Health Care and Education Reconciliation Act of 2010: A Section-by-Section Summary

2010

Contents

Preface

On March 30, 2010, the United States Congress passed Health Care and Education Reconciliation Act as part of comprehensive health care reform legislation. The Reconciliation Act makes numerous changes to the Patient Protection and Affordable Care Act. This document is a section-by-section summary of the health-related portions of the Reconciliation Act as signed into law.

The reader should note that the summary maintains the same structure of the actual legislation. All references to "the Secretary" refer to the Secretary of the Department of Health and Human Services, unless otherwise stated.

Title I – Coverage, Medicare, Medicaid, and Revenues

Subtitle A - Coverage

Section 1001. Tax Credits

The following 5 paragraphs modify section 36B of the Internal Revenue Code as added by section 1401 and amended by section 10105 of the Patient Protection and Affordable Care Act.

The applicable percentage used to calculate an individual's premium tax credit will be based on household income within an income tier and increased on a sliding scale from the initial premium percentage to the final premium percentage as follows:

In the case of household income (expressed as a percent of the Federal poverty line):	The initial premium percentage is:	The final premium percentage is:
Up to 133%	2%	2%
133% up to 150%	3%	4%
150% up to 200%	4%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

In taxable years after 2014, the initial and final applicable percentages will be adjusted to reflect, for the preceding year, the excess of:

- Premium growth rate ÷ Income growth rate.

After 2018, the percentages will also be adjusted to reflect, for the preceding year, the excess (if any) of:

- Premium growth rate ÷ Growth rate in the consumer price index.

This will only apply if the aggregate amount of premium tax credits and cost-sharing reductions (section 1402 of the Patient Protection and Affordable Care Act) for the preceding calendar year is more than 0.504 percent of the gross domestic product.

Regarding employer-sponsored health coverage, in order to meet minimum essential requirements the employee's required contribution will not be more than 9.5 percent of the applicable taxpayer's household income. The 9.5 percent will be adjusted in the same manner as indicated for the applicable percentage above.

Section 1402 of the Patient Protection and Affordable Care Act is amended as follows.

The Secretary will ensure that a qualified health plan's share of total allowed costs of benefits will not exceed:

- 94 percent for an eligible insured with household income 100 to 150 percent of the Federal poverty line
- 87 percent for an eligible insured with household income 150 to 200 percent of the Federal poverty line;
- 73 percent for an eligible insured with household income 200 to 250 percent of the Federal poverty line; and

- 70 percent for an eligible insured with household income 250 to 400 percent of the Federal poverty line.

Section 1002. Individual Responsibility

This section amends section 5000A of the Internal Revenue Code as added by section 1501 and amended by section 10106 of the Patient Protection and Affordable Care Act.

The penalty for not having health insurance is an amount equal to 1/12 of the greater of a flat dollar amount or percentage of income for each month without such coverage. The percentage of income is an amount equal to the following percentage of the taxpayer's household income for the taxable year:

- 1 percent for taxable years beginning in 2014;
- 2 percent for taxable years beginning in 2015; and
- 2.5 percent for taxable years beginning after 2015.

The applicable dollar amount is phased-in such that it will be $325 in 2015 and $695 in 2016.

Individuals with household income below the filing threshold for the taxable year are exempt from penalties.

Section 1003. Employer Responsibility

This section amends section 4980H of the Internal Revenue Code as added by section 1513 and amended by section 10106 of the Patient Protection and Affordable Care Act.

An applicable large employer will no longer include construction industry employers with an average of at least 5 full-time employees and with annual payroll expenses over $250,000.

The number of individuals employed full-time by a large employer will be reduced by 30 for calculating the assessable payment for employers with at least one full-time employee receiving a premium tax credit or cost-sharing reduction. The monthly penalty for a large employer (offering coverage with 1 or more employees receiving a premium tax credit or cost-sharing reduction) will be:

- Number of full-time employees × (1/12 × $3,000)

The applicable payment amount for an employer that does not offer health coverage is increased to $2000 (a year per full-time employee). Full-time equivalents will be treated as full-time employees for determining applicable large employers. The assessment for employers with a waiting period is eliminated.

Section 1004. Income Definitions

This section changes "modified gross income" to "adjusted gross income" in specific sections of the Internal Revenue Code of 1986 and the Social Security Act.

The following paragraph amends the Internal Revenue Code as amended by section 1401 of the Patient Protection and Affordable Care Act.

Each Exchange will provide the Secretary and the taxpayer the following information regarding any health plan provided through the Exchange:

- The level of coverage (bronze, silver, gold, or platinum);

- The total premium for coverage without tax credits or cost-sharing reductions;
- The aggregate amount of any advance payment of such credit or reductions;
- The name, address, and tax identification number (TIN) of the primary insured and the name and TIN of each individual obtaining coverage under the policy;
- Any information provided to the Exchange; and
- Information necessary to determine whether a taxpayer has received excess advance payments.

The Internal Revenue Code is amended to exclude expenses for employer provided coverage for adult children under age 27 from gross income.

Section 1005. Implementation Funding

A Health Insurance Reform Implementation Fund is established within the Department of Health and Human Services to carry out the Patient Protection and Affordable Care Act and this Act. There is $1 billion appropriated to the Fund.

Subtitle B - Medicare

Section 1101. Closing the Medicare Prescription Drug "Donut Hole"

The Social Security Act is amended as follows: if an individual has exceeded the initial coverage limit for Medicare Part D in 2010, the Secretary will provide a one-time $250 rebate to the individual.

Section 3315 (Immediate Reduction in Coverage Gap in 2010) of the Patient Protection and Affordable Care Act is repealed.

The following 2 paragraphs amend the Social Security Act as amended by section 3301 of the Patient Protection and Affordable Care Act.

Drug manufacturer discounts for Medicare Part D beneficiaries will begin in 2011. As Federal subsidies for generic and prescription drugs are phased in, the Medicare Part D coinsurance is reduced. The coinsurance percentage for covered generic and brand name drugs will be decreased to 25 percent by 2020.

The annual out-of-pocket threshold for Medicare Part D is revised to slow growth.

Section 1102. Medicare Advantage Payments

Section 3201 (Medicare Advantage Payment) and 3203 (Application of Coding Intensity Adjustment during Medicare Advantage Payment Transition) of the Patient Protection and Affordable Care Act are repealed.

The following 5 paragraphs modify the Social Security Act.

Beginning in 2012 a blended benchmark amount will be applicable within Medicare Advantage (MA) as follows:

- 1/12 (the applicable amount for the area and year) + 1/12 (base payment × the applicable percentage for the area and year).
  *the applicable percentage will range from 95 to 115 percent based on ranking by the Secretary

There are provisions to phase-in the benchmark over 4 years and 6 years for certain areas. These benchmarks do not apply to payments to a program of all-inclusive care for the elderly (PACE).

Plans with a quality rating of 4 stars or higher (in a 5-star rating system) based on the most recent data available will receive a base payment increase as follows:

- For 2012, by 1.5 percentage points;
- For 2013, by 3 percentage points;
- For 2014 or subsequent years, by 5 percentage points.

These increases will be doubled for a qualifying plan located in a qualifying county. An MA plan that fails to report data will be counted as having a rating of less than 3.5 stars. Exceptions may be made for an MA plan with low enrollment. New MA plans will be eligible for a smaller increase.

Modifications are made to the beneficiary rebate rule for MA plans based on quality ratings and phased-in over time.

The Comparative Cost Adjustment Program under the Medicare Prescription Drug, Improvement, and Modernization At of 2003 is repealed.

Section 1103. Savings from Limits on MA Plan Administrative Costs

Medicare Advantage plans must have a medical loss ratio of at least 85 percent. Plans that fail to meet this requirement will be subject to the following penalties:

- An administrative fee;
- The Secretary will not permit enrollment of new enrollees in such plan that does not meet the requirement for 3 consecutive years; and
- The Secretary will terminate the plan contract if it does not meet the requirement for 5 consecutive years.

Section 1104. Disproportionate Share Hospital (DSH) Payments

This section amends section 1886 of the Social Security Act as added by section 3133 and amended by section 10316 of the Patient Protection and Affordable Care Act.

Modifications to disproportionate share hospital (DSH) payments will begin in 2014 (not 2015). In fiscal years 2018 and 2019 the factor two for adjusting DSH payments will be reduced as follows:

- 1 – (Percent uninsured in 2013 – Percent uninsured based on most recent data – 0.2%).

Section 1105. Market Basket Updates

This section further modifies market basket updates in section 1886 of the Social Security Act as added by section 3401 and amended by section 10319 of the Patient Protection and Affordable Care Act. Affected providers are inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospitals.

Section 1106. Physician Ownership-Referral

This section modifies section 1877 of the Social Security Act as added by section 6001 and amended by section 10601 of the Patient Protection and Affordable Care Act.

The deadline for physician-owned hospitals to have a provider agreement to participate in Medicare under the rural provider and hospital exception is December 31, 2010.

Section 1107. Payment for Imaging Services

This section amends section 1886 of the Social Security Act as added by section 3133 and amended by section 10316 of the Patient Protection and Affordable Care Act.

The assumed utilization rate will be 75 percent with respect to the fee schedule for 2011 and subsequent years for the practice expense portion of advanced diagnostic imaging services.

Section 1108. PE GPCI Adjustment for 2010

This section amends section 3102 of the Patient Protection and Affordable Care Act to modify the employee wage and rent portions of the practice expense geographic index adjustment for 2010 and subsequent years as follows:

- 1/2 (Relative cost of employee wages and rent – National average of such wages and rent).

Section 1109. Payment for Qualifying Hospitals

The Secretary will provide payments to subsection (d) hospitals located in a county that ranks (based on age, sex, and race adjusted spending for Medicare Parts A and B benefits) in the bottom quartile for fiscal years 2011 and 2012. There will be a total of $400 million available for these payments.

Subtitle C - Medicaid

Section 1201. Federal Funding for States

This section modifies section 1905 of the Social Security Act as amended by sections 2001 and 10201 of the Patient Protection and Affordable Care Act.

The Federal medical assistance percentage (FMAP) for newly eligible individuals (under the Medicaid expansion) will be:

- 100 percent in 2014, 2015, and 2016;
- 95 percent in 2017;
- 94 percent in 2018;
- 93 percent in 2019; and
- 90 percent in 2020 and each year thereafter.

The provision for a permanent 100 percent FMAP for expansion costs of Medicaid in Nebraska is repealed.

The formula for calculating increased FMAP in expansion States (offer health benefits coverage to parents and non-pregnant childless adults with income at least 100 percent of the poverty line) is

modified. The State share of the cost for providing coverage for non-pregnant childless adults will be reduced by 50 percent in 2014, 60 percent in 2015, 70 percent in 2016, 80 percent in 2017, 90 percent in 2018, and in 2019 and subsequent years expansion States will have the same State share for covering this population as non-expansion States.

Section 1202. Payments to Primary Care Physicians

In 2013 and 2014, Medicaid will pay at least 100 percent of Medicare rates for primary care services. The FMAP will be 100 percent for primary care services provided between January 1, 2013 and January 1, 2015.

Section 1203. Disproportionate Share Hospital Payments

This section modifies section 1923 of the Social Security Act as amended by sections 2551 and 10201 of the Patient Protection and Affordable Care Act.

DSH payments will be reduced for each of fiscal years 2014 through 2020. The aggregate reductions in DSH allotments for all States will be: $500 million in 2014, $600 million in 2015 and 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020.

The Secretary will develop a methodology to distribute DSH reductions in a manner that imposes the largest reductions on States with the lowest percentage of uninsured individuals, imposes smaller reductions on low DSH States, and takes into account DSH allotments for States with a 1115 waiver.

The quarterly DSH allotment will be $47.2 million in 2012 and $53.1 million in 2013 for a State with a DSH allotment of $0.

Section 1204. Funding for the Territories

The following section is added to Part III of Subtitle D of Title I of the Patient Protection and Affordable Care Act.

Section 1323. Funding for the Territories

There is appropriated $1 billion for payments to territories that elect to establish an Exchange. Funds will be available from 2014 to 2019.

The Secretary will increase the amounts available to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the period July 1, 2011, through September 30, 2019.

Subsection (b) (Disregard of Payments for Mandatory Expanded Enrollment) in section 2005 of the Patient Protection and Affordable Care Act is repealed.

The increase in FMAP for territories will begin July 1, 2010.

Section 1205. Delay in Community First Choice Option

Section 2401 of the Patient Protection and Affordability act is amended to delay the option for State Medicaid programs to cover home and community-based services and supports for individuals who require an institutional level of care to begin October 1, 2011.

Section 1206. Drug Rebates for New Formulations of Existing Drugs

Section 2501 of the Patient Protection and Affordability act is amended to narrow the definition of a new formulation of a drug eligible for the rebate under Medicaid.

Subtitle D – Reducing Fraud, Waste, and Abuse

Section 1301. Community Mental Health Centers

A community mental health center providing partial hospitalization services, which do not include services in an individual's home or in an inpatient or residential setting, to Medicare beneficiaries is required to provide at least 40 percent of its services to non-Medicare beneficiaries. This is effective 12 months after enactment of this Act.

Section 1302. Medicare Prepayment Medical Review Limitations

Section 1874A(h) (Conduct of prepayment review for contracts with Medicare Administrative contractors) of the Social Security Act is repealed.

Section 1303. Funding to Fight Fraud, Waste, and Abuse

The following amounts are appropriated to the Health Care Fraud and Abuse Control Account to cover the costs of the health care fraud and abuse control program and the Medicare Integrity Program:

- $95 million for fiscal year 2011;
- $55 million for fiscal year 2012;
- $30 million for each of fiscal years 2013 and 2014; and
- $20 million for each of fiscal years 2015 and 2016.

Future appropriations for the Medicaid Integrity Program will be increased by the percentage increase in the consumer price index.

Section 1304. 90-Day Period of Enhanced Oversight for Initial Claims of DME Suppliers

Beginning January 1, 2011, the Secretary may withhold payment from a supplier of durable medical equipment for a 90-day oversight period if it is determined that there is a significant risk of fraud.

Subtitle E – Provisions Relating to Revenue

Section 1401. High-Cost Plan Excise Tax

Section 9001 of the Patient Protection and Affordable Care Act will be effective for taxable years beginning after December 31, 2017 and is amended as follows.

The tax on insurers for high-cost employer-sponsored health plans is delayed until 2018 and the dollar thresholds are increased to $10,200 for single coverage and $27,500 for family coverage. This threshold is increased by $1,650 for single coverage and by $$3,450 for family coverage for qualified retirees and employees in high-risk professions.

The threshold amounts may be increased if health care costs rise more than expected prior to the implementation of the tax in 2018. Additionally, threshold amounts will be increased for employers that

have health costs higher than the national average due to the age and gender of their workers. Supplemental coverage for dental or vision care will not be included when calculating the aggregate value of health plans.

Section 1402. Unearned Income Medicare Contribution

Medicare contributions are modified to include net investment income by imposing a 3.8 percent tax on interest, dividends, annuities, royalties, rents, gross income from a trade or business involving passive activities, and net gain from the disposition of property above a threshold amount. The threshold amount is $200,000 for an individual and $250,000 for a married couples filing jointly. This is effective for taxable years beginning after December 31, 2012.

Section 1403. Delay of Limitation on Health Flexible Spending Arrangements under Cafeteria Plans

The $2,500 cap on contributions to health flexible spending arrangements is delayed until 2013.

Section 1404. Brand Name Pharmaceuticals

Section 9008 of the Patient Protection and Affordable Care Act is amended to delay the fee on drug manufacturers and importers until 2011. The fee amount is also changed from $2.3 billion to an applicable amount that changes over time:

- $2.5 billion in 2011;
- $2.8 billion in 2012 and 2013;
- $3 billion in 2014, 2015, and 2016;
- $4 billion in 2017;
- $4.1 billion in 2018; and
- $2.8 billion in 2019 and subsequent years.

Section 1405. Excise Tax on Medical Device Manufacturers

Effective December 31, 2012, a 2.3 percent tax will be imposed on the sale of any taxable medical device by the manufacturer, producer, or importer. Exemptions are made for eyeglasses, contact lenses, hearing aids, and any medical device specified by the Secretary that is generally purchased by the general public at retail for individual use.

Section 9009 (Annual fee on medical device manufacturers and importers) as amended by section 10904 of the Patient Protection and Affordable Care Act is repealed.

Section 1406. Health Insurance Providers

Section 9010 (as amended by section 10905) of the Patient Protection and Affordable Care Act is amended to delay the annual fee on health insurance providers until 2014, and the fee for tax-exempt insurers will be calculated with 50 percent of their net premiums that relate to their tax-exempt status.

Additional exemptions from the annual fee are made for voluntary employee benefit associations (VEBAs) and nonprofit providers with more than 80 percent of gross revenue from government programs that target low-income, elderly or disabled populations (Medicare, Medicaid, and CHIP).

The applicable amount (liability across all insurance providers) will be $8 billion in 2012 and increases to $14.3 billion in 2018. In 2019 and subsequent years the applicable amount will be increased by the rate of premium growth in the previous year. A penalty fee will be assessed on any insurance provider that understates net premiums (which are used for calculating each entities fee).

Section 1407. Delay of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy

Section 9012 of the Patient Protection and Affordable Care Act will be effective in 2013.

Title II – Education and Health

Subtitle B - Health

Section 2301. Insurance Reforms

This section amends section 1251 of the Patient Protection and Affordable Care Act to apply certain insurance reforms will apply to grandfathered health plans. All grandfathered plans will be subject to the:

- Limitation on excessive waiting periods for enrollment;
- Restrictions on lifetime limits;
- Prohibition on rescissions; and
- Extension of coverage for adult children up to age 26 (includes married adult children).

Grandfathered group health plans will additionally be subject to the restriction on annual limits and will be prohibited from excluding people for having a pre-existing condition. These plans will extend coverage to adult children up to age 26 if the adult child is not eligible to enroll in another employer-sponsored health plan.

Section 2302. Drugs Purchased by Covered Entities

Sections 7101 and 7192 of the Patient Protection and Affordable Care Act (which amend section 340B of the Public Health Service Act) are modified to repeal the 340B expansion to inpatient drugs, the exclusion on group purchasing organizations, and the Medicaid credit for inpatient drugs.

Orphan drugs, pharmaceuticals developed for a rare disease or condition, are exempted from the required discounts for new 340B entities.

Section 2303. Community Health Centers

Amounts authorized for the Community Health Center Fund in section 10503 of the Patient Protection and Affordable Care Act are increased to $9.5 billion over five years for enhanced funding of community health centers.