

## Provisions

H.R. 3590 is divided into 10 titles.

The bill contains provisions that will go into effect immediately, on June 21, 2010 (90 days after enactment); on September 23, 2010 (six months after enactment); and provisions that will go into effect in 2014. For simplicity, the amendments in the Health Care and Education Reconciliation Act of 2010 are integrated into this timeline.

Below are some of the key provisions of the bill:

### Effective at enactment

- The Food and Drug Administration is authorized to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.
- The Medicare Improvement Fund is eliminated
- The Medicaid drug rebate for brand name drugs is increased to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%), and the rebate is extended to Medicaid managed care plans; the Medicaid rebate for non-innovator, multiple source drugs is increased to 13% of average manufacturer price
- Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act is eliminated.
- Creation of task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services.
- The Indian Health Care Improvement Act is reauthorized and amended.

### Effective June 21, 2010

- Adults with pre-existing conditions will be eligible to join a temporary high-risk pool, which will be superseded by the health care exchange in 2014.

### Effective September 23, 2010

- Dependent children will be permitted to remain on their parents' insurance plan until their 26th birthday.

- Insurers are prohibited from charging co-payments or deductibles for preventive care and medical screenings on all *new* insurance plans.
- Individuals affected by the Medicare Part D coverage gap will receive a \$250 rebate, and 50% of the gap will be eliminated in 2011. The gap will be eliminated by 2020.
- Insurers' abilities to enforce annual spending caps will be restricted, and completely prohibited by 2014.
- Insurers are prohibited from dropping policyholders when they get sick.
- Insurers are required to reveal details about administrative and executive expenditures.
- Insurers are required to implement an appeals process for coverage determination and claims on all new plans.
- Indoor tanning services are subjected to a 10% service tax.
- Enhanced methods of fraud detection are implemented.
- Medicare is expanded to small, rural hospitals and facilities.
- Non-profit Blue Cross insurers are required to maintain a loss ratio (money spent on procedures over money incoming) of 85% or higher to take advantage of IRS tax benefits.
- Companies which provide early retiree benefits for individuals aged 55-64 are eligible to participate in a temporary program which reduces premium costs.
- A new website installed by the Secretary of Health and Human Services will provide consumer insurance information for individuals and small businesses in all states.
- A temporary credit program is established to encourage private investment in new therapies for disease treatment and prevention.

### **Effective by January 1, 2011**

- Insurers will be required to spend 85% of large-group and 80% of small-group plan premiums (with certain adjustments) on health care or to improve health-care quality, or return the difference to the customer as a rebate.

## Effective by January 1, 2014.

- Insurers are prohibited from discriminating against or charging higher rates for any individuals based on pre-existing medical conditions.
- Insurers are prohibited from establishing annual spending caps.
- Expand Medicaid eligibility; individuals with income up to 133% of the poverty line qualify for coverage.
- Offer tax credits to small businesses who have fewer than 25 employees and provide health care benefits for them.
- Impose a \$2000 per employee tax penalty on employers with over 50 employees who do not offer health insurance to their full-time workers (as amended by the reconciliation bill).<sup>1</sup> (In 2008, over 95% of employers with at least 50 employees offered health insurance. )
- Impose an annual penalty of \$95, or up to 1 percent of income, whichever is greater, on individuals who do not secure insurance; this will rise to \$695, or 2.5 percent of income, by 2016. This is an individual limit; families have a limit of \$2,085. Exemptions to the fine in cases of financial hardship or religious beliefs are permitted.
- Creation of a new voluntary long-term care insurance program; enrollees are provided aid in the event that disabilities or chronic illnesses make it difficult for them to live unassisted at home.
- Creation of tax credits for individuals who purchase private insurance policies.
- Employed individuals who pay more than 9.5% of their income on health insurance premiums will be permitted to purchase insurance policies from a state-controlled health insurance option.
- Pay for new spending, in part, through spending and coverage cuts in Medicare Advantage, slowing the growth of Medicare provider payments, reducing Medicare and Medicaid drug reimbursement rate, cutting other Medicare and Medicaid spending.
- Revenue increases from a new \$2,500 limit on tax-free contributions to flexible spending accounts (FSAs), which allow for payment of health costs.
- Chain restaurants and food vendors with 20 or more locations are required to display the caloric content of their foods on menus, drive-through menus, and vending machines. Additional information, such as saturated fat, carbohydrate, and sodium content, must also be made available upon request.

- Establish health insurance exchanges, and subsidization of insurance premiums for individuals with income up to 400% of the poverty line, as well as single adults. According to Congressional Budget Office estimates, in 2014 the income-based premium caps for a "silver" plan would be the following:

<b>Income</b>	<b>Premium Cap as a Share of Income</b>	<b>Middle of Income Range<sup>(a)</sup></b>	<b>Annual Enrollee Premium</b>	<b>Average Cost-Sharing Subsidy</b>
133–150% of <u>federal poverty level</u>	4–4.7% of income	\$30,000	\$600	\$3,300
150–200% of <u>federal poverty level</u>	4.7–6.5% of income	\$42,000	\$2,400	\$1,800
200–250% of <u>federal poverty level</u>	6.5–8.4% of income	\$54,000	\$4,000	0
250–300% of <u>federal poverty level</u>	8.4–10.2% of income	\$66,000	\$6,100	0
300–400% of <u>federal poverty level</u>	10.2% of income	\$78,000	\$9,200	0

<sup>(a)</sup> Note: In 2016, the FPL is projected to equal about \$11,800 for a single person and about \$24,000 for family of four. See Subsidy Calculator for specific dollar amount

- Members of Congress and their staff will only be offered health care plans through the exchange or plans otherwise established by the bill (instead of the Federal Employees Health Benefits Program that they currently use).

- Investment income of individuals earning \$200,000 annually or couples earning \$250,000 annually will be subject to Medicaid Payroll withholding.
- Medicare Payroll withholding increases from 2.9% to 3.8% on all earned income.
- A new excise tax goes into effect that is applicable to pharmaceutical companies and is based on the market share of the company; it is expected to create \$2.5 billion in annual revenue.
- Most medical devices become subject to a 2.9% excise tax collected at the time of purchase.
- Health insurance companies become subject to a new excise tax based on their market share; the rate gradually raises between 2014 and 2018 and thereafter increases at the rate of inflation. The tax is expected to yield up to \$14.3 billion in annual revenue.
- The qualifying medical expenses deduction for Schedule A tax filings increases from 7.5% to 10% of earned income.

### **Effective by January 1, 2017**

- A state may apply to the Secretary of Health & Human Services for a waiver of certain sections in the law, with respect to that state, such as the individual mandate, provided that the state develops a detailed alternative that "will provide coverage that is at least as comprehensive" and "at least as affordable" for "at least a comparable number of its residents" as the waived provisions. The decision of whether to grant this waiver is up to the Secretary (who must annually report to Congress on the waiver process) after a public comment period.

### **Effective by 2018**

- All *existing* health insurance plans must cover preventive care and checkups without co-payment.
- A new 40% excise tax on high cost ("Cadillac") insurance plans is introduced. The tax (as amended by the reconciliation bill) is on the cost of coverage in excess of \$27,500 (family coverage) and \$10,200 (individual coverage), and it is increased to \$30,950 (family) and \$11,850 (individual) for retirees and employees in high risk professions. The dollar thresholds are indexed with inflation; employers with higher costs on account of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.