**Summary of the 2010 federal health reform law, the Affordable Care Act**

*As of October 21, 2010*

The chart below serves to highlight the major components of the final health reform package, based on the Senate bill (H.R. 3590), signed into law (P.L. 111-148) by President Obama on March 23, 2010 and the reconciliation bill (H.R. 4872) signed into law (P.L. 111-152) by President Obama on March 30, 2010.

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<tr>
<th>Medicare</th>
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<td><strong>Program Solvency/Delivery of Care</strong></td>
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<td>- Creates an independent, 15-member Medicare Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Board’s proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.</td>
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<td>- Establishes the Center for Medicare and Medicaid Innovation (CMI) within CMS and provides funding for CMI to test innovative Medicare and Medicaid payment and service delivery models that move away from the traditional fee-for-service (volume-based) model to value-based payment models that may include bundled payments, capitated payments, and shared savings payments involving a broader swath of the care continuum. Such initiatives include pilot projects and demonstration programs to create Accountable Care Organizations, an integrated group of providers that will be held accountable for the overall cost and quality of care of traditional fee-for-service Medicare beneficiaries with the cost, risk,</td>
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and financial rewards shared among all the providers in an ACO. Financial incentives to ACOs would
begin in 2012. The impact on oral and maxillofacial surgery is still being assessed, but private insurers
are already monitoring these initiatives to see how they can benefit from them.

-Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will
adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and
cost measures will be risk-adjusted and geographically standardized. The Secretary will phase-in the
new payment system over a 2-year period beginning in 2015.

-Authorizes funding for the development of quality measures and to support the use of quality measures
in Medicare, reporting performance information to the public and in health care programs.

**Provider Reimbursement Reform**

-Does not include SGR reform provision.

-Beginning in 2011-2015, allots primary care practitioners, as well as general surgeons practicing in
health professional shortage areas, with a 10 % Medicare payment bonus. Half of the cost of the bonuses
would be offset through an across-the-board reduction in all other services.

-Directs Secretary to regularly review fee schedule rates for provider services paid for by Medicare,
including services that have experienced high growth rates; strengthens Secretary’s authority to adjust
fee schedule rates that are found to be misvalued or inaccurate.

- Sets for 2011 the assumed utilization rate at 75% for the practice expense portion of advanced
diagnostic imaging services.

**PQRI Modifications**

-Extends through 2014 payments under PQRI. Beginning in 2014, physicians who do not submit
measures to PQRI will have their Medicare payments reduced.

- Adds an additional requirement to the Medicare for in-office ancillary services to the prohibition on physician self-referral for certain imaging services.

**Fraud & Abuse**

- Increases funding for the Health Care Fraud and Abuse Control Fund by $250 million over the next decade. Indexes funds to fight Medicaid fraud based on the increase in the Consumer Price Index.

- Reduces the period for Medicare claims submission to no later than 12 months.

- Requires overpayments to be reported and returned within 1 year from the date the overpayment was identified or the date a corresponding cost report was due.

- Requires that HHS establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP. At a minimum, all providers and suppliers would be subject to licensure checks. The Secretary would have the authority to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-State data base inquiries, and random or unannounced site visits. An application fee of $200 for individual practitioners and $500 for institutional providers and suppliers would be imposed to cover the costs of screening each time they re-verify their enrollment (every five years).

- Providers and suppliers enrolling or re-enrolling in Medicare, Medicaid, or CHIP would be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked. The Secretary would be authorized to deny enrollment in these programs if these affiliations pose an undue risk to a program.

- Within 6 months of enactment, HHS required to establish a self-referral disclosure protocol to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law.
- Requires CMS to include in the integrated data repository (IDR) claims and payment data from the following programs: Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS).

**Medicaid**
- Expands Medicaid to all individuals underage 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income. All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits. While a requirement for comprehensive adult dental services does not exist, the compulsory standard adult coverage may offer some dental services.

- To finance the coverage for the newly eligible, states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2020 they receive the same federal financing (90%) as other states. In addition, increases Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2014).

- Expands the Medicaid and CHIP Payment Access Commission (MACPAC) to include assessments of adult services, including services for dually-eligible individuals. The MACPAC will assess policies affecting Medicaid beneficiaries, including payments to providers.

**Quality Initiatives**

- Establishes the Patient-Centered Outcomes Research Institute private/non-profit) governed by a public-private sector board appointed by the Comptroller General to identify priorities for and provide for the
conduct of comparative outcomes research. Prohibits any findings to be construed as mandates on “practice guidelines, coverage recommendations, payment, or policy recommendations.”

**Quality Measures**

- Requires the Secretary to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Establishes, not later than January 1, 2011, a Federal health care quality internet website.

### Shared Responsibility

#### Individual Mandate

- All U.S. citizens and legal residents will be required to have ‘qualifying’ health coverage (hardship exemptions made) by 2014. Those that do not comply will face a tax maximum penalty of $95 in 2014, $325 in 2015, and $695 starting in 2016 per adult per year or pay 1.0% of taxable income in 2014, 2.0% in 2015 and 2.5% in 2016, whichever is higher.

  - Provides refundable and advanceable premium credits to individuals and families with incomes between 100-400% FPL to purchase insurance through the health insurance exchanges.

  - Provides reduced cost-sharing for individuals and families with incomes between 100-400% FPL enrolled in qualified health plans.

#### Employer Responsibility

- Does not include a comprehensive employer mandate.

  - Assesses employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee.
- Provides a sliding scale tax credit (35% from 2010-2013, then 50% from 2014 on) to small employers with no more than 25 employees and average annual wages of no more than $50,000 that purchase health insurance for their employees. The full credit is available to employers with 10 or less employees and average annual wages less than $25K and who contribute 50 percent of total premium costs or 50 percent of a benchmark premium. The tax credit covers up to 50% of their contribution for two years by 2014.

- Requires employers beginning on January 1, 2012 to report the value of the health insurance coverage they provide employees on each employee's annual Form W-2. This reporting is for informational purposes only, to show employees the value of their health care benefits so they can be more informed consumers. The amount reported does not affect tax liability, as the value of the employer contribution to health coverage continues to be excludible from an employee's income, and it is not taxable.

- Establishes a “Simple Cafeteria Plan” to provide small businesses a safe harbor from the nondiscrimination requirements for cafeteria plans to enable them to better offer tax-free employee benefits.

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### Health Insurance Exchange or Gateway

- Creates state-based exchanges for the individual market and small business health options program (SHOP) exchanges for the small group market to be operational by 2014.

- Allows small businesses with up to 100 employees to purchase coverage through the SHOP exchanges beginning in 2014 (states may limit this market to businesses with 50 employees until 2016) and permits states to allow businesses with more than 100 employees to purchase coverage in the SHOP exchange beginning in 2017.

- Creates the Consumer Operated and Oriented Plan (CO-OP) program and appropriates money to qualified insurance issuers to create non-profit, member-run health insurance companies in all 50 states and District of Columbia.

- Creates four Qualified Health Benefit Plans (QHBP) categories of plans plus a separate “young
**Invincible Plan** (aka Catastrophic Plan) to be offered through the exchange, and in the individual and small group markets. Allows states flexibility to establish basic health programs by contracting with 1 or more standard health plans for low-income individuals (below 200%FPL) not eligible for Medicaid.

- Four benefit categories under which the plan pays for the specified percentage of costs:
  * Bronze: 60 percent
  * Silver: 70 percent
  * Gold: 80 percent
  * Platinum: 90 percent

- Requires the Secretary to establish a system for residents of each State to utilize when applying for their respective State health subsidy programs. The system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a State children’s health insurance program (CHIP), the individual is enrolled for assistance under such plan or program.

- Instead of offering coverage through the Exchange, states may offer “standard health plans” molded to the requirements of Medicaid disqualified, low income individuals.

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<th>Public Option</th>
<th>- No public plan provision.</th>
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<td>- Would require the Office of Personnel Management (OPM) to contract with insurers to offer at least two multi-state plans in each Exchange. OPM currently operates the Federal Employees Health Benefit Program, but these new multi-state plans will be offered separately from the FEHB plans and have a separate risk pool.</td>
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<th>Insurance/Essential Benefits</th>
<th>- Private insurance must guarantee issue/renewability may not be based on gender. Prohibits exclusion for pre-existing conditions or other discrimination based on health status. Also prohibits rescissions except in instances of fraud or misrepresentation.</th>
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<td>- Prohibits plans from establishing lifetime or unreasonable annual limits on the dollar value of benefits.</td>
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<td>- Requires coverage of preventative health services recommended by the Health Resources and Services Administration without cost sharing.</td>
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- All plans in the individual and group markets are required to provide coverage for children up to age 26.

- Permits employers to vary insurance premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs.

- Prohibits insurers from discriminating against health providers acting within the scope of their professional licensure and applicable state laws.

- Requires all health plans operating in the exchange to cover the following defined minimum benefits: preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by Federal and state laws.

- Stand-alone dental plans would be permitted to offer pediatric dental benefits directly and to offer coverage through the exchange. Stand-alone dental plans may operate in the Exchange either separately or in conjunction with a medical plan if the dental plan provides the required children’s oral health coverage. These plans must comply with all consumer protection requirements in order to participate in the exchange.

- There is no requirement for health care providers to participate in any of the exchanged-based insurance plans.

- Insurance providers will be obligated to maintain at least an 85% medical loss ratio (the fraction of revenue from a plan’s premiums that goes to pay for medical services) for the large group market, and a ratio of 80% for the individual and small group market. Failure to comply will result in the payment of rebates.

- By 7/1/2013, two or more states may agree to allow insurers to offer individual qualified health plans...
across state lines. Insurance providers can also choose to offer individual or small group nationwide qualified health plans.

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<th>Public Health/Workforce Development</th>
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<td><strong>Health Care Workforce Commission</strong></td>
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<td>- Establishes a National Health Care Workforce Commission to analyze data on the current health professional workforce which includes “oral health care workforce capacity at all levels”, project future worker demand, determine education and training capacity and infrastructure, and evaluate implications of new and existing federal policies that impact the health care workforce; establishes a state grant program to conduct similar strategies.</td>
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<th>Dental Training Program</th>
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<td>- Allows dental schools and education programs to use grants for pre-doctoral training, faculty development, dental faculty loan repayment, and academic administrative units.</td>
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<th>“Alternative Dental Health Care Providers”</th>
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<td>- Authorizes the Secretary to award grants to establish training programs for alternative dental health care providers to increase access to dental health care services in rural, tribal, and underserved communities. The term ‘alternative dental health care providers’ includes “community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.” The program must be CODA accredited or within a dental education program in an accredited institution. Each entity must also be in compliance with all applicable state licensing requirements.</td>
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- Incorporated the Indian Health Care Improvement Act (IHCIA), which includes ADA-agreed language that limits the scope of practice of a Dental Health Aide Therapist (DHAT) and precludes DHATs from being part of the Community Health Aide Program (CHA) beyond Alaska if the program is nationalized; however, it also contains a provision to allow tribes in states that license dental therapists to establish a DHAT program.

- These provisions could promote midlevel dental providers to perform surgical dental procedures and expand the availability of the Alaska DHAT model to other tribal areas of the country.
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<th>Misc.</th>
<th><strong>Liability Reform</strong></th>
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<td>- “Expresses the sense of the Senate” that health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives.</td>
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<td>- Awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance.</td>
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<td>- Provides liability protection to individuals who are employed at free clinics.</td>
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**Oral Health Provisions**

- Establishes an oral healthcare prevention education campaign at CDC focusing on preventive measures and targeted towards key populations including children and pregnant women.

- Authorizes funding for grants to provide geriatric education training centers for health professionals including faculty in dental schools and public health officials.

**Trauma Care**

- Provides grants to states and trauma centers to strengthen the nation’s trauma system.

- Reauthorizes the Wakefield Emergency Medical Services for Children Act which provides grants to states and medical schools to support emergency medical services for children.

**Diagnostic Equipment Standards**
Within two years of enactment the FDA will set forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician’s offices, clinics, emergency rooms, hospitals, and other medical settings to ensure they are handicapped accessible. Includes examination chairs and x-ray machines.

**Residency Issues (GME)**

- Provides incentives for the training of primary care physicians and encourages medical residency training in non-hospital settings

- Secretary directed to redistribute residency positions that have been unfilled for training of primary care physicians.

**Wellness**

- Institutes the National Prevention, Health Promotion, and Public Health Council which coordinates federal prevention, wellness, and public health endeavors.

- Establishes a Prevention and Public Health Fund to finance prevention research and health screenings, the Education and Outreach Campaign for preventive benefits, and an immunization agenda.

**Prohibition Against Degree of Provider Discrimination**

- Prohibits health insurance issuers from discriminating against providers acting within the scope of practice of their professional licensure and in accordance with state law.

### Financing

- **CBO Cost** - $938 billion over 10 years

**Medicare/Medicaid Savings & Revenue**

- Primarily financed through reducing payments to Medicare Advantage plans, expected savings via newly created Medicare Commission, changing Medicaid drug rebate provisions and cutting Medicaid
and Medicare DSH payments.

- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% tax on unearned income for higher-income tax-payers. (Effective January 1, 2013)

**Excise Tax on High-Cost Health Plans**

- Effective Jan 1, 2018, imposes an excise tax (equal to 40% of the value of the plan that exceeds the threshold amount) on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. The tax is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer.

- The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers.

- The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage.

**Flexible Spending Accounts (FSA) & Health Savings Accounts (HSA)**

- Effective January 1, 2013, limits the amount of contributions to a FSA for health-related expenses to $2,500 per year, indexed for inflation.

- Increases the tax on distributions from a HSA and Archer medical savings amounts (MSAs) (prior to
age 65) that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount.

- Removes over-the-counter medications from list of deductible items from health reimbursement arrangements (HRA), FSAs, and HSAs. The change does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays and deductibles.

- HSA/FSA accounts are used by patients for dental care, which is not always included in employer-provided insurance. These limitations may have a negative effect on access to dental care for patients without dental coverage.

- Increases the itemized deduction threshold for unreimbursed medical expenses from 7.5% of adjusted gross income to 10%

**Tanning Tax**

- Imposes a tax of 10% on the amount paid for indoor tanning services.

**Medical Device Tax**

- Imposes on device manufacturers an excise tax of 2.3% on the sale of any taxable medical device. (Effective for sales after December 31, 2012). Exempts from the tax Class I medical devices, eyeglasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use.

**Pharmaceutical Manufacturer Tax**

- Imposes annual fees on the pharmaceutical manufacturing sector based on the following schedule: – $2.8 billion in 2012-2013; $3.0 billion in 2014-2016; $4.0 billion in 2017; $4.1 billion in 2018; and $2.8 billion in 2019 and later.

**Insurance Industry Tax**
-Imposes an annual fee on the health insurance sector, according to the following schedule: – $8 billion in 2014; $11.3 billion in 2015-2016; $13.9 billion in 2017; $14.3 billion in 2018. For subsequent years, the fee shall be the amount from the previous year increased by the rate of premium growth.

**1099 Tax Form Requirement**

-Requires all businesses and nonprofits beginning January 1, 2012 to file a 1099 tax form for any vendor to which they pay more than $600 annually in goods and services. While previous tax law only applied to unincorporated businesses that purchased more than $600 annually in services, the new law is designed to capture more unreported tax revenue.