, will specifically examine the PE GPCI, its inputs and weights. Study findings are due in 2011, with GPCI adjustments to be made in 2012.

**Medicare/Medicaid physician incentive payments.** Subject to criteria, a 10% Medicare bonus payment for primary care (family medicine, internal medicine, geriatrics, pediatrics) and a 10% Medicare incentive payment for general surgeons for certain major procedures performed in health professional shortage areas are available for 2011-2016. In 2010, a 5% Medicare payment incentive is available for psychotherapy services. In 2013-2014, Medicaid payments to primary care physicians (family medicine, general internal medicine, pediatrics) can be no less than 100% of Medicare; states will receive 100% federal funding for the increased payment portions.

**Health coverage mandate/tax credits/subsidies.** Beginning in 2014, citizens and legal residents without qualifying health coverage will

pay a tax penalty at the greater of \$95 or 1.0% of taxable income, increasing in 2015 to the greater of \$325 or 2.0% of taxable income, and in 2016, to the greater of \$695 or 2.5% of taxable income. Exemptions are provided. Tax credits for the purchase of insurance are established on a sliding-scale basis. Cost-sharing subsidies are available for individuals/families with incomes up to 400% of the federal poverty level (FPL).

**State-based American Health Benefit Exchanges (Exchanges) and Small Business Health Options Program (SHOP).** The Exchanges, to be administered by a government agency or a non-profit organization, provide qualified health coverage options to individuals and small businesses. Funding is available to assist states in establishing Exchanges. Other initiatives include a grant-based Consumer Operated and Oriented Plan (CO-OP) program supporting non-profit, member-run health plans in each state; state-established Basic Health Plans for uninsured individuals with incomes between 133-200% of FPL; and at least two national or multi-state commercial health plans that must be included as part of the Exchanges of each state.

**Employer responsibilities/small business tax credits.** Starting in 2014, employers with more than 50 full-time equivalent employees (FTEs) must offer qualified coverage to their employees or risk a monthly “free rider” penalty (\$2,000 x number of employees, the first 30 of which are not counted) if at least one FTE receives subsidized coverage through an Exchange. A sliding-scale tax credit is available to small employers with no more than 25 FTEs paid annual average wages of less than \$50,000 to assist in the purchase of employee health coverage. In 2014, employers providing basic insurance coverage must offer “free-choice”



Jeanine Freeman, JD, is Senior Vice President of Legal Affairs for the Iowa Medical Society.

vouchers to lower-income employees who may elect coverage through an Exchange.

**Pre-existing medical conditions.** As of January 1, 2014, individuals cannot be denied private health insurance coverage because of a pre-existing medical condition. Until then, \$5 billion is appropriated for temporary high-risk pools to provide coverage for adults with pre-existing medical conditions who have been uninsured for at least 18 months. Effective for plan years beginning on or after September 23, 2010, children age 18 and younger cannot be denied coverage for, or on the basis of, a pre-existing medical condition.

**Dependent coverage.** Effective for plan years beginning on or after September 21, 2010, individual and group health plans must allow uninsured children up to the age of 26 to remain on or return to their parent's plan. Eligible children need not reside with their parent and may be married (but the child's spouse/children could not be carried on the child's parent's plan).

**Tax changes.** Employers will be required to disclose the value of medical coverage on the Form W-2 beginning in 2011. For tax year 2013, the threshold for the itemized deduction for unreimbursed medical expenses increases from 7.5% to 10% of adjusted gross income, with a waiver for older taxpayers in tax years 2013-2016. In 2013, the Medicare Part A tax rate on wages will increase from 1.45% to 2.35% on earnings over \$200,000/individuals or \$250,000/married filing jointly.

**Fraud and abuse enforcement.** All Medicare and Medicaid providers must implement compliance programs. Specific disclosures to patients of certain financial incentives under the

Stark law will be required. Enforcement under the federal False Claim Act is bolstered and civil monetary penalties are increased. All Medicare providers and suppliers must be screened. New emphasis is placed on voluntary self-disclosure and overpayment returns.

**National Health Care Workforce Commission.** This commission will focus on training, recruitment, and retention. Regional centers will perform workforce analyses, emphasizing primary care. Scholarships and loan repayment programs will assist in recruiting medical students to underserved or rural areas and/or to work with uninsured or minority populations. Grants will support training programs in family medicine, general internal medicine, general pediatrics, and mental and behavioral health.

**Health plans – premium dollar rebates.** In 2010, health plans will be required to report the proportion of premium dollars spent on clinical services, quality, and other costs. In 2011, large group plans that spend 15% or more of their premium dollars on costs other than medical/quality and small group/individual plans that spend 20% or more on costs other than medical/quality must give consumer rebates.

**Health plans – administrative simplification.** By January 1, 2011, HHS must receive stakeholder input on an ICD-9-CM crosswalk to ICD-10 (which goes into effect on October 1, 2013). By October 1, 2012, HHS shall adopt a health plan identifier system as required by HIPAA. Operating rules for eligibility and health plan claims status transactions shall be in place by January 1, 2013. By January 1, 2014, operating rules for electronic funds transfers (EFT) and health care payment and remittance advice shall become effective.