



Overview of New Health Insurance Reform Law

HR 3590, the Patient Protection and Affordable Health Care Act, and
HR 4872, the Health Care and Education Reconciliation Act of 2010

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How the Health Insurance Reform Legislation Became Law

- 1) HR 3590, the Patient Protection and Affordable Health Care Act, was passed by the US Senate on December 24, 2009. Identical legislation was passed by the US House of Representatives on March 21, 2010.
- 2) HR 4872, the Health Care and Education Reconciliation Act of 2010, was also passed by the House on March 21 and modifies certain provisions in the Patient Protection and Affordable Health Care Act. HR 4872 was slightly revised and passed by the Senate on March 25, 2010 and passed again by the US House of Representatives on that same day.
- 3) HR 3590 was signed into law by President Obama on March 23, 2010, as P.L. 111-148. HR 4872 was signed into law on March 30, 2010.
- 4) HR 3590, as amended by HR 4872, is the nation's new health care reform law.

CBO Estimates

The Congressional Budget Office estimates that the combined legislation will cost \$938 billion and will reduce the deficit by \$143 billion over 10 years. The new law is expected to reduce the number of uninsured Americans by 32 million by 2019.

Medicare Payment Fix

Medicare's sustainable growth rate (SGR) formula, which determines Medicare reimbursement for physicians and all health care professionals providing covered services under Medicare, was not addressed through the health care reform measures. There is widespread agreement in Congress that the SGR is flawed and must be corrected; the question is how the problem can be paid for and through what time period. Separate legislation addressing this is expected to be enacted before the end of the current fiscal year.

New Law's General Framework

The new law requires that most uninsured individuals purchase health insurance coverage by 2014 through a health benefit exchange established by each state. The exchanges are to offer plans at four cost levels, from 60% to 90% of the actuarial value. Catastrophic coverage only plans will be limited to individuals under 30 and those who meet the individual mandate exception. All plans participating in the exchange must meet standards on affordability, basic benefits, and consumer protections. The new law does not contain a public option, but it does permit the development of multi-state plans that would be overseen by the Office of Personnel Management.

A tax penalty will be imposed on uninsured adults who do not obtain health insurance coverage by 2014, and a fee will be imposed on employers with more than 50 employees who do not offer health insurance coverage.

Health insurance tax credits will be made available to small businesses, and "affordability premium credits" will be made available to non-Medicaid eligible individuals with incomes 100-400% above the federal poverty level and who are not enrolled in an employer-sponsored plan. States will be provided increased federal assistance to expand Medicaid coverage to all non-elderly individuals up to 133% of the federal poverty level.

The new law extends reauthorization of the Children's Health Insurance Program (CHIP) and requires states to maintain children's eligibility levels through 2019 with an increased federal matching rate. The new law also creates a new long-term care insurance program, the Community Living Assistance Service and Supports Program -- the CLASS Program -- that is to be financed entirely through voluntary payroll deductions.

Beginning in 2010, a \$250 rebate will be made available to beneficiaries who reach the "donut hole" in Medicare's prescription drug coverage program with additional drug discounts in 2011; the donut hole would be completely closed by 2020.

Insurance market reforms will prohibit health insurers from denying coverage for any reason, with some reforms beginning as early as 2010. Among the new insurance reforms are prohibitions on lifetime limits on required health benefits, along with a prohibition on coverage exclusion of preexisting conditions. Insurers could no longer drop coverage when an individual becomes sick. Additionally, the law requires plans to cover dependent children up to age 26; to cover routine care coverage during a clinical trial; and to honor mental health parity requirements. Waiting periods for coverage would be limited to 90 days.

Immediate help would be provided through a \$5 billion, temporary high-risk pool for Americans who are currently uninsured because of a pre-existing condition.

PA Specific Provisions

The new health care reform law contains several provisions that specifically affect physician assistants. The new law --

- Establishes a 15% carve-out for PA educational programs in the funding cluster on primary care medicine; updates the definition of PA educational programs; and makes PA educational programs eligible for faculty loan repayment grants through the reauthorization of the Public Health Service Act's Title VII, Health Professions Programs. (The reauthorization applies to fiscal years 2010 through 2014.)
- Fully integrates PAs into the new Independence at Home demonstration program. The Independence at Home demonstration acknowledges the existence of physician led medical practices and medical practices led by nurse practitioners. However, language in the statute is clear that the role of physicians, PAs, and NPs in the primary care team is the same. The bill language states --



“(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—
“(A) all the requirements of this section are met;
“(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and
“(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).”

- Creates a 5-year 10% Medicare bonus for select primary care codes furnished by PAs, as well as other primary care providers, for whom at least 60% of services provided during a period to be determined by the Secretary are in primary care. The provision is effective beginning in 2011 through 2015. The applicable Medicare primary care codes are HCPCS codes (and modifiers) 99201 through 99215; 99304 through 99340; and 99341 through 99350.
- Amends Medicare to allow PAs to order skilled nursing facility care for Medicare beneficiaries. (The effective date is January 1, 2011.)

Additional Provisions of Interest to PAs

- A \$200 enrollment fee will be charged in 2010 for health care professionals, including PAs, who provide medical services through the Medicare, Medicaid, and Children’s Health Insurance Program, to cover the cost of provider screening and background checks.
- The Indian Health Care Improvement Act was amended and reauthorized for the first time in a decade.
- An Independent Payment Advisory Board will be established to submit legislative proposals to reduce the per capita rate of growth in Medicare spending should the spending exceed a target growth rate.
- Medicare providers who are organized as accountable care organizations and meet quality thresholds will share in the savings they achieve for the Medicare program.
- An Innovation Center will be created within the Centers for Medicare and Medicaid Services to test, evaluate, and expand different payment structures and methodologies to improve quality and reduce the rate of cost growth.
- The Food and Drug Administration is now authorized to approve generic versions of biologic drugs and to grant manufacturers 12 years of exclusive use before generic versions can be developed.
- A non-profit Patient-Centered Outcomes Research Institute will be created to support comparative effectiveness research.
- Five-year demonstration grants will be awarded to states to develop and evaluate alternatives to current litigation regarding medical malpractice.
- A Medicare pilot program will be established to develop and evaluate bundled payment for acute, inpatient hospital, physician services and post-acute care services for certain episodes of care.
- New Medicaid demonstration projects will be developed to explore bundled payments for episodes of care involving hospitalization.
- Increased collection of reporting will take place on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations
- A National Prevention, Health Promotion and Public Health Council will be developed to coordinate prevention, wellness, and public health initiatives.
- Chain restaurants and vending machines will be required to post nutritional information on food items.
- A national Workforce Advisory Committee will be charged with developing a national workforce strategy.
- Funding for community health centers and the National Health Service Corps will be increased by \$11 billion over five years.



Implementation Timeline

Although the individual mandate and the health insurance exchanges will not be in place until 2014, a number of provisions will take place in the next year. Among them are –

Effective Immediately:

- Small business tax credits and the \$250 rebate for Medicare beneficiaries facing the prescription drug benefit “donut hole.”

Effective July 1, 2010 (90 days after enactment):

- Assistance for currently uninsured Americans through a temporary high-risk pool;
- Prohibition on plans denying coverage to children because of pre-existing conditions;
- Coverage of dependents up to age 26 on parents’ insurance policies;
- Prohibition of plans from dropping coverage when individuals become sick;
- Prohibition of plans placing lifetime caps on coverage; and
- Prohibition of plans placing annual limits on coverage.

Effective January 1, 2011:

- Eliminates co-payments and deductibles for preventive services provided through Medicare;
- Requires health insurance plans in small group markets to spend 80% of premium dollars on medical services; and
- Requires health insurance plans in the large group market to spend 85% of premium dollars on medical services.

The Road Ahead

The nation’s course for health care reform is ambitious and will require a massive effort in implementation throughout the next decade. The possibilities and challenges presented by the new law are both enormous and daunting.

AAPA will advocate for the PA profession throughout the implementation of the health care reform plan and provide updates and more detailed information to the AAPA membership throughout the implementation of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

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