



**Summary of Select Provisions of
Final Health Reform Legislation**

**This is not an exhaustive summary. Please contact your Ropes & Gray attorney for additional information.*

Senate Patient Protection Act and Affordable Health Care Act, H.R. 3590
(Signed into Law on March 23, 2010, Public Law No. 111-148)
Combined with the Health Care and Education Reconciliation Act of 2010, H.R. 4872
(Signed into Law on March 30, 2010, Public Law No. 111-152)

General	
Estimated Cost of Bill	<ul style="list-style-type: none"> • \$938 billion. Estimated to reduce deficits by \$143 billion/10 years.
Coverage Provisions	
Percentage of People Covered	<ul style="list-style-type: none"> • 92% of all non-elderly residents • 94% of all non-elderly, excluding undocumented immigrants • Reduces the number of uninsured by 32 million by 2019 • 23 million people left uninsured in 2019
Insurance Reforms	<ul style="list-style-type: none"> • Prohibits individual and group health plans from: applying lifetime limits on required health benefits; imposing annual limits beyond those permitted by the Secretary; imposing any preexisting condition exclusions; varying premiums by more than 3:1 for age and 1.5:1 for tobacco use (rating changes do not apply to self-insured plans); imposing excessive waiting periods for coverage (does not apply to individual plans); rescinding coverage for enrollees; and, imposing prior authorization for emergency and OB/GYN services. [As indicated below, only certain insurance reforms apply to “grandfathered health plans,” which are plans in effect as of the date of enactment.] • Requires individual and group health plans to extend dependent care coverage to children up to 26 years of age. Requires grandfathered group health plans to similarly extend coverage before 2014, and requires all grandfathered health plans to extend coverage beginning in 2014. • Requires individual and group health plans to cover routine care provided during a clinical trial that would have been covered had it not been provided through a clinical trial. • Imposes guaranteed issue requirements on insurers and mental health parity requirements to all individual and group health plans.



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Insurance Reforms	<ul style="list-style-type: none"> • Imposes a medical loss ratio of 85% on all large group plans and 80% on small group and individual plans, including grandfathered health plans. • Applies prohibitions on excessive waiting periods, lifetime limits, and rescissions to both individual and group grandfathered health plans and requires these plans to comply with uniform explanation of coverage and cost accounting requirements. Applies restrictions on annual limits and prohibitions on preexisting conditions to grandfathered health plans that are group health plans.
Exchange	<ul style="list-style-type: none"> • Requires each state to establish an American Health Benefit Exchange, including a small business exchange, by 2014. States may form regional exchanges. • Each plan participating in an Exchange must meet standardized affordability, essential benefit, and consumer protection requirements. Exchange plans must meet state benefits requirements; however, states must defray premium and cost-sharing costs related to additional benefits for subsidized individuals. • Provides four plan levels: bronze plan (60% actuarial value), silver plan (70% actuarial value), gold plan (80% actuarial value), and platinum plan (90% actuarial value). Permits the offering of catastrophic coverage only plans to individuals under 30 and those meeting the individual mandate hardship exception. • In 2014-2016, only individuals and employers in the small group market are eligible to participate in the Exchange; beginning in 2017, states may permit employers in the large group market to participate. • Requires each Exchange to provide information to the Secretary of the Treasury and taxpayer regarding the level of coverage obtained through the Exchange, the period of coverage, the premium paid, identification of each individual covered, information provided to the Exchange regarding eligibility for credits, and information to determine whether any individual has received excess advance credits.
Public Plan/National Plan/CO-Ops	<ul style="list-style-type: none"> • No provision for a public plan. • Instead, creates at least two Multi-State plans to be overseen and negotiated by the Office of Personnel Management. Plans would comply with Exchange plan requirements and Federal Employees Health Benefits Plan requirements. At least one Multi-State plan must be not-for-profit. A Multi-State plan initially must be offered in at least 60% of states and in all states by the plan's fourth year of operation.



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Public Plan/National Plan/CO-Ops	<ul style="list-style-type: none"> • Authorizes \$6 billion to fund a Consumer Operated and Oriented Plan (CO-OP) to support the creation of non-profit, member-run health insurance companies that would be offered through the Exchange. • Permits states to create a federally-funded, non-Medicaid state plan for non-elderly individuals with incomes between 133% and 200% FPL who are not eligible to receive affordable employer-sponsored insurance under which the employee contribution is equal to or less than 9.5% of income (as well as lawfully present immigrants with incomes below 133% FPL who are ineligible for Medicaid due to the 5 year bar to eligibility). Eligible individuals would enroll in such a state plan instead of obtaining coverage through the Exchange and would not be permitted to enroll in an Exchange plan.
Individual and Employer Requirements	<ul style="list-style-type: none"> • Imposes a tax penalty on each uninsured adult who does not obtain coverage by 2014. Penalties are gradually phased in between 2014 and 2016. When in full effect, the tax penalty will be the greater of a flat penalty of \$695 or 2.5% of the excess of household income over the threshold amount requiring a tax return to be filed. Provides a hardship exemption for individuals for whom the lowest cost premium exceeds 8% of income. • Employers with more than 50 employees that do not offer coverage and that have at least one full time employee who receives a premium tax credit, must pay a fee of \$2,000 per year (\$166.67 per month) per full time employee, excluding the first 30 full time employees. • Employers with more than 50 employees that offer coverage must pay a fee of \$3000 per year (\$250 per month) per employee for each full time employee who receives a premium tax credit, excluding the first 30 full time employees. • Requires employers that provide employer-sponsored coverage to offer free choice vouchers to assist employees for whom the required contribution to the employer’s plan is between 8 and 9.8% of their income to purchase Exchange coverage instead. The voucher amount would equal the employer’s contribution to its own plan. <p>From 2010-2013, provides a health insurance tax credit of up to 35% (25% for tax-exempt small employers) to small employers with 25 or fewer “full-time equivalent” employees and average annual wages of no more than \$50,000 of the employer's contribution to the cost of providing health insurance to their employees so long as the employer contribution meets or exceeds 50% of the total cost of coverage. The full credit is available to employers with 10 or fewer employees and wages less than \$25,000, and is phased out based on the number of employees and average wages. In 2014, the tax credit rises to up to 50% for-profit small businesses (35% to tax-exempt small businesses) with 25 or fewer employees and average wages up to \$25,000. After 2014, the credit is available for two consecutive years, and fully phases out for firms with average wages equal to or greater than \$50,000.</p>



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Affordability Credits	<ul style="list-style-type: none">• Provides affordability premium credits and cost-sharing credits to non-Medicaid eligible individuals and individuals not enrolled in an affordable employer-sponsored plan with incomes between 100-400% FPL. Credits are based on the second lowest cost silver plan.<ul style="list-style-type: none">○ Premium credits are set on a sliding scale based on income, with individuals' premium contributions limited to the following percentages:<ul style="list-style-type: none">▪ Up to 133% FPL: 2% of income▪ 133 to 150% FPL: 3 – 4% of income▪ 150 to 200% FPL: 4 – 6.3% of income▪ 200 to 250% FPL: 6.3 – 8.05% of income▪ 250 to 300% FPL: 8.05% - 9.5% of income▪ 300 to 400% FPL: 9.5% of income○ Premium credits will be increased annually based on the excess of premium growth over income growth.○ Cost-sharing credits equal an amount necessary to reduce cost-sharing as follows:<ul style="list-style-type: none">▪ 100 to 150% FPL: 94%▪ 150 to 150% FPL: 87%▪ 200 to 250% FPL: 73%▪ 250 to 400% FPL: 70%
Medicaid Expansion	<ul style="list-style-type: none">• Effective 2014, requires states to expand Medicaid to all non-elderly individuals up to 133% FPL. States may voluntarily expand coverage up to this level beginning on April 1, 2010.• For most states, the federal government would pay 100% of costs related to newly eligible individuals for the first three years (2014-2016), 95% for 2017, 94% for 2018, 93% for 2019, and 90% for years 2020 and beyond. [Note this cap is lower than the 95% cap under the Senate bill prior to reconciliation.]• Provides increased assistance to “expansion states” as compared with the Senate bill. States that have already expanded coverage to both parents and childless adults with incomes up to 100% FPL will receive a phased-in increase to their FMAP for non-pregnant childless adults so that by 2020 they receive the same 90% federal funding as other states for these populations.



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Medicaid Expansion	<ul style="list-style-type: none"> • Louisiana would receive a limited extension of federal assistance from the Recovery Act. Removes the Nebraska and Massachusetts provisions, and limits special assistance to Vermont to two years.
CHIP	<ul style="list-style-type: none"> • Preserves the CHIP program and requires states to maintain children’s eligibility levels until 2019. Increases the federal matching rate. • Extends the current reauthorization period of CHIP for two years, through September 30, 2015. • Provides states a 23% increase in their CHIP federal match rates for fiscal years 2016 through 2019.
Undocumented Immigrants	<ul style="list-style-type: none"> • Undocumented immigrants are not eligible to receive affordability credits or to enroll in an Exchange.
Abortion Coverage	<ul style="list-style-type: none"> • States may prohibit coverage of abortion services through an Exchange. • Federal funds for the public plan and for Exchange subsidies must be segregated and cannot be used toward the cost of abortion services for which funding is prohibited under federal law. • At least one Multi-State plan must not cover abortion services.
Long-Term Care Program	<ul style="list-style-type: none"> • Creates a long-term care insurance program, the CLASS program, to be financed by voluntary payroll deductions that would cover the full cost of the program. To be eligible to draw on coverage, an individual must be enrolled in the program for at least five years, including two consecutive years, and meet certain earnings requirements.



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Delivery System Reforms	
Value-Based Purchasing	<ul style="list-style-type: none"> • Implements a budget neutral value-based purchasing program for hospitals, under which Medicare inpatient prospective payment system (IPPS) payments would be reduced by 1% in fiscal year FY 2013, 1.25% in FY 2014, 1.5% in FY 2015, 1.75% in FY 2016, and 2% in FY 2017 and thereafter to fund incentive payments to hospitals achieving certain quality-based performance scores. • Requires the Secretary of HHS to issue a plan by October 1, 2011, to develop value-based purchasing programs for skilled nursing facilities and home health agencies. • Requires the Secretary of HHS to issue a plan by January 1, 2011 to develop a value-based purchasing program for ambulatory surgical centers. • Requires the Secretary of HHS to establish and apply a value-based payment modifier to the physician fee schedule (PFS), separate from geographic adjustment factors.
Hospital Readmissions	<ul style="list-style-type: none"> • Reduces hospital payments under Medicare, for hospital discharges on or after October 1, 2012, to account for “excess readmissions” for a limited number of conditions. Payment reductions would apply to all admissions. Planned readmissions would be exempt. Hospitals’ readmission rates would be publicly available on the CMS Hospital Compare website.
Hospital-Acquired Conditions (HACs)	<p><u>Medicare</u></p> <ul style="list-style-type: none"> • Beginning in FY 2015, hospitals in the top quartile of national, risk-adjusted HAC rates in a year would receive only 99% of their otherwise applicable Medicare payments the next year. <p><u>Medicaid</u></p> <ul style="list-style-type: none"> • Requires the Secretary of HHS to adopt regulations effective July 1, 2011 to prohibit federal payments to states for services related to health-care acquired conditions.

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<p>Payment Bundling</p>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> Requires the Secretary of HHS to establish a Medicare pilot program no later than January 1, 2013 to evaluate alternative payment methodologies that promote care coordination, including bundled payments, for 10 conditions to be selected by the Secretary. Authorizes the Secretary to expand the pilot if it reduces spending without decreasing quality. <p><u>Medicaid</u></p> <ul style="list-style-type: none"> Creates a Medicaid bundled payment demonstration, to begin on January 1, 2012 in up to 8 states, under which hospitals would receive bundled payments for a hospitalization and physician services provided during the hospitalization.
<p>Accountable Care Organizations (ACOs)</p>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> Beginning January 1, 2012, permits qualifying groups of providers, including physicians and hospitals, to be recognized as Medicare ACOs and to share in Medicare cost savings above a certain threshold, provided that certain quality standards are satisfied. The Secretary may pay ACOs using a partial capitation model or other payment models that improve quality and efficiency. <p><u>Medicaid</u></p> <ul style="list-style-type: none"> Creates a pediatric Medicaid ACO demonstration beginning January 1, 2010, under which certain pediatric medical providers would be eligible for incentive payments based on quality and cost savings
<p>CMS Payment Innovation Center</p>	<ul style="list-style-type: none"> Establishes a CMS Innovation Center by January 2011 and appropriates \$15 billion over ten years to the Center to design, implement, test, evaluate and expand different payment models and methodologies under Medicare, Medicaid, and CHIP that aim to foster patient-centered care, improve quality, and reduce the cost of care. Suggests various models for the Center to consider testing, which could include, but would not be limited to, coordination of care for dual eligibles, establishment of Healthcare Innovation Zones centered around teaching hospitals, and utilization of telehealth services, particularly in medically underserved areas, among other models.
<p>Graduate Medical Education</p>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> Redistributes 65% of unused residency slots to increase primary care and general surgery residencies. Of the pool of redistributed slots, 70% would be reserved for hospitals in states with resident to population ratios in the lowest quartile. Counts time spent on certain training activities toward DGME and IME payments, effective for cost reporting periods beginning on or after July 1, 2009 for DGME and October 1, 2001 for IME, although settled cost reports would not be reopened unless under appeal. Provides flexibility in counting time spent by residents in non-hospital settings toward Medicare DGME and IME payments effective July 1, 2010.



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<p>Graduate Medical Education</p>	<ul style="list-style-type: none"> • Makes qualified teaching health centers (including FQHCs, among other designated clinics) eligible to receive payments for the direct and indirect costs of operating residency programs. • Creates a graduate nurse education demonstration program in Medicare for advance practice nurses. Eligible hospitals would receive Medicare reimbursement for the clinical training costs attributable to the training of advance practice nurses. • Creates a demonstration through which grants would be available to FQHCs and nurse-managed health clinics training family nurse practitioners. <p><u>Medicaid</u> No provisions.</p>
<p>Primary Care Reimbursement</p>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> • Establishes five-year, 10% Medicare bonus for select E&M codes furnished by physicians and other primary care providers (e.g., nurse practitioners, clinical nurse specialists, or physician assistants) and major surgical procedures furnished by general surgeons in a health professional shortage area, beginning January 1, 2011. <p><u>Medicaid</u></p> <ul style="list-style-type: none"> • Increases fee-for-service and managed care payments for primary care services from physicians in family medicine, general internal medicine, and internal medicine to no less than 100% of the adjusted Medicare Part B rates in 2013 and 2014. Federal government will pay 100% of the costs of the amount of the increased payments during these two years.
<p>Community Health Centers</p>	<ul style="list-style-type: none"> • Authorizes the establishment of a Community Health Center Fund and appropriates to the fund: <ul style="list-style-type: none"> ○ \$9.5 billion from 2011 to 2015 for the Community Health Center (CHC) Program ○ \$1.5 billion available from 2011 to 2015 for construction and renovation of CHCs ○ \$1.5 billion from 2011 to 2015 for the National Health Service Corp. • Authorizes an additional \$34 billion in funding from FY 2010 to FY 2015 for Section 330 grants to CHCs. CHC funding for FY 2016 and beyond would be based on the prior year's appropriated funds, which would be increased to account for increases in costs per patient and increases in the number of patients served. • These funds would be available only to Section 330 grantees and not to FQHC look-alikes. • Establishes a prospective payment system beginning October 1, 2014 for Medicare-covered services furnished by FQHCs. Payment rates under the PPS would be based on 100% of the estimated reasonable costs that would have been incurred in the first year had the PPS not been implemented.



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340B Program	<ul style="list-style-type: none"> • Removes the Senate bill’s extension of 340B discounts to inpatient drugs. • Expands the program to children’s hospitals, critical access hospitals, and rural referral centers. These entities will not receive discounts on orphan drugs. • Adds new program integrity requirements for manufacturers and covered entities. • These provisions are effective beginning January 1, 2010.
Provider Payment Changes	
Medicare Market Basket Updates	<ul style="list-style-type: none"> • Implements a market basket reduction of 0.25% in 2010 and 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016, and 0.75% in 2017 through 2019 for inpatient and outpatient hospitals, inpatient rehabilitation facilities, and psychiatric hospitals. • For long-term care hospitals (LTCHs), implements a market basket reduction of 0.25% in 2010, 0.5% in 2011, 0.1% in 2012 and 2013, 0.3% in 2014, 0.2% in 2015 and 2016, and 0.75% in 2017 through 2019. • For the above providers, removes language that would have eliminated planned reductions for 2014 through 2019 if the total percentage of the insured population for the applicable year had been more than five percentage points below CBO projections. • Implements a 0.1% market basket reduction for home health agencies in 2011, 2012, and 2013. • Implements a 0.3% market basket reduction for hospice providers from 2013 through 2019, except no reduction would occur from 2014 through 2019 if the total percentage of the insured population for the applicable year is more than five percentage points below CBO projections.
Medicare Productivity Adjustments	<ul style="list-style-type: none"> • To account for economy-wide productivity gains, adjusts downward the annual market basket increase for inpatient and outpatient hospital services, SNFs, LTCHs, IRFs, home health, psychiatric hospitals, hospice, ASCs, and other services (e.g., ambulance, laboratory, DME, dialysis, and prosthetics). Most reductions would begin in FY 2012. Provides that productivity adjustments could result in negative market basket changes and a reduction in payment rates from the preceding fiscal year.

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<p>Medicare Fast-Tracker Payment Reform Initiatives</p>	<ul style="list-style-type: none"> • Establishes an independent, fifteen member Independent Payment Advisory Board (IPAB) required to submit proposals aimed at reducing excess Medicare cost growth by targeted amounts to MedPAC, the President, and Congress annually beginning January 15, 2014, unless the Chief Actuary of CMS makes certain findings related to cost growth. The CBO has estimated that the IPAB will result in \$15.5 billion in provider reductions over ten years. <ul style="list-style-type: none"> ○ For certain providers, including Medicare Advantage and Part D Plans, the Advisory Board’s proposals automatically would be implemented by the Secretary of HHS if Congress, using fast-track procedures, fails to pass an alternative package that meets the same savings targets. ○ For hospitals and other providers scheduled to receive a reduction to inflationary payment updates in excess of a productivity adjustment through 2019 (e.g., LTCHs, IRFs, psychiatric hospitals, and hospice), the Advisory Board’s recommendations would be nonbinding until 2020. • Requires the Board to submit, no less than biennially, non-binding recommendations to Congress, the President, and the public on constraining costs and improving quality in the private sector.
<p>Medicare Geographic Payment Disparities</p>	<ul style="list-style-type: none"> • Extends the 1.00 floor on the geographic index for physician work under the Medicare PFS through December 2012. Also directs the Secretary of HHS to adjust the practice expense geographic practice cost indices in 2010 and 2011 by .5% (accelerating the adjustment in 2010 by an additional .25% compared to the Senate bill) and thereafter to ensure accurate geographic adjustments across fee schedule areas. • Provides for a permanent wage index floor of 1.00 for “frontier states.” • Provides \$400 million in supplemental payments under the inpatient prospective payment system for hospitals located in counties in the bottom quartile of counties as ranked by risk adjusted spending per Medicare enrollee.
<p>Medicare & Medicaid DSH</p>	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> • Reduces Medicaid DSH payments by an aggregate \$500m for 2014, \$600m for 2015, \$600m for 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020. The Secretary will determine the amount of cuts imposed on each state based on a defined methodology (to which the reconciliation bill adds the requirements (1) that the Secretary impose a smaller percentage reduction on low DSH states and (2) that the methodology take into account the extent to which DSH allotments have been used for coverage expansion). <p><u>Medicare</u></p> <p>Reduces Medicare DSH payments by an estimated \$22 billion over 10 years beginning in 2014, and redistributes a slightly greater portion of the funds that otherwise would have been paid to hospitals with high uncompensated care.</p>



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Medicare Advantage	<ul style="list-style-type: none"> Freezes Medicare Advantage payments in 2011. Transitions payments to a benchmark that will vary from 95% of fee-for-service payment levels in high-spending states to 115% in low-spending states. Beginning in 2012, benchmarks will be phased in over 3 years in most plan areas; some areas will be given 4 to 6 years, depending on the initial difference between current MA payments and the benchmark. Awards additional payments of 1.5% in 2012 and up to 5% after 2014 for Medicare Advantage plans with quality rankings of 4 stars or better (out of 5); some plans in qualifying areas may receive double bonuses. Ties rebate system to quality of plans: those with 4.5 stars may offer rebates of up to 70% of the difference between the benchmark and their bid, those with 3.5-4.5 stars may offer 60% rebates, and those with less than 3.5 stars may offer 50% rebates. Adjusts payments to plans indefinitely for coding adjustments relating to the health status of MA enrollees. Repeals comparative cost adjustment program that was part of the Medicare Modernization Act of 2003. Removes language from Senate bill that would have applied a competitive benchmark amount to MA plans. Requires Medicare Advantage plans to have a medical loss ratio of at least 85% beginning in 2014, and imposes penalties on plans that fail to achieve this goal. Extends the authority for MA special needs plans through 2014.
Other Financing	
Drug Rebates	<p><u>Medicare</u></p> <ul style="list-style-type: none"> Provides for discounts to beneficiaries in the Part D coverage gap. See Medicare Part D below. <p><u>Medicaid</u></p> <ul style="list-style-type: none"> Increases the minimum percentage rebate on brand-name drugs to 23.1 percent of average manufacturer price in January 2010 (although the minimum rebate percentage for certain clotting factors and drugs approved for pediatric medications would be 17.1%). Increases the rebate for other drugs to 13 percent in 2010. Establishes an additional rebate for new formulations of brand-name drugs effective as of the date of enactment. Strikes exemption for new formulations of orphan drugs. Extends rebate requirement to drugs prescribed by Medicaid managed care organizations.



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<p>Pharmaceutical Industry Fees</p>	<ul style="list-style-type: none"> • Imposes an annual fee on branded pharmaceutical manufacturers and importers equal to the following: <ul style="list-style-type: none"> ○ \$2.5 billion in 2011; ○ \$2.8 billion in 2012 and 2013; ○ \$3 billion in 2014 through 2016; ○ \$4 billion in 2017; ○ \$4.1 billion in 2018; and ○ \$2.8 billion in 2019 and thereafter. • The fee will be assessed based on a company’s branded pharmaceutical sales to certain government programs, including Medicare and Medicaid, with the exception of orphan drug sales. • This revised fee is estimated to raise \$27 billion in revenues in contrast to the \$22.2 billion that was estimated to be raised under the Senate bill. 								
<p>Medical Device Industry Fees</p>	<ul style="list-style-type: none"> • Imposes a 2.3% excise tax on all taxable medical devices, excluding eyeglasses, contact lenses, and hearing aids effective for all sales after December 31, 2012. • This revised excise tax is estimated to raise \$27 billion in revenues in contrast to the \$19.2 billion that was estimated to be raised under the Senate bill. 								
<p>Insurance Industry Fees</p>	<ul style="list-style-type: none"> • Imposes a \$2 per enrollee fee on insurers, including self-insured employer plans, to finance the bill’s comparative effectiveness research fund. The calculation of the fee does not include government program enrollees. • Imposes an annual fee on health insurance plans (estimated to raise \$60.1 billion in revenue over ten years) beginning January 1, 2014, as follows: <table style="margin-left: 20px;"> <tr> <td>2014</td> <td>\$8,000,000,000</td> </tr> <tr> <td>2015-2016.....</td> <td>\$11,300,000,000</td> </tr> <tr> <td>2017.....</td> <td>\$13,900,000,000</td> </tr> <tr> <td>2018.....</td> <td>\$14,300,000,000</td> </tr> </table> <p>Each year thereafter will equal the applicable amount for the previous year increased by the rate of premium growth.</p> • The fee would be apportioned based on an insurer’s net premiums. Only 50% of tax-exempt insurers premiums are included in the calculation of the fee. 	2014	\$8,000,000,000	2015-2016.....	\$11,300,000,000	2017.....	\$13,900,000,000	2018.....	\$14,300,000,000
2014	\$8,000,000,000								
2015-2016.....	\$11,300,000,000								
2017.....	\$13,900,000,000								
2018.....	\$14,300,000,000								

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<p>Insurance Industry Fees</p>	<ul style="list-style-type: none"> • Exempts: <ul style="list-style-type: none"> ○ Governmental entities, ○ self-insured employer plans, ○ any entity that is a non-profit corporation under state law, which does not pay dividends to any shareholder or individual and does not engage in lobbying activities (except as permitted under section 501(h) of the Internal Revenue Code) or participate in political campaigns, and for which 80% of gross revenues are received from Medicare, Medicaid or CHIP; ○ and voluntary employee benefit associations.
<p>Tax on High-Cost Health Plans</p>	<ul style="list-style-type: none"> • Effective for plan years occurring after December 31, 2017, in the case of individual coverage, imposes a 40% excise tax on the value of any employer-sponsored plan that exceeds \$10,200 multiplied by the health cost adjustment percentage. In the case of family coverage, imposes a 40% excise tax on the value of any employer-sponsored coverage that exceeds \$27,500 multiplied by the health cost adjustment percentage. • The health cost adjustment percentage is based on the increase in cost of health insurance for federal employees from 2010 to 2018. <p>This provision estimated to raise \$32 billion in revenue over ten years.</p>
<p>Tax on High-Income Individuals</p>	<ul style="list-style-type: none"> • Imposes an additional 0.9% hospital insurance tax on wages or self-employment income above \$200,000 for individual filers, \$125,000 for married filing separate filers, and \$250,000 for joint filers effective as of January 1, 2013. • Imposes a 3.8% surtax on the lesser of net investment income or the excess of the modified adjusted gross income over \$200,000 for individual filers, \$125,000 for married filing separate filers, and \$250,000 for joint filers effective as of January 1, 2013. Net investment income includes income from interest, dividends, annuities, royalties, rents, and capital gains.
<p>Tax on Indoor Tanning</p>	<ul style="list-style-type: none"> • Imposes a 10% service tax on indoor tanning effective July 1, 2010.
<p>Cafeteria Plans</p>	<ul style="list-style-type: none"> • Effective January 1, 2013, limits annual salary contributions to health flexible spending arrangements to \$2,500 a year and indexes the limit by CPI-U beginning in 2014. • Effective January 1, 2011, limits distributions for medicines to prescribed drugs and insulin only. • Increases the penalty from 10 to 20% for nonqualified Health Savings Account (HSA) payments effective January 1, 2011.

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<p>Itemized Deduction of Medical Expenses</p>	<ul style="list-style-type: none"> Increases the threshold for itemized deductions for medical expenses from 7.5% to 10% of adjusted gross income effective January 1, 2012. The threshold is not increased until January 1, 2017, for individuals over the age of 65.
<p>Compliance & Transparency</p>	
<p>Expansion of False Claims Act</p>	<ul style="list-style-type: none"> Applies the False Claims Act to payments made by, through, or in connection with the Exchange if payments include any federal funds. Narrows application of the public disclosure bar to permit an individual who has independent knowledge that materially adds to the publicly disclosed allegations can serve as an original source.
<p>Enhanced Penalties for Federal Health Care Offenses</p>	<ul style="list-style-type: none"> Expands the crimes that constitute a “Federal health care offense” to include violations of the anti-kickback statute and the Federal Food, Drug, and Cosmetic Act. Mandates increased sentences for defendants convicted of Federal health care offenses.
<p>Anti-Kickback Statute Intent Standard</p>	<ul style="list-style-type: none"> Amends the anti-kickback statute intent standard to provide that a person may violate the anti-kickback statute without actual knowledge of or specific intent to violate the statute, making prosecution under the anti-kickback statute easier in some jurisdictions.
<p>Physician Payment Sunshine</p>	<ul style="list-style-type: none"> Effective March 31, 2013, requires drug and device manufacturers to report annually to the Secretary of HHS all payments or other transfers of value greater than \$10 (and any payments less than \$10 if they exceed \$100 in the aggregate in a particular year) to physicians and teaching hospitals. Also requires drug and device manufacturers and GPOs to report physician ownership and investment data annually.
<p>Physician-Owned Hospitals</p>	<ul style="list-style-type: none"> Limits the availability of the Stark law’s whole-hospital exception to existing hospitals and new hospitals that obtain a Medicare provider agreement by December 31, 2010. Physician-owned hospitals cannot expand licensed facility capacity at any time on or after March 23, 2010 (or after the effective date of its provider agreement, if such is granted after March 23, 2010 but before December 31, 2010) unless granted an exception under a process to be developed by the Secretary of HHS by February 1, 2012.



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Physician-Owned Hospitals	<ul style="list-style-type: none"> Permits “High Medicaid” facilities, which are those hospitals that are not the sole hospital in the county and whose Medicaid inpatient admissions percentage exceeds the percentage of any other hospital located in the same county, to apply for an exception.
PBM Transparency	<ul style="list-style-type: none"> Requires PBMs that manage Medicare Part D and Exchange plan prescription drug coverage to disclose certain information to the Secretary, including number of prescriptions filled by mail order compared to retail pharmacies and the aggregate amount and type of price concessions received, including rebates.
Mandatory Compliance Programs	<ul style="list-style-type: none"> Requires providers and suppliers to establish and maintain compliance programs that satisfy requirements to be established by the Secretary of HHS, in consultation with the Inspector General of HHS, as a condition of enrollment in Medicare, Medicaid, and CHIP.
Stark Self-Disclosure Protocol	<ul style="list-style-type: none"> Requires the Secretary of HHS, in cooperation with the Inspector General of HHS, to establish a self-referral disclosure protocol no later than six months after enactment.
Antitrust Exemption for Health Insurers	<ul style="list-style-type: none"> No provision. The House passed a separate bill, H.R. 4626, on February 24, 2010, to repeal the health insurer antitrust exemption. The Senate has not acted on this bill.
Recovery Audit Contractor Program Expansion	<ul style="list-style-type: none"> Expands the program to Medicare Parts C & D, and Medicaid.
Medicare Prepayment Medical Review	<ul style="list-style-type: none"> Eliminates statutory limitations on Medicare prepayment medical review.
Durable Medical Equipment Supplier Oversight	<ul style="list-style-type: none"> Beginning January 1, 2011, the Secretary may withhold payment from any durable medical equipment supplier for a period of 90 days if the Secretary determines there is a significant risk of fraudulent activity among DME suppliers in the same category or geographic area.
Funding to Combat Health Care Fraud and Abuse	<ul style="list-style-type: none"> Provides additional funding for the Health Care Fraud Abuse and Control Fund in the following amounts: \$95 million in FY 2011; \$55 million in FY 2012; \$30 million in FY 2014; and \$20 million for each of FY 2015 and FY 2016. Provides additional funding for the Medicaid Integrity Program by increasing the prior year’s appropriated amount by the percent increase in the CPI.

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<p>Study on Possible New Causes of Action</p>	<ul style="list-style-type: none"> • Directs the General Accountability Office to study, within two years of enactment, whether implementation of health reform legislation would result in the establishment of any new causes of action or claims.
<p style="text-align: center;">Other Provisions</p>	
<p>Disclosure of Hospital Charges and Specific Requirements for Tax-Exempt Hospitals</p>	<ul style="list-style-type: none"> • All hospitals operating within the United States must annually establish, update, and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital, including for Medicare DRGs. • Limits the amount that a tax-exempt hospital can charge individuals eligible for assistance under the hospital's financial assistance policy for emergency or medically necessary care to “the amount generally billed” to individuals who have insurance. • Each tax-exempt hospital must conduct a community health needs assessment at least once every three years and adopt an implementation strategy that must be disclosed on the hospital’s 990. Failure to do so will result in a penalty of \$50,000. These provisions take effect in the first taxable year after enactment. • Each hospital must adopt and widely publicize a written financial assistance policy and may bill patients who qualify for financial assistance no more than the amounts generally billed. Hospitals must follow current Medicare policies regarding collection of debt and are prohibited from undertaking extraordinary collection actions without first making reasonable attempts to inform the patient about the hospital’s financial assistance policy. • HHS must report annually to Congress on the levels of charity care, bad debt expenses, and unreimbursed costs of means tested government programs incurred by private tax-exempt, taxable, and governmental hospitals, as well as the cost of community benefit activities incurred by private tax-exempt hospitals.
<p>Follow-on Biologics</p>	<ul style="list-style-type: none"> • Establishes a pathway for FDA approval of follow-on biologics and a follow-on biologics user fee. Provides 12 years exclusivity to reference products and an additional six months exclusivity period if pediatric studies are conducted. • Provides a period of exclusivity of at least one year to the first follow-on biologic approved for a particular reference product.



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Medicare Part D	<ul style="list-style-type: none">• Closes the donut hole by lowering the beneficiary coinsurance from 100% to 25% over ten years. For generic drugs, the coinsurance will drop to 93% in 2011, and will continue to be reduced annually until reaching 25% in 2020. For brand-name drugs, manufacturers will provide a 50% discount starting in 2011, in addition to federal subsidies that will phase in beginning in 2013.• Provides a one-time rebate of \$250 for Part D beneficiaries who reach the donut hole in 2010.• Eliminates the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments effective January 1, 2013.
Prevention & Wellness	<ul style="list-style-type: none">• Requires Exchange plans and Medicare to cover all preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force without any cost sharing. Exchange plans also must cover (without imposing cost sharing) immunizations recommended by the CDC, with respect to infants, children, and adolescents, evidence-informed preventive care and screenings recommended by HRSA, and, with respect to women, additional preventive care and screenings recommended by HRSA.• Effective January 1, 2011, Medicare beneficiaries would be eligible to receive an annual visit for personalized prevention plan services, including a comprehensive health risk assessment.• Establishes an employer wellness grant program to assist employers with 100 employees or less to implement wellness programs.• Provides a one percentage point FMAP increase to states that provide Medicaid coverage for all services recommended by the U.S. Preventive Services Task Force and prohibits cost-sharing for such services.• Creates a \$100 million program to provide incentives to Medicaid beneficiaries who successfully complete programs to lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and to address co-morbidities, such as depression, associated with these conditions.• Permits employers to provide premium discounts, rebates or other rewards equal to up to 30% of the cost of employee-only coverage to employees who participate in wellness programs and satisfy standards that are related to health status factors. The Secretary of the Treasury may increase the allowable amount to 50%.• Establishes a wellness program demonstration project under which states may permit individual health insurance plans to offer similar wellness programs.



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Prevention & Wellness	<ul style="list-style-type: none">• Establishes a \$15 billion Prevention and Public Health Fund to fund prevention, wellness, and public health activities, including prevention research and health screenings between FY 2010-2019. In particular, these funds will finance the newly-established Community Transformation grant program to implement, evaluate, and disseminate evidence-based community preventive health activities and Healthy Aging, Living Well pilot program to provide public health intervention services to individuals aged 55 to 64.• Establishes a demonstration program to award grants to states to improve the provision of recommended immunizations for children, adolescents, and adults.• Establishes a national diabetes prevention program at the CDC to carryout community-based prevention activities, training, outreach, and evaluation.• Establishes the National Prevention, Health Promotion and Public Health Council, which is tasked with developing a national wellness and prevention strategy within one year of enactment.
Medical Malpractice Reform	<ul style="list-style-type: none">• Establishes a state demonstration program to evaluate alternatives to current tort litigation for resolving medical malpractice disputes. States will receive 5 year grants to develop tort litigation alternatives that allow for dispute resolution and promote reduction in health care errors. Demonstration programs must permit patients to opt out and pursue remedies through the courts.• Requires MedPAC and MACPAC to study the impact of these alternatives on the Medicare and Medicaid programs and must report to Congress by December 31, 2016 on the efficiency and effectiveness of the programs. Appropriates \$50 million for the five-year period beginning with FY 2011.• Extends federal medical malpractice coverage to free clinics.