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PRESENTS...

A COURSE by Ted PERKINS  
JD, LL.M., CPA



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## **The Patient Protection and Affordable Care Act**

**TAX and NONTAX  
Provisions**

**CPE CREDIT - 1.0 Hour**

**FIELD OF STUDY - Taxation - Non-Interactive Self Study**

**PROGRAM LEVEL - Basic**

**PREREQUISITE - None**

**ADVANCE PREPARATION REQUIRED - None**



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**Course Summary**

This course will provide an overview of the Tax and Nontax Provisions in the Patient Protection and Affordable Care Act, a federal statute signed into law by President Barack Obama on March 23rd, 2010.

## **Your Instructor**

Edward L. Perkins, BA, JD, LLM (TAX), CPA

## **Course Content**

The Practice Units are as follows:

Part One - Tax Provisions  
Part Two - Nontax Provisions

## **Learning Objective**

This Course consists of multiple sections and one Quizzer. You must view every Unit in full prior to moving forward, and upon the completion of the final Unit will be tested on the materials discussed therein.

## **Obtaining Course Credit**

At the end of the main presentation, after you will have completed the Course Material, you will be given an opportunity to take the Quizzer. If your score is less than 70%, you may retake the Quizzer as many times as you like until you answer at least 70% of the Questions correctly. In order to receive your Certificate of Completion and your Credit, you must complete the Quizzer and answer 70% of the Questions correctly.

## **I. Tax Changes Relating to Universal Health Coverage Mandate**

### **A. Penalty for remaining uninsured.**

1. Effective for tax years beginning after Dec. 31, 2013, non-exempt U.S. citizens and legal residents would have to maintain minimum essential coverage, or pay a penalty.
2. Those failing to maintain minimum essential coverage in 2016 would be subject to a penalty equal to the greater of:
  - a. 2.5% of household income over the threshold amount of income required for income tax return filing, or
  - b. \$695 per uninsured adult in the household.
3. The fee for an uninsured individual under age 18 would be one-half of the fee for an adult.
4. The total household penalty wouldn't exceed 300% of the per adult penalty (\$2,085), nor exceed the national average annual premium for the "bronze level" health plan offered through the Insurance

### **B. Exchange that year for the household size.**

1. The per adult annual penalty would be phased in as follows: \$95 for 2014; \$325 for 2015; and \$695 in 2016.
2. For years after 2016, the \$695 amount would be indexed to CPI-U, rounded to the next lowest \$50.
3. The percentage of income would be phased in as follows: 1% for 2014; 2% in 2015; and 2.5% beginning after 2015.
4. If a taxpayer files a joint return, the individual and spouse would be jointly liable for any penalty payment.
5. The penalty, which would apply to any period the individual does not maintain minimum essential coverage (determined monthly) would be assessed through the Code.

### **C. Among those individuals who would be exempted from the penalty:**

Individuals who cannot afford coverage because their required contribution for employer sponsored coverage or the lowest cost "bronze plan" in the local Insurance Exchange exceeds 8% of household income; those who are exempted for religious reasons; and those residing outside of the U.S.

### **D. Low-income tax credits for participating in health exchanges.**

1. For tax years ending after 2013, tax credits would be available for individuals and families with incomes up to 400% of the federal poverty level (\$43,420 for an individual or \$88,200 for a family of four) that are not eligible for Medicaid, employer sponsored insurance, or other acceptable coverage.
2. These individuals and families would have to obtain health care coverage in newly established Insurance Exchanges in order to obtain credits.
3. Additionally, effective on the enactment date, a "cost-sharing subsidy" would be provided to low income individuals to help with health insurance costs.

**E. Employer responsibilities.**

1. Effective for months beginning after Dec. 31, 2013 an “applicable large employer” (generally, one that employed an average of at least 50 full-time employees during the preceding calendar year) not offering coverage for all its full-time employees, offering minimum essential coverage that is unaffordable, or offering minimum essential coverage that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%, would have to pay a penalty if any full-time employee is certified to the employer as having purchased health insurance through a state exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee.

2. The penalty for any month would be an excise tax equal to the number of full-time employees over a 30-employee threshold during the applicable month (regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) multiplied by one-twelfth of \$2,000.

3. Also, an applicable large employer that offers, for any month, its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer sponsored plan would be subject to a penalty if any full-time employee is certified to the employer as having enrolled in health insurance coverage purchased through a State exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to such employee or employees.

4. Most small businesses are exempted from penalties for not offering coverage to their employees. Employers with fewer than fifty employees aren't subject to the penalty provisions.

**F. “Free choice vouchers.”**

1. After 2013, employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage would have to provide qualified employees with a voucher whose value could be applied to purchase of a health plan through the Insurance Exchange.

2. Qualified employees would be those employees: who do not participate in the employer's health plan; whose required contribution for employer sponsored minimum essential coverage exceeds 8%, but does not exceed 9.5% of household income; and whose total household income does not exceed 400% of the poverty line for the family.

3. The value of the voucher would be equal to the dollar value of the employer contribution to the employer offered health plan.

**G. Tax credits for small employers offering health coverage.**

1. Effective for tax years beginning after 2009, a qualified small employer would be given a tax credit for nonelective contributions to purchase health insurance for its employees.

2. A qualified small business employer for this purpose generally would be an employer with no more than 25 full-time equivalent employees (FTEs) employed during the employer's tax year, and whose employees have annual full-time equivalent wages that average no more than \$50,000.

3. However, the full amount of the credit would be available only to an employer with 10 or fewer FTEs and whose employees have average annual fulltime equivalent wages from the employer of less than \$25,000.

4. These wage limits would be indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) for years beginning in 2014.

5. For tax years beginning in 2010 through 2013, the credit would be 35% for small employers with fewer than 25 employees and average annual wages of less than \$50,000 who offer health insurance coverage to their employees. In 2014 and later, eligible small employers who purchase coverage through the Insurance Exchange would be eligible for a tax credit for two years of up to 50% of their contribution.

6. Small Business Employers will be allowed to take an ordinary and necessary business expense deduction equal to the amount of the employer contribution less the dollar amount of any credits that they are afforded. E.g. if the employer spends \$100 dollars and receives a \$50 credit, their deduction will be \$50.

#### **H. Dependent coverage in employer health plans.**

1. Effective on the enactment date, the health reform measure would extend the general exclusion for reimbursements for medical care expenses under an employer-provided accident or health plan to any child of an employee who has not attained age 27 as of the end of the tax year.

2. This change would also be intended to apply to the exclusion for employer-provided coverage under an accident or health plan for injuries or sickness for such a child.

A parallel change would be made for VEBA and 401(h) accounts.

3. Also, self-employed individuals would be permitted to take a deduction for any child of the taxpayer who has not attained age 27 as of the end of the tax year.

## **II. Health-Related Revenue Raisers**

#### **A. Excise tax on high-cost employer-sponsored health coverage.**

1. For tax years beginning after Dec. 31, 2017, the bill would place a 40% nondeductible excise tax on insurance companies and plan administrators for any health coverage plan to the extent that the annual premium exceeds \$10,200 for single coverage and \$27,500 for family coverage.

2. An additional threshold amount of \$1,650 for single coverage and \$3,450 for family coverage would apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

3. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals).

4. Stand-alone dental and vision plans would be disregarded in applying the tax.

5. The dollar amount thresholds would be automatically increased if the inflation rate for group medical premiums between 2010 and 2018 is higher than the Congressional Budget Office (CBO) estimates in 2010.

6. Employers with age and gender demographics that result in higher premiums could value the coverage provided to employees using the rates that would apply using a national risk pool.

7. The excise tax would be levied at the insurer level. Employers would be required to aggregate the coverage subject to the limit and issue information returns for insurers indicating the amount subject to the excise tax.

**B. New employer reporting responsibilities.**

For tax years beginning after Dec. 31, 2010, employers would have to disclose the value of the benefit provided by them for each employee's health insurance coverage on the employee's annual Form W-2.

**C. Additional Hospital Insurance Tax (HI) for high wage workers.**

For tax years beginning after Dec. 31, 2012, the HI tax rate would be increased by 0.9 percentage points on an individual taxpayer earning over \$200,000 (\$250,000 for married couples filing jointly); these figures are not indexed.

**D. Surtax on unearned income.**

1. For tax years beginning after Dec. 31, 2012, a 3.8% surtax called the Unearned Income Medicare Contribution, would be placed on net investment income of a taxpayer earning over \$200,000 (\$250,000 for a joint return).

2. Net investment income would be interest, dividends, royalties, rents, gross income from a trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business).

3. Net investment income would be reduced by properly allocable deductions to such income.

**E. New limit on health FSA contributions.**

The amount of contributions to health flexible spending accounts (FSAs) would be limited to \$2,500 per year, effective for tax years beginning after Dec. 31, 2012. The dollar amount would be inflation indexed after 2013.

**F. Restricted definition of medical expenses for employer provided coverage.**

1. For purposes of employer provided health coverage (including health reimbursement accounts (HRAs) and health flexible savings accounts (FSAs), health savings accounts (HSAs), and Archer medical savings accounts (MSAs)), the definition of medicine expenses deductible as a medical expense would generally be conformed to the definition for purposes of the itemized deduction for medical expenses.

2. But this change would not apply to doctor prescribed over-the-counter medicine.

3. Thus, the cost of over-the-counter medicine (other than insulin or doctor prescribed medicine) could not be reimbursed through a health FSA or HRA.

4. In addition, the cost of over-the-counter medicines (other than insulin or doctor prescribed medicine) could not be reimbursed on a tax-free basis through an HSA or Archer MSA.

5. These changes would be effective for tax years beginning after Dec. 31, 2010.

**G. Increased tax on nonqualifying HSA or Archer MSA distributions.**

The additional tax for HSA withdrawals before age 65 that are used for purposes other than qualified medical expenses would be increased from 10% to 20%, and the additional tax for

Archer MSA withdrawals that are used for purposes other than qualified medical expenses would be increased from 15% to 20%, both effective for distributions made after Dec. 31, 2010.

**H. Modified threshold for claiming medical expense deductions.**

1. For tax years beginning after Dec. 31, 2012, the adjusted gross income (AGI) threshold for claiming the itemized deduction for medical expenses would be increased from 7.5% to 10%.

2. However, the 7.5%-of-AGI threshold would continue to apply through 2016 to individuals age 65 and older (and their spouses).

**I. Deduction for employer Part D would be eliminated.**

The deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees would be eliminated, for tax years beginning after Dec. 31, 2012.

**J. Industry-specific revenue raisers.**

1. The following revenue raising changes would be imposed on health related industries:

a. A new deduction limit on executive compensation would apply to insurance providers.

b. If at least 25% of the insurance provider's gross premium income is derived from health insurance plans that meet the minimum essential coverage requirements in the bill ("covered health insurance provider"), an annual \$500,000 per tax year compensation deduction limit would apply for all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider.

2. The limit would apply for remuneration paid in tax years beginning after 2012, with respect to services performed after 2009. Pharmaceutical manufacturers and importers would have to pay an annual flat fee beginning in 2011 allocated across the industry according to market share.

3. The schedule for the flat fee would be: 2011, \$2.5 billion; 2012 to 2016, \$3 billion; 2017, \$4 billion; 2018, \$4.1 billion; 2019 and later, \$2.8 billion.

a. The fee would not apply to companies with sales of branded pharmaceuticals of \$5 million or less.

b. Manufacturers or importers of medical devices would have to pay a 2.3% of the sale price is imposed on the sale of any taxable medical device by the manufacturer, producer, or importer of the device.

4. A taxable medical device would be any device, defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act, intended for humans.

5. The excise tax would not apply to eyeglasses, contact lenses, hearing aids, and any other medical device determined by IRS to be of a type that is generally purchased by the general public at retail for individual use.

6. Health insurance providers would face an annual flat fee on the health insurance sector effective for calendar years beginning after Dec. 31, 2013.

7. The fee would be allocated based on market share of net premiums written for a U.S. health risk for calendar years beginning after Dec. 31, 2012.

8. The schedule for the flat fee would be: 2014, \$8 billion; 2015 and 2016, \$11.5 billion; 2017, \$13.5 billion; 2018, \$14.3 billion and indexed to medical inflation for later years. The fee would not apply to companies whose net premiums written are \$25 million or less.

a. The indoor tanning industry would be hit with a 10% excise tax on indoor tanning services, effective for services provided on or after July 1, 2010.

b. Non-profit Blue Cross Blue Shield organizations would have to maintain a medical loss ratio of 85% or higher in order to take advantage of the special tax benefits provided to them, including the deduction for 25% of claims and expenses and the 100% deduction for unearned premium reserves. The provision is effective in 2010.

## **Iii. Non-Health Related Revenue Raisers**

### **A. Corporate information reporting.**

1. Businesses that pay any amount greater than \$600 during the year to corporate providers of property and services would have to file an information report with each provider and with IRS, effective for payments made after Dec. 31, 2011.

2. Codification of economic substance doctrine and imposition of penalties.

3. The economic substance doctrine is a judicial doctrine that has been used by the courts to deny tax benefits when the transaction generating these tax benefits lacks economic substance.

4. The courts have not applied the economic substance doctrine uniformly.

5. The manner in which the economic substance doctrine should be applied by the courts would be clarified and a penalty would be imposed on understatements attributable to a transaction lacking economic substance.

6. These changes would be effective for transactions entered into after the enactment date.

### **B. Elimination of credit for “black liquor.”**

1. A \$1.01 per gallon tax credit applies for the production of biofuel from cellulosic feedstocks in order to encourage the development of new production capacity for biofuels that are not derived from food source materials.

2. Congress is aware that some taxpayers are seeking to claim the cellulosic biofuel tax credit for unprocessed fuels, such as “black liquor.”

3. For fuel sold or used after Dec. 31, 2009, eligibility for the tax credit would be limited to processed fuels (i.e., fuels that could be used in a car engine or in a home heating application).

### **C. Estimated taxes for large corporations.**

The required corporate estimated tax payments factor for corporations with assets of at least \$1 million would be increased by 15.75 percentage points for payments due in July, August, and September of 2014.

## **IV. Other Tax Changes**

### **A. Simple cafeteria plans for small businesses.**

1. For tax years beginning after 2010, a new employee benefit cafeteria plan to be known as a Simple Cafeteria Plan would be established.

2. This plan would be subject to eased participation restrictions so that small businesses could provide tax-free benefits to their employees; it would include self-employed individuals as qualified employees.

**B. Liberalized adoption credit and adoption assistance rules.**

1. For tax years beginning after Dec. 31, 2009, the adoption tax credit would be increased by \$1,000, made refundable, and extended through 2011.

2. The adoption assistance exclusion also would be increased by \$1,000.

**C. New credit for new therapies.**

Effective for expenses paid or incurred after Dec. 31, 2008, in tax years beginning after that date, a two-year temporary credit would be created, subject to an overall cap of \$1 billion, to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.

**D. New exclusion for certain health professionals.**

1. Payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas would be excluded from gross income, effective for amounts received by an individual in tax years beginning after Dec. 31, 2008.

2. A separate provision would exclude from gross income the value of specified Indian tribal health benefits, effective for benefits and coverage provided after the enactment date.

## **I. Non-Tax Changes Relating to Universal Health Coverage Mandate**

### **A. Introduction.**

1. The *Patient Protection and Affordable Care Act* will ensure that all Americans have access to quality, affordable health care and will create the transformation within the health care system necessary to contain costs.

2. The Congressional Budget Office (CBO) has determined that the *Patient Protection and Affordable Care Act* is fully paid for, ensures that more than 94 percent of Americans have health insurance, bends the health care cost curve, and reduces the deficit by \$118 billion over the next ten years and even more in the following decade.

### **B. Quality, Affordable Health Care for All Americans**

1. The *Patient Protection and Affordable Care Act* includes immediate changes to the way health insurance companies do business to protect consumers from discriminatory practices and provide Americans with better preventive coverage and the information they need to make informed decisions about their health insurance.

2. Uninsured Americans with a pre-existing condition will have access to an immediate insurance program to help them avoid medical bankruptcy and retirees will have greater certainty due to reinsurance provisions to help maintain coverage.

3. New health insurance Exchanges will make coverage affordable and accessible for individuals and small businesses.

4. Premium tax credits and cost-sharing assistance will help those who need assistance.

5. Insurance companies will be barred from discriminating based on pre-existing conditions, health status, and gender.

6. A substantial investment in Community Health Centers will provide funding to expand access to health care in communities where it is needed most.

### **C. The Role of Public Programs**

1. The *Patient Protection and Affordable Care Act* expands eligibility for Medicaid to include all non-elderly Americans with income below 133 percent of the Federal Poverty Level (FPL), with substantial assistance to States for the cost of covering these individuals.

2. The *Patient Protection and Affordable Care Act* maintains current funding levels for the Children's Health Insurance Program (CHIP) for an additional two years, through fiscal year 2015.

#### **D. Improving the Quality and Efficiency of Health Care**

1. Congress is committed to protecting and strengthening the Medicare program for America's seniors.

2. Medicare is a sacred trust with seniors and people with disabilities, and the *Patient Protection and Affordable Care Act* will ensure that trust is preserved.

3. The cost of inaction is unacceptable for seniors and the Medicare program that serves them; without action, the Medicare hospital insurance trust fund is expected to go broke in just over seven years.

4. The *Patient Protection and Affordable Care Act* will make Medicare a stronger, more sustainable program.

5. Medicare currently reimburses health care providers on the basis of the volume of care they provide rather than the value of care.

6. For each test, scan or procedure conducted, Medicare provides a separate payment, rewarding those who do more, regardless of whether the test or treatment contributes to helping a patient recover.

7. The *Patient Protection and Affordable Care Act* includes a number of proposals to move away from the "a la carte" Medicare fee-for-service system toward paying for quality and value and reducing costs to America's seniors.

#### **E. Preventing Chronic Disease and Improving Public Health**

1. The *Patient Protection and Affordable Care Act* promotes preventive health care and improves the public health to help Americans live healthy lives and help restrain the growth of health care costs over time.

2. The *Patient Protection and Affordable Care Act* will eliminate co-pays and deductibles for recommended preventive care, including preventive care for women, provide individuals with the information they need to make healthy decisions, improve education on disease prevention and public health, and invest in a national prevention and public health strategy.

#### **F. Health Care Workforce**

1. Currently, 65 million Americans live in communities where they cannot easily access a primary care provider, and an additional 16,500 practitioners are required to meet their needs.

2. The *Patient Protection and Affordable Care Act* will address shortages in primary care and other areas of practice by making necessary investments in our nation's health care workforce.

3. Specifically, the *Patient Protection and Affordable Care Act* will invest in the National Health Service Corps, scholarship and loan repayment programs to expand the health care workforce.

4. The bill also includes incentives for primary care practitioners and for providers to serve underserved areas.

#### **G. Transparency and Program Integrity**

1. The *Patient Protection and Affordable Care Act* will provide consumers with information about physician ownership of hospitals and medical equipment as well as nursing home ownership and other characteristics.

2. The bill also includes provisions that will crack down on waste, fraud, and abuse in Medicare, Medicaid, CHIP and private insurance.

3. Finally, the *Patient Protection and Affordable Care Act* will establish a private, non-profit entity to identify priorities for and provide for the conduct of comparative outcomes research.

#### **H. Improving Access to Innovative Medical Therapies**

1. The *Patient Protection and Affordable Care Act* will establish a regulatory pathway for FDA approval of biosimilar versions of previously licensed biological products.

2. The Patient Protection and Affordable Care Act will also expand the scope of the existing 340B drug discount program, so that patients at children's hospitals, cancer hospitals, rural hospitals and in other underserved communities have access to medicines at lower cost.

#### **I. Community Living Assistance Services and Supports (CLASS)**

1. The *Patient Protection and Affordable Care Act* will make long-term supports and services more affordable for millions of Americans by providing a lifetime cash benefit that will help people with severe disabilities remain in their homes and communities. CLASS is a voluntary, self-funded, insurance program provided through the workplace.

2. For those whose employers participate, affordable premiums will be paid through payroll deductions. Participation by workers is entirely voluntary.

3. The Congressional Budget Office confirms that the program, which has been revised from earlier versions, is actuarially sound.

#### **J. Revenue Provisions**

1. The *Patient Protection and Affordable Care Act* is fully paid for and reduces the deficit in the next ten years and beyond.
2. The revenue provisions in the bill focus on paying for reform within the health care system.
3. This is accomplished by tightening current health tax incentives, collecting industry fees, and slightly increasing the Medicare Hospital Insurance tax for individuals who earn more than \$200,000 and couples who earn more than \$250,000.
4. This increase will not only help fund health care reform, but, when combined with other provisions in the bill, will also extend the solvency of the Medicare Trust Fund by nine years to 2026.
5. The bill also includes a fee on insurance companies when they sell high cost health insurance plans, designed to generate smarter, more cost-effective health coverage choices.
6. Changes to health care tax incentives include capping FSA contributions, conforming definitions of deductible medical expenses and changing penalties for HSA spending that is not devoted to health care.
7. The industry fees reflect responsible contributions from industries who have long profited from health care and who will benefit from the expanded coverage of millions of additional Americans under health care reform. The bill also assesses a small excise tax on indoor tanning services.
8. Together, these revenue provisions represent a balanced, responsible package of proposals that bend the health care cost curve by putting downward pressure on health spending.

## **II. Quality, Affordable Health Care for All Americans**

### **A. Overview.**

1. The *Patient Protection and Affordable Care Act* will attempt to accomplish a fundamental transformation of health insurance in the United States through shared responsibility.
2. Systemic insurance market reform is aimed at eliminating discriminatory practices by health insurers such as pre-existing condition exclusions.
3. The stated objective of the Act is to achieve reform without increasing health insurance premiums will mean that all Americans must have coverage.
4. Tax credits for individuals, families, and small businesses are enacted to reduce the cost of health insurance.

## **B. Immediate Improvements.**

1. Implementing health insurance reform will take some time. However, many immediate reforms will take effect in 2010.

2. The *Patient Protection and Affordable Care Act* will:

- a. Eliminate lifetime and unreasonable annual limits on benefits, with annual limits prohibited in 2014
- b. Prohibit rescissions of health insurance policies
- c. Provide assistance for those who are uninsured because of a pre-existing condition
- d. Prohibit pre-existing condition exclusions for children
- e. Require coverage of preventive services and immunizations
- f. Extend dependant coverage up to age 26
- g. Develop uniform coverage documents so consumers can make apples-to-apples comparisons when shopping for health insurance
- h. Cap insurance company non-medical, administrative expenditures
- i. Ensure consumers have access to an effective appeals process and provide consumer a place to turn for assistance navigating the appeals process and accessing their coverage
- j. Create a temporary re-insurance program to support coverage for early retirees
- k. Establish an internet portal to assist Americans in identifying coverage options
- l. Facilitate administrative simplification to lower health system costs

## **C. Health Insurance Market Reform.**

1. Beginning in 2014, more significant insurance reforms will be implemented.

2. Across individual and small group health insurance markets in all states, new rules will end medical underwriting and pre-existing condition exclusions.

3. Insurers will be prohibited from denying coverage or setting rates based on gender, health status, medical condition, claims experience, genetic information, evidence of domestic violence, or other health-related factors.

4. Premiums will vary only by family structure, geography, actuarial value, tobacco use, participation in a health promotion program, and age (by not more than three to one).

#### **D. Available Coverage.**

1. A qualified health plan, to be offered through the new American Health Benefit Exchange, must provide essential health benefits which include cost sharing limits.

2. No out-of-pocket requirements can exceed those in Health Savings Accounts, and deductibles in the small group market cannot exceed \$2,000 for an individual and \$4,000 for a family.

3. Coverage will be offered at four levels with actuarial values defining how much the insurer pays: Platinum – 90 percent; Gold – 80 percent; Silver – 70 percent; and Bronze – 60 percent.

4. A less costly catastrophic-only plan will be offered to individuals under age 30 and to others who are exempt from the individual responsibility requirement.

#### **E. American Health Benefit Exchanges.**

1. By 2014, each state will establish an Exchange to help individuals and small employers obtain coverage.

2. Plans participating in the Exchanges will be accredited for quality, will present their benefit options in a standardized manner for easy comparison, and will use one, simple enrollment form. Individuals qualified to receive tax credits for Exchange coverage must be ineligible for affordable, employer-sponsored insurance any form of public insurance coverage.

3. Undocumented immigrants are ineligible for premium tax credits.

4. Federal support will be available for new non-profit, member run insurance cooperatives, and the Office of Personnel Management will supervise the offering by private insurers of multi-State plans, available nationwide.

5. States will have flexibility to establish basic health plans for non-Medicaid, lower-income individuals; states may also seek waivers to explore other reform options; and states may form compacts with other states to permit cross-state sale of health insurance.

6. No federal dollars may be used to pay for abortion services.

#### **F. Making Coverage Affordable.**

1. New, refundable tax credits will be available for Americans with incomes between 100 and 400 percent of the federal poverty line (FPL) (about \$88,000 for a family of four).

2. The credit is calculated on a sliding scale beginning at two percent of income for those at 100 percent FPL and phasing out at 9.8 percent of income at 300-400 percent FPL.

3. If an employer offer of coverage exceeds 9.8 percent of a worker's family income, or the employer pays less than 60 percent of the premium, the worker may enroll in the Exchange and receive credits.

4. Out of pocket maximums (\$5,950 for individuals and \$11,900 for families) are reduced to one-third for those with income between 100-200 percent FPL, one-half for those with incomes between 200-300 percent FPL, and two-thirds for those with income between 300-400 percent FPL.

5. Credits are available for eligible citizens and legally-residing aliens.

6. A new credit will assist small businesses with fewer than 25 workers for up to 50 percent of the total premium cost.

#### **G. Shared Responsibility.**

1. Beginning in 2014, most individuals will be responsible for maintaining minimum essential coverage or paying a penalty of \$95 in 2014, \$495 in 2015 and \$750 in 2016, or up to two percent of income by 2016, with a cap at the national average bronze plan premium.

2. Families will pay half the amount for children up to a cap of \$2,250 for the entire family.

3. After 2016, dollar amounts will increase by the annual cost of living adjustment.

4. Exceptions to this requirement are made for religious objectors, those who cannot afford coverage, taxpayers with incomes less than 100 percent FPL, Indian tribe members, those who receive a hardship waiver, individuals not lawfully present, incarcerated individuals, and those not covered for less than three months.

5. Any individual or family who currently has coverage and would like to retain that coverage can do so under a "grandfather" provision.

6. This coverage is deemed to meet the individual responsibility to have health coverage.

7. Similarly, employers that currently offer coverage are permitted to continue offering such coverage under the "grandfather" policy.

8. Employers with more than 200 employees must automatically enroll new full-time employees in coverage.

9. Any employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit will make a payment of \$750 per full-time employee.

10. An employer with more than 50 employees that offers coverage that is deemed unaffordable or does not meet the standard for minimum essential coverage and but has at least one full-time employee receiving the premium assistance tax credit because the coverage is either unaffordable or does not cover 60 percent of total costs, will pay the lesser of \$3,000 for each of those employees receiving a credit or \$750 for each of their full-time employees total.

### **III. The Role of Public Programs**

#### **A. Overview.**

1. The *Patient Protection and Affordable Care Act* expands eligibility for Medicaid to lower income persons and assumes federal responsibility for much of the cost of this expansion.

2. It provides enhanced federal support for the Children's Health Insurance Program, simplifies Medicaid and CHIP enrollment, improves Medicaid services, provides new options for long-term services and supports, improves coordination for dual-eligibles, and improves Medicaid quality for patients and providers.

#### **B. Medicaid Expansion.**

1. States may expand Medicaid eligibility as early as April 1, 2010.

2. Beginning on January 1, 2014, all children, parents and childless adults who are not entitled to Medicare and who have family incomes up to 133 percent FPL will become eligible for Medicaid. Between 2014 and 2016, the federal government will pay 100 percent of the cost of covering newly-eligible individuals. In 2017 and 2018, states that initially covered less of the newly-eligible population ("Other States") will receive more assistance than states that covered at least some non-elderly, non-pregnant adults ("Expansion States").

3. States will be required to maintain the same income eligibility levels through December 31, 2013 for all adults, and this requirement would be extended through September 30, 2019 for children currently in Medicaid.

#### **C. Children's Health Insurance Program.**

1. States will be required to maintain income eligibility levels for CHIP through September 30, 2019.

2. The current reauthorization period of CHIP is extended for two years, to September 30, 2015.

3. Between fiscal years 2016 and 2019, states would receive a 23 percentage point increase in the CHIP federal match rate, subject to a 100 percent cap.

**D. Simplifying Enrollment.**

1. Individuals will be able to apply for and enroll in Medicaid, CHIP and the Exchange through state-run websites.

2. Medicaid and CHIP programs and the Exchange will coordinate enrollment procedures to provide seamless enrollment for all programs.

3. Hospitals will be permitted to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

**E. Community First Choice Option.**

A new optional Medicaid benefit is created through which states may offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require care in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

**F. Disproportionate Share Hospital Allotments.**

1. States disproportionate share hospital (DSH) allotments are reduced once a state's uninsured rate decreases by 45 percent.

2. The initial reduction for States that spent 99.90 percent of their allotments over the five-year period of 2004 through 2008 would be 50 percent, unless they are defined as low DSH states, in which case they would receive a 25 percent reduction.

3. The initial reduction for states that spent greater than 99.90 percent of their allotments would be 35 percent, or 17.5 percent for low DSH states in this category.

4. As the uninsured rate continues to decline, states' DSH allotments would be reduced by a corresponding amount.

5. At no time could a state's allotment be reduced by more than 50 percent compared to its FY2012 allotment.

**G. Dual Eligible Coverage and Payment Coordination.**

The Secretary of Health and Human Services (HHS) will establish a Federal Coordinated Health Care Office by March 1, 2010 to integrate care under Medicare and Medicaid, and improve

coordination among the federal and state governments for individuals enrolled in both programs (dual eligibles).

## **IV. Improving the Quality and Efficiency of Health Care**

### **A. Overview.**

1. The *Patient Protection and Affordable Care Act* will improve the quality and efficiency of U.S. medical care services for everyone, and especially for those enrolled in Medicare and Medicaid. Payment for services will be linked to better quality outcomes, and the *Patient Protection and Affordable Care Act* will make substantial investments to improve the quality and delivery of care and support research to inform consumers about patient outcomes resulting from different approaches to treatment and care delivery.

2. New patient care models will be created and disseminated, rural patients and providers will see meaningful improvements, and payment accuracy will improve.

3. The Medicare Part D prescription drug benefit will be enhanced and the coverage gap, or donut hole, will be reduced.

4. An Independent Payment Advisory Board will develop recommendations to ensure long-term fiscal stability.

### **B. Linking Payment to Quality Outcomes in Medicare.**

1. A value-based purchasing program for hospitals will launch in FY2013 to link Medicare payments to quality performance on common, high-cost conditions.

2. The Physician Quality Reporting Initiative (PQRI) is extended through 2014, with incentives for physicians to report Medicare quality data – physicians will receive feedback reports beginning in 2012.

3. Long-term care hospitals, inpatient rehabilitation facilities, certain cancer hospitals, and hospice providers will participate quality measure reporting starting in FY2014, with penalties for non-participating providers.

### **C. Strengthening the Quality Infrastructure.**

The HHS Secretary will establish a national strategy to improve health care service delivery, patient outcomes, and population health. The President will convene an Interagency Working Group on Health Care Quality to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.

### **D. Encouraging Development of New Patient Care Models.**

1. A new Center for Medicare & Medicaid Innovation will research, develop, test, and expand innovative payment and delivery arrangements.

2. Accountable Care Organizations (ACOs) that take responsibility for cost and quality of care will receive a share of savings they achieve for Medicare.

3. The HHS Secretary will develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute providers to improve patient care and achieve savings through bundled payments.

4. A new demonstration program for chronically ill Medicare beneficiaries will test payment incentives and service delivery using physician and nurse practitioner-directed home-based primary care teams. Beginning in 2012, hospital payments will be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions.

#### **E. Ensuring Beneficiary Access to Physician Care and Other Services.**

1. The Act extends a floor on geographic adjustments to the Medicare fee schedule to increase provider fees in rural areas and gives immediate relief to areas affected by geographic adjustment for practice expenses.

2. The Act extends Medicare bonus payments for ground and air ambulance services in rural and other areas.

3. The Act creates a 12 month enrollment period for military retirees, spouses (and widows/widowers) and dependent children, who are eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, who have declined Part B.

#### **F. Rural Protections.**

1. The Act extends the outpatient hold harmless provision, allowing small rural hospitals and Sole Community Hospitals to receive this adjustment through FY2010 and reinstates cost reimbursement for lab services provided by small rural hospitals from July 1, 2010 to July 1, 2011.

2. The *Patient Protection and Affordable Care Act* extends the Rural Community Hospital Demonstration Program for five years and expands eligible sites to additional states and hospitals.

#### **G. Improving Payment Accuracy.**

1. The HHS Secretary will rebase home health payments starting in 2014 to better reflect the mix of services and intensity of care provided to patients.

2. The Secretary will update Medicare hospice claims forms and cost reports to improve payment accuracy and revise the underlying payment system to better reflect the cost of providing care to hospice patients.

3. The Secretary will revise Disproportionate Share Hospital (DSH) payments to better account for hospitals' costs of treating the uninsured and underinsured, including adjustments to DSH payments to reflect lower uncompensated care costs resulting from increases in the number of insured patients.

4. The bill also makes changes to improve payment accuracy for imaging services and power-driven wheelchairs.

5. The Secretary will study and report to Congress on reforming the Medicare hospital wage index system and will establish a demonstration program to allow hospice eligible patients to receive all other Medicare covered services during the same period.

#### **H. Medicare Advantage (Part C).**

1. Medicare Advantage (MA) payments will be based on the average of the bids submitted by insurance plans in each market.

2. Bonus payments will be available to improve the quality of care and will be based on an insurer's level of care coordination and care management, as well as achievement on quality rankings.

3. New payments will be implemented over a four-year transition period.

4. MA plans will be prohibited from charging beneficiaries cost sharing for covered services greater than what is charged under fee-for-service.

5. Plans providing extra benefits must give priority to cost sharing reductions, wellness and preventive care prior to covering benefits not currently covered by Medicare.

#### **I. Medicare Prescription Drug Plan Improvements (Part D).**

1. In order to have their drugs covered under the Medicare Part D program, drug manufacturers will provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010.

2. The initial coverage limit in the standard Part D benefit will be expanded by \$500 for 2010.

#### **J. Ensuring Medicare Sustainability.**

1. A productivity adjustment will be added to the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities.

2. The Act creates a 15-member Independent Payment Advisory Board to present Congress with proposals to reduce costs and improve quality for beneficiaries.

3. When Medicare costs are projected to exceed certain targets, the Board's proposals will take effect unless Congress passes an alternative measure to achieve the same level of savings.

4. The Board will not make proposals that ration care, raise taxes or beneficiary premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

#### **K. Health Care Quality Improvements.**

1. The *Patient Protection and Affordable Care Act* will create a new program to develop community health teams supporting medical homes to increase access to community-based, coordinated care.

2. It supports a health delivery system research center to conduct research on health delivery system improvement and best practices that improve the quality, safety, and efficiency of health care delivery.

3. And, it support medication management services by local health providers to help patients better manage chronic disease.

### **V. Prevention of Chronic Disease and Improving Public Health**

#### **A. Overview.**

1. To better orient the nation's health care system toward health promotion and disease prevention, a set of initiatives will provide the impetus and the infrastructure.

2. A new interagency prevention council will be supported by a new Prevention and Public Health Investment Fund. Barriers to accessing clinical preventive services will be removed.

3. Developing healthy communities will be a priority, and a 21st century public health infrastructure will support this goal.

#### **B. Modernizing Disease Prevention and Public Health Systems.**

1. A new interagency council is created to promote healthy policies and to establish a national prevention and health promotion strategy.

2. A Prevention and Public Health Investment Fund is established to provide an expanded and sustained national investment in prevention and public health.

3. The HHS Secretary will convene a national public/private partnership to conduct a national prevention and health promotion outreach and education campaign to raise awareness of activities to promote health and prevent disease across the lifespan.

### **C. Increasing Access to Clinical Preventive Services.**

The Act authorizes important new programs and benefits related to preventive care and services:

1. For the operation and development of School-Based Health Clinics.
2. For an oral healthcare prevention education campaign.
3. To provide Medicare coverage – with no co-payments or deductibles – for an annual wellness visit and development of a personalized prevention plan.
4. To waive coinsurance requirements and deductibles for most preventive services, so that Medicare will cover 100 percent of the costs.
5. To provide States with an enhanced match if the State Medicaid program covers: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) adult immunizations recommended by the Advisory Committee on Immunization Practices without cost sharing.
6. To require Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use.
7. To award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles.

### **D. Creating Healthier Communities.**

1. The Secretary will award grants to eligible entities to promote individual and community health and to prevent chronic disease.
2. The CDC will provide grants to states and large local health departments to conduct pilot programs in the 55-to-64 year old population to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk.
3. The Act authorizes all states to purchase adult vaccines under CDC contracts.
4. Restaurants which are part of a chain with 20 or more locations doing business under the same name must disclose calories on the menu board and in written form.

### **E. Support for Prevention and Public Health Innovation.**

1. The HHS Secretary will provide funding for research in public health services and systems to examine best prevention practices.
2. Federal health programs will collect and report data by race, ethnicity, primary language and any other indicator of disparity.
3. The CDC will evaluate best employer wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion.
4. A new CDC program will help state, local, and tribal public health agencies to improve surveillance for and responses to infectious diseases and other important conditions.
5. An Institute of Medicine Conference on Pain Care will evaluate the adequacy of pain assessment, treatment, and management; identify and address barriers to appropriate pain care; increase awareness; and report to Congress on findings and recommendations.

## **VI. Health Care Workforce**

### **A. Overview.**

1. To ensure a vibrant, diverse and competent workforce, the *Patient Protection and Affordable Care Act* will encourage innovations in health care workforce training, recruitment, and retention, and will establish a new workforce commission. Provisions will help to increase the supply of health care workers.
2. These workers will be supported by a new workforce training and education infrastructure.

### **B. Innovations in the Health Care Workforce.**

1. The *Patient Protection and Affordable Care Act* establishes a National Health Workforce commission to review current and projected workforce needs and to provide comprehensive information to Congress and the Administration to align federal policies with national needs.
2. It will also establish competitive grants to enable state partnerships to complete comprehensive workforce planning and to create health care workforce development strategies.

### **C. Increasing the Supply of Health Care Workers.**

1. The federal student loan program will be modified to ease criteria for schools and students, shorten payback periods, and to make the primary care student loan program more attractive.
2. The Nursing Student Loan Program will be expanded and updated.

3. A loan repayment program is established for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who work in a Health Professional Shortage Area, a Medically Underserved Area, or with a Medically Underserved Population.

4. Loan repayment will be offered to public health students and workers in exchange for working at least three years at a federal, state, local, or tribal public health agency.

5. Loan repayment will be offered to allied health professionals employed at public health agencies or in health care settings located in Health Professional Shortage Areas, Medically Underserved Areas, or with Medically Underserved Populations.

6. A mandatory fund for the National Health Service Corps scholarship and loan repayment program is created. A \$50 million grant program will support nurse-managed health clinics.

7. A Ready Reserve Corps within the Commissioned Corps is established for service in times of national emergency.

8. Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere.

#### **D. Enhancing Health Care Workforce Education and Training.**

New support for workforce training programs is established in these areas:

1. Family medicine, general internal medicine, general pediatrics, and physician assistantship.

2. Rural physicians.

3. Direct care workers providing long-term care services and supports.

4. General, pediatric, and public health dentistry.

5. Alternative dental health care provider.

6. Geriatric education and training for faculty in health professions schools and family caregivers.

7. Mental and behavioral health education and training grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health.

8. Cultural competency, prevention and public health and individuals with disabilities training.
9. Advanced nursing education grants for accredited Nurse Midwifery programs.
10. Nurse education, practice, and retention grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention.
11. Nurse practitioner training program in community health centers and nurse-managed health centers.
12. Nurse faculty loan program for nurses who pursue careers in nurse education.
13. Grants to promote the community health workforce to promote positive health behaviors and outcomes in medically underserved areas through use of community health workers.
14. Fellowship training in public health to address workforce shortages in state and local health departments in applied public health epidemiology and public health laboratory science and informatics.
15. A U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavior health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in affiliated institutions.

**E. Supporting the Existing Health Care Workforce.**

1. The *Patient Protection and Affordable Care Act* reauthorizes the Centers of Excellence program for minority applicants for health professions, expands scholarships for disadvantaged students who commit to work in medically underserved areas, and authorizes funding for Area Health Education Centers (AHECs) and Programs.
2. A Primary Care Extension Program is established to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health.

**F. Strengthening Primary Care and Other Workforce Improvements.**

1. Beginning in 2011, the HHS Secretary may redistribute unfilled residency positions, redirecting those slots for training of primary care physicians.
2. A demonstration grant program is established to serve low-income persons including recipients of assistance under Temporary Assistance for Needy Families (TANF) programs to develop core training competencies and certification programs for personal and home care aides.

3. Also, a grant program is established to provide grant funding and payments to teaching health centers that are focused on training primary care providers in the community. Medicare is also directed to test new models for improving the training of advance practice nurses.

#### **G. Improving Access to Health Care Services.**

1. The *Patient Protection and Affordable Care Act* authorizes new and expanded funding for federally qualified health centers and reauthorizes a program to award grants to states and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment.

2. Also supported are grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.

3. A Commission on Key National Indicators is established.

### **VII. Transparency and Program Integrity**

#### **A. Overview.**

To ensure the integrity of federally financed and sponsored health programs, this Title creates new requirements to provide information to the public on the health system and promotes a newly invigorated set of requirements to combat fraud and abuse in public and private programs.

#### **B. Physician Ownership and Other Transparency.**

1. Physician-owned hospitals that do not have a provider agreement prior to August 2010 will not be able to participate in Medicare.

2. Drug, device, biological and medical supply manufacturers must report gifts and other transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital.

3. Referring physicians for imaging services must inform patients in writing that the individual may obtain such service from a person other than the referring physician, a physician who is a member of the same group practice, or an individual who is supervised by the physician or by another physician in the group.

4. Prescription drug makers and distributors must report to the HHS Secretary information pertaining to drug samples currently being collected internally.

5. Pharmacy benefit managers (PBM) or health benefits plans that provide pharmacy benefit management services that contract with health plans under Medicare or the Exchange must report information regarding the generic dispensing rate; rebates, discounts, or price concessions negotiated by the PBM.

**C. Nursing Home Transparency and Improvement.**

1. The Act requires that skilled nursing facilities (SNFs) under Medicare and nursing facilities (NFs) under Medicaid make available information on ownership. SNFs and NFs will be required to implement a compliance and ethics program.

2. The Secretary of HHS will publish new information on the Nursing Home Compare Medicare website such as standardized staffing data, links to state internet websites regarding state survey and certification programs, a model standardized complaint form, a summary of complaints, and the number of instances of criminal violations by a facility or its employee.

3. The Secretary also will develop a standardized complaint form for use by residents in filing complaints with a state survey and certification agency or a state long-term care ombudsman.

**D. Targeting Enforcement.**

1. The Secretary may reduce civil monetary penalties for facilities that self-report and correct deficiencies.

2. The Secretary will establish a demonstration project to test and implement a national independent monitoring program to oversee interstate and large intrastate chains.

3. The administrator of a facility preparing to close must provide written notice to residents, legal representatives of residents, the state, the Secretary and the long-term care ombudsman program in advance of the closure.

**E. Improving Staff Training.**

Facilities must include dementia management and abuse prevention training as part of pre-employment training for staff.

**F. Nationwide Program for Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers.**

The Secretary will establish a nationwide program for national and state background checks of direct patient access employees of certain long-term supports and services facilities or providers.

**G. Patient-Centered Outcomes Research.**

1. The *Patient Protection and Affordable Care Act* establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private board appointed by the Comptroller General to provide for the conduct of comparative clinical outcomes research.

2. No findings may be construed as mandates on practice guidelines or coverage decisions and important patient safeguards will protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference.

#### **H. Medicare, Medicaid, and CHIP Program Integrity Provisions.**

1. The Secretary will establish procedures to screen providers and suppliers participating in Medicare, Medicaid, and CHIP. Providers and suppliers enrolling or re-enrolling will be subject to new requirements including a fee, disclosure of 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.

2. The Secretary is authorized to deny enrollment in these programs if these affiliations pose an undue risk.

#### **I. Enhanced Medicare and Medicaid Program Integrity Provisions.**

1. CMS will include in the integrated data repository (IDR) claims and payment data from 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).

2. New penalties will exclude individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment.

3. Each violation would be subject to a fine of up to \$50,000. The Secretary may suspend payments to a provider or supplier pending a fraud investigation.

4. Health Care Fraud and Abuse Control (HCFAC) funding will be increased by \$10 million each year for fiscal years 2011 through 2020.

5. The Secretary will establish a national health care fraud and abuse data collection program for reporting adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB).

6. The Secretary will have the authority to disenroll a Medicare enrolled physician or supplier who fails to maintain and provide access to written orders or requests for payment for durable medical equipment (DME), certification for home health services, or referrals for other items and services.

7. The HHS Secretary will expand the number of areas to be included in round two of the DME competitive bidding program from 79 of the largest metropolitan statistical areas (MSAs) to 100 of the largest MSAs, and to use competitively bid prices in all areas by 2016.

#### **J. Additional Medicaid Program Integrity Provisions.**

1. States must terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program.

2. Medicaid agencies must exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

3. Agents, clearinghouses, or other payees that submit claims on behalf of health care providers must register with the state and the Secretary. States and Medicaid managed care entities must submit data elements for program integrity, oversight, and administration.

4. States must not make any payments for items or services to any financial institution or entity located outside of the United States.

#### **K. Additional Program Integrity Provisions.**

1. Employees and agents of multiple employer welfare arrangements (MEWAs) will be subject to criminal penalties if they provide false statements in marketing materials regarding a plan's financial solvency, benefits, or regulatory status.

2. A model uniform reporting form will be developed by the National Association of Insurance Commissioners, under the direction of the HHS Secretary.

3. The Department of Labor will adopt regulatory standards and/or issue orders to prevent fraudulent MEWAs from escaping liability for their actions under state law by claiming that state law enforcement is preempted by federal law.

4. The Department of Labor is authorized to issue "cease and desist" orders to temporarily shut down operations of plans conducting fraudulent activities or posing a serious threat to the public, until hearings can be completed.

5. MEWAs will be required to file their federal registration forms, and thereby be subject to government verification of their legitimacy, before enrolling anyone.

#### **L. Elder Justice Act.**

1. The Elder Justice Act will help prevent and eliminate elder abuse, neglect, and exploitation.

2. The HHS Secretary will award grants and carry out activities to protect individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities.

3. Owners, operators, and employees would be required to report suspected crimes committed at a facility.

4. Owners or operators of such facilities would be required to submit to the Secretary and to the state written notification of an impending closure of a facility within 60 days prior to the closure.

**M. Sense of the Senate Regarding Medical Malpractice.**

The Act 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.

## **VIII. Improving Access to Innovative Medical Therapies**

**A. Biologics Price Competition and Innovation.**

1. The *Patient Protection and Affordable Care Act* establishes a process under which FDA will license a biological product that is shown to be biosimilar or interchangeable with a licensed biological product, commonly referred to as a reference product.

2. No approval of an application as either biosimilar or interchangeable is allowed until 12 years from the date on which the reference product is first approved.

3. If FDA approves a biological product on the grounds that it is interchangeable to a reference product, HHS cannot make a determination that a second or subsequent biological product is interchangeable to that same reference product until one year after the first commercial marketing of the first interchangeable product.

**B. More Affordable Medicines for Children and Underserved Communities:**

Drug discounts through the 340B program are extended to inpatient drugs and also to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers.

## **IX. Community Living Assistance Services and Supports**

**A.** The *Patient Protection and Affordable Care Act* establishes a new, voluntary, self-funded long-term care insurance program, the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations.

**B.** The HHS Secretary will develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides a cash benefit that is not less than an average of \$50 per day.

C. No taxpayer funds will be used to pay benefits under this provision.

## **X. STRENGTHENING QUALITY, AFFORDABLE CARE**

Title X made many improvements to the preceding nine titles, and descriptions of those changes are included above. Changes included in Title X that do not amend previous titles are described below.

### **A. Coverage Improvements.**

1. Requires employers that offer and make a contribution towards employee coverage to provide free choice vouchers to qualified employees for the purchase of qualified health plans through Exchanges.

2. Requires the Secretary to consult stakeholders and the National Committee on Vital and Health Statistics and the Health Information Technology Standards and Policy Committees to identify opportunities to create uniform standards for financial and administrative health care transactions, not already named under HIPAA, that would improve the operation of the health system and reduce costs.

### **B. Improvements in the Role of Public Programs.**

Creates financial incentives, including Federal Medical Assistance Percentage (FMAP) increases, for States to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). Establishes a Pregnancy Assistance Fund for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women, with a matching requirement.

### **C. Indian Health Care Improvement.**

Authorizes appropriations for the Indian Health Care Improvement Act, including programs to increase the Indian health care workforce, new programs for innovative care delivery models, behavioral health care services, new services for health promotion and disease prevention, efforts to improve access to health care services, construction of Indian health facilities, and an Indian youth suicide prevention grant program.

### **D. Medicare Improvements.**

1. Makes improvements to Medicare beneficiary services, including coverage for individuals exposed to environment health hazards, prescription drug review through medication therapy management programs, development of a "Physician Compare" website to help beneficiaries learn more about their doctors, and a study on beneficiary access to dialysis services.

2. Medicare payment changes include financial protections for states in which at least 50 percent of counties are frontier, an additional 0.5 percent bonus for physicians who report quality measures, delay of certain skilled nursing facility "RUGs-IV" payment changes, authority for the Secretary of HHS to test value-based purchasing programs for certain providers, and

authorization for release and use of certain Medicare claims data to measure provider and supplier performance in a way that protects patient privacy.

3. Other changes in this section include grants to develop networks of providers to deliver coordinated care to low-income populations, a requirement for the Secretary of HHS to develop a methodology to measure health plan value and to develop a plan to modernize computer and data systems at the Centers for Medicare & Medicaid Services, codification of the Office of Minority Health and elevation of the National Center on Minority Health and Health Disparities at NIH to the Institute level.

## IX. REVENUE PROVISIONS

**A. Excise Tax on High Cost Employer-Sponsored Health Coverage.** The *Patient Protection and Affordable Care Act* levies a new excise tax of 40 percent on insurance companies or plan administrators for any health coverage plan with an annual premium that is above the threshold of \$8,500 for single coverage and \$23,000 for family coverage. The tax applies to self-insured plans and plans sold in the group market, and not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). The tax applies to the amount of the premium in excess of the threshold. A transition rule increases the threshold for the 17 highest cost states for the first three years. An additional threshold amount of \$1,350 for singles and \$3,000 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

**B. Increasing Transparency in Employer W-2 Reporting of Value of Health Benefits.** This provision requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

**C. Distributions for Medicine Qualified Only if for Prescribed Drug or Insulin.** Conforms the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the definition used for the medical expense itemized deduction. Over-the-counter medicine obtained with a prescription continues to qualify as qualified medical expenses.

**D. Increase in Additional Tax on Distributions from HSAs and Archer MSAs Not Used for Qualified Medical Expenses.** Increases the additional tax for HSA withdrawals prior to age 65 that are used for purposes other than qualified medical expenses from 10 percent to 20 percent and increases the additional tax for Archer MSA withdrawals from 15 percent to 20 percent.

**E. Limiting Health FSA Contributions.** This provision limits the amount of contributions to health FSAs to \$2,500 per year, indexed to CPI-U for years after December 31, 2011.

**F. Corporate Information Reporting.** This provision requires businesses that pay any amount greater than \$600 during the year to corporate providers of property and services to file an information report with each provider and with the IRS.

**G. Non-profit Hospitals.** This provision would establish new requirements applicable to nonprofit hospitals. The requirements would include a periodic community needs assessment.

- H. Pharmaceutical Manufacturers Fee.** This provision imposes an annual flat fee of \$2.3 billion on the pharmaceutical manufacturing sector beginning in 2010 allocated across the industry according to market share. The fee does not apply to companies with sales of branded pharmaceuticals of \$5 million or less.
- I. Medical Device Manufacturers Fee.** This provision imposes an annual fee of \$2 billion in years 2011 through 2017 and \$3 billion in years thereafter on the medical device manufacturing sector. The fee is allocated across the industry according to market share. The fee does not apply to companies with sales of medical devices in the U.S. of \$5 million or less. The fee also does not apply to any sale of a Class I product or any sale of a Class II product that is primarily sold to consumers at retail for not more than \$100 per unit (under the FDA product classification system).
- J. Health Insurance Provider Fee.** This provision imposes an annual fee on the health insurance sector allocated across the industry according to market share. The fee will be \$2 billion for 2011, \$4 billion for 2012, \$7 billion for 2013, \$9 billion for years 2014 through 2016, and \$10 billion for years after 2016. The fee does not apply to companies whose net premiums written are \$25 million or less, and there is a limited exemption from the fee for certain non-profit insurers with a medical loss ratio (MLR) of 90 percent or more in the individual, small group and large group markets and whose overall MLR is at least 92 percent.
- K. Department of Veterans Affairs Report.** The Secretary of the U.S. Department of Veterans Affairs will review and report to Congress on the effect that the fees assessed on pharmaceutical and medical device manufacturers and health insurance providers have on the cost of medical care provided to veterans and veterans' access to medical devices and branded drugs.
- L. Eliminating the Deduction for Employer Part D Subsidy.** This provision eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.
- M. Modification of the Threshold for Claiming the Itemized Deduction for Medical Expenses.** This provision increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent. Individuals age 65 and older would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.
- N. Executive Compensation Limitations.** This provision limits the deductibility of executive compensation for insurance providers if at least 25 percent of the insurance provider's gross premium income is derived from health insurance plans that meet the minimum essential coverage requirements in the bill ("covered health insurance provider"). The deduction is limited to \$500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider.

- O. Additional Hospital Insurance Tax for High Wage Workers.** The provision increases the hospital insurance tax rate by 0.9 percentage points on an individual taxpayer earning over \$200,000 (\$250,000 for married couples filing jointly).
- P. Special Deduction for Blue Cross Blue Shield (BCBS).** Requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves.
- Q. Indian Tribal Health Services.** The provision would provide an exclusion from gross income for the value of specified Indian tribal health benefits.
- R. Simple Cafeteria Plans for Small Businesses.** This provision would establish a new employee benefit cafeteria plan to be known as a Simple Cafeteria Plan. This eases the participation restrictions so that small businesses can provide tax-free benefits to their employees and it includes self-employed individuals as qualified employees.
- S. Credit to Encourage Investment in New Therapies.** This provision creates a two-year temporary tax credit subject to an overall cap of \$1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.

**Public Health Program Improvements.** Directs the Secretary of HHS to develop a national report card on diabetes to be updated every two years, and to work with States to improve data collection related to diabetes and other chronic diseases. Authorizes grants for small businesses to provide comprehensive workplace wellness programs. Authorizes the Cures Acceleration Network, within the National Institutes of Health (NIH), to award grants and contracts to develop cures and treatments of diseases. Directs the Administrator of the Substance Abuse and Mental Health Services Administration to award grants to centers of excellence in the treatment of depressive disorders. Allows the Secretary of HHS to enhance and expand existing infrastructure to track the epidemiology of congenital heart disease. Amends and reauthorizes the Automated Defibrillation in Adam's Memory Act. Directs the Secretary of HHS to develop a national education campaign for young women and health care professionals about breast health and risk factors for breast cancer.

**Workforce Improvements.** Authorizes grants for medical schools to establish programs that recruit students from underserved rural areas who have a desire to practice in their hometowns. Amends and reauthorizes the preventive medicine and public health residency program. Improves the National Health Service Corps program by increasing the loan repayment amount, allowing for half-time service, and allowing for teaching to count for up to 20 percent of the Corps service commitment. Provides funding to HHS for construction or debt service on hospital construction costs for a new health facility meeting certain criteria. Establishes a Community Health Centers and National Health Service Corps Fund. Directs the Secretary of HHS to establish a 3-year demonstration project in States to provide comprehensive health care services to the uninsured at reduced fees.

**Transparency and Program Integrity Improvements.** Enhances the fraud sentencing guidelines, changes the intent requirement for fraud under the anti-kickback statute, and increases subpoena authority relating to health care fraud. Authorizes grants to States to test alternatives to civil tort litigation that emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes, and allow patients to opt-out of these alternatives at any time. The Secretary of HHS would be required to conduct an evaluation to determine the effectiveness of the alternatives. Extends the protections from liability contained in the Federal Tort Claims Act to free clinics. Modifies requirements applicable to the labeling of generic drugs.

**Revenue Changes.** Imposes a ten percent tax on amounts paid for indoor tanning services for services provided on or after July 1, 2010. Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. Increases the adoption tax credit and adoption assistance exclusion (\$12,170 for 2009) by \$1,000, and makes the credit refundable. The credit is extended through 2011.

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